

**NGO Parallel Report on the
Republic of Estonia's Third Report
on the Implementation of the
International Covenant on Economic, Social and
Cultural Rights**

Submitted to the

UN Committee on Economic, Social and Cultural Rights

for consideration in the formulation of the

List of Issues during the 62nd Pre-Sessional Working Group (03 – 06 April 2018)

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ESTONIA – EXECUTIVE SUMMARY

This “Parallel Report” is to assist the Committee on Economic, Social and Cultural Rights in the formulation of the List of Issues during the 62nd Pre-Sessional Working Group (03 April 2018 – 06 April 2018), leading to the discussion of Estonia’s Third Periodic Reports on its implementation of the Covenant on Economic, Social and Cultural Rights.

Since accession to the European Union, in 2004, Estonia has become a Research & Development power-house. Despite its small size (the 4th smallest state in the EU by size, with only 1.3 million inhabitants), Estonia maintains a well-established economy, characterized by strong investment in Research & Development, and a renowned presence in the fields of biomedicine and biotechnology. Yet, unseized opportunities in fields such as human Embryonic Stem Cells (hESC), artificial reproductive technologies (ART), and reproductive medicine in general hinder its capacity to fully comply with its obligation to “take the steps necessary for the conservation, the development and the diffusion of science and culture,” as required by Article 15.2 of the Covenant. The rights to science (Art. 15), health (Art. 12), and family (Art. 10) are human rights directly affected by emerging medicine, science, and technology. Estonia’s Periodic Report to the Committee is silent on these issues entirely and the Committee has a chance to fill this gap by asking specific questions during the upcoming preparation of the List of Issues.

Estonia recognizes that biotechnology and biomedicine – specifically human Embryonic Stem Cells (hESC) research and research on assisted reproductive technologies and medicine – are promising fields for investment. Yet, although Estonia permits research on hESC and assisted reproductive technologies, it lacks a comprehensive, legal framework to regulate properly these practices. Estonia’s domestic laws regulate the creations and use of embryos as well as permit embryos to be donated and used for scientific research. However, Estonia has not enacted any domestic laws to address specifically the actual hESC research methods nor the prospective medicines and treatments that may result from those methods. The lack of specific legal framework within which scientists in Estonia can operate with confidence is a hindrance to the development of biotechnology and biomedicine.

Alarmingly, Estonia continues prohibiting the practice of surrogacy entirely. As a result, women incapable of bearing children, homosexual couples, and prospective parents finding surrogacy

as the safest and most viable method of having a biological offspring are denied the medical procedure altogether.

Although Estonia does not criminalize nor penalize women, doctors, or health care providers for participating in an abortion procedure, the requirement for three doctors' approval in select cases may be an arduous obstacle to overcome especially for teenagers and women living in rural areas.

Although this Committee, as well as the Committee on Elimination of Discrimination against Women, persistently urge Estonia to address accessibility to contraception among rural women and teenagers, Estonia's country report remains silent on this issue. Access to contraceptives remains difficult for teenagers and adults in rural areas.

Until Estonia makes contraceptives accessible to all teenagers and adults, regardless of gender or geographical location, removes arduous obstacles for women seeking an abortion, addresses the causes of teenage pregnancy, and increases its investment in research on reproduction and gender-specific needs, it will not adequately meet the rights to reproductive autonomy, to family, to health, and to science.

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PURPOSE OF THE REPORT

1. The purpose of this “Parallel Report” is to assist the Committee on Economic, Social and Cultural Rights in the formulation of the List of Issues during the 62nd Pre-Sessional Working Group (03 April 2018 – 06 April 2018), leading to the discussion of Estonia’s Third Periodic Reports on its implementation of the Covenant on Economic, Social and Cultural Rights.

2. The Republic of Estonia acceded the Covenant on Economic, Social and Cultural Rights (hereinafter “CESCR” or “Covenant”) on 21 October 1991, and it entered into force in respect to Estonia on 21 January 1992.¹ Its last periodic review (2nd) was completed in 2011. It is currently undergoing its 3rd periodic review.

3. Estonia’s 3rd periodic report, published on 29 September 2017, has several lacunae.² Under Article 10 (“Right to Family Life”), it discusses the exploitation of children, domestic violence, and human trafficking. It does not, however, address access to Assisted Reproductive Technology (ART), surrogacy, abortion, or contraception. Abortion is briefly discussed under Article 12 (“Right to Health”) in the context of teenage pregnancy and the overall decline of abortion nationwide by 40% from 2006 to 2014. The report dedicates an Article 12 discourse primarily to the health of elderly people, water quality, alcohol consumption, drug use, tuberculosis, and mental health. It does not discuss, however, the limitations Estonia imposes on research on human Embryonic Stem Cells (hESC), Assisted Reproductive Technology (ART) including surrogacy, or the accessibility to abortion and contraception – which are all issues that directly affect the rights to health and family. Finally, under Article 15 (“Right to Benefit from Scientific and Technological Progress” and the “Rights of Science”), Estonia reports on cultural accessibility including the digitalization of culture, the protection of cultural rights of elderly people and individuals with special needs, the cultural inclusion of disadvantaged and excluded persons; the preservation of cultural identity of ethnic minorities situated within the legal framework; and scientific research including research financing, intellectual property, promoting scientific values and education via mass media, and overall support and publicizing of science. Notwithstanding, a dialogue on Estonia’s lack of legislation on human Embryonic Stem Cell

¹ International Covenant on Economic, Social and Cultural Rights, art. 15(1)(b), Dec. 16, 1966, S. Treaty Doc. No. 95-19, 6 I.L.M. 360 (1967), 993 U.N.T.S. 3 [hereinafter CESCR]. *States Party to the International Covenant on Economic, Social and Cultural Rights*, United Nations Treaty Collection, https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-3&chapter=4&clang=en. (last visited 14 Dec. 2017).

² U.N. Economic and Social Council, *Third Periodic Report Submitted by Estonia under articles 16 and 17 of the Covenant, due in 2016*, UN Doc. E/C.12/EST/3, (29 Sep. 2017).

(hESC) research and deficient investment on research and developing Artificial Reproductive Technologies (ART) will reveal consequent impacts on the nation, especially in the context of science, fertility rates, and human rights. This report complements Estonia's report to enable the Honorable Committee to form a clearer picture of how Estonia is discharging its obligations under Articles 10, 12, and 15 of the Covenant.

ABOUT THE AUTHORS OF THIS REPORT AND SOURCES

4. This report has been prepared by Alda Merino-Caan, JD Candidate 2019, of the International Human Rights Clinic of Loyola Law School, Los Angeles, under the supervision of Professors Cesare Romano and Mary Hansel, and by the Luca Coscioni Association for the Freedom of Scientific Research.

5. The International Human Rights Clinic of Loyola Law School, Los Angeles is committed to achieving the full exercise of human rights by all persons, and seeks to maximize the use of international and regional political, judicial, and quasi-judicial bodies through litigation, advocacy, and capacity-building.³ Loyola Law School, Los Angeles is the school of law of Loyola Marymount University, a Jesuit university.

6. The Luca Coscioni Association for the Freedom of Scientific Research is a non-profit organization comprised of members of parliament, academics, researchers and students, along with representatives of patients and advocacy associations. The Luca Coscioni Association promotes the freedom of scientific research and treatment as well as the civil and political rights of patients and people with disabilities. It was founded in 2002 by Dr. Luca Coscioni, an Italian economist affected by Amyotrophic Lateral Sclerosis, who launched a national campaign to promote freedom of scientific research on embryonic stem cells.⁴ Since its foundation, the Association has been active on a range of issues, including the rights of persons afflicted with illness and disabilities, the right to die, reproductive health, and freedom of scientific research.

7. The World Congress for Freedom of Scientific Research is a permanent forum of activities to promote freedom of scientific research worldwide. Since the founding session of the Word

³ See *International Human Rights Clinic*, Loyola Law School, Los Angeles, <http://www.lls.edu/academics/experientiallearning/clinics/socialcriminaljusticeclinics/internationalhumanrightsclinic/> (last visited 11 Dec. 2017).

⁴ See Luca Coscioni Association, <http://www.associazionelucacoscioni.it> (last visited 11 Dec. 2017).

Congress, in October 2004, the Luca Coscioni Association is the Operational Secretariat of the World Congress.

8. The Research and Self Determination Index is one of the main projects of the World Congress for Freedom of Scientific Research.⁵ First published in 2014, the Index is a tool for comparative assessment of the degree to which researchers, health care professionals and patients enjoy the right to science around the globe. It measures key legal and regulatory indicators of the right to science in four areas: Assisted Reproduction Technologies (ART); research with human Embryonic Stem Cells (hESC); End-of-Life decisions; and Abortion and Contraception (A&C). For each indicator, points are allocated with highest score allotted to legal environments that recognize the right to science to the greatest degree.⁶ Currently, 46 countries are indexed. At least 80% of data are complete for these countries. In particular, Estonia's A&C data is complete.

9. Statistics Estonia (SE) is a government agency in the area of administration of the Ministry of Finance.⁷ SE is tasked with providing public institutions, business and research circles, international organizations with reliable and objective information and analytical overviews.⁸ SE complies with the Official Statistics Act and is guided by the principles of impartiality, reliability, relevancy, profitability, confidentiality and transparency.⁹ The agency also cooperates with the Statistical Office of the European Communities (Eurostat), the United Nations Economic Commission for Europe (UNECE), the Organization for Economic Cooperation and Development (OECD), Eesti Pank (central bank of Estonia), the University of Tartu, ministries, county governments and local governments.¹⁰

10. Eesti Pank is the central bank of Estonia and the primary agency, besides Statistics Estonia, that conducts official statistics in Estonia. It is compliant with the Official Statistics Act and statistical standards of the European System of Central Banks (ESCB).¹¹ Eesti Pank cooperates with the International Monetary Fund (IMF) as well as participates in the work of the Bank for International Settlements (BIS) and the Organization for Economic Cooperation and development (OECD).¹² It

⁵ See *Research and Self Determination Index*, World Congress for Freedom of Scientific Research, <http://www.freedomofresearch.org/research-and-self-determination-index> (last visited 11 Dec. 2017).

⁶ See *id.* ("If data are not available, the answer is not included in the calculation.")

⁷ See *About Statistics Estonia*, Statistics Estonia, <http://www.stat.ee/en> (last visited 11 Dec. 2017).

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ See *Statistics*, Eesti Pank, <https://www.eestipank.ee/en/statistics> (last visited 11 Dec. 2017).

¹² See *International Cooperation*, Eesti Pank, <https://www.eestipank.ee/en/eesti-pank/international-cooperation> (last visited 11 Dec. 2017).

also works closely with other European national central banks and the European Central Bank. It participates in the working groups of the Council of the European Union and of the European Commission and in the European Banking Authority's (EBA) Board of Supervisors as an observer.¹³

11. "Knowledge-Based Estonia 2007-2013" is Estonia's research, development and innovation strategy.¹⁴ It launched the thematic state Research and Development programme "Estonian Biotechnology Programme (EBP)" to contribute to the development of biotechnology in Estonia.¹⁵

BACKGROUND

12. The Republic of Estonia is a European country, on the shores of the Baltic Sea. It has been a member of the United Nations since 17 September 1991 and a member of the European Union since 1 May 2004.¹⁶ With just 1,316,000 inhabitants, it is the fourth smallest country in the EU after Malta, Luxembourg, and Cyprus.¹⁷ The population of Estonia has been on the decline due to external migration and a negative natural increase.¹⁸ In 2016, the total fertility rate based on the number of children per woman was 1.6.¹⁹

13. In the International Monetary Fund's 2017 Country Report, it noted Estonia's "sound economic and institutional fundamentals, [includes] one of the strongest public finances in Europe and a business-friendly environment."²⁰ Notwithstanding its sluggish growth in 2016 estimated at 1.3%, the IMF expected this year's growth to reach 2.3% and 2.8% in 2018. The World Bank reported Estonia's 2016 GDP as US \$23.137 billion which was an increase from 2015's GDP at US \$22.46 billion.²¹ According to *Statistics Estonia*, the expenditure on research and development (R&D) in

¹³ *Id.*

¹⁴ Estonian Biotechnology Programme, *Feasibility study for an Estonian biotechnology programme: Final Report*, 3, (2010). https://www.mkm.ee/sites/default/files/inno_13.pdf (last visited 11 Dec. 2017).

¹⁵ *Id.*

¹⁶ Statistics Estonia, *Minifacts about Estonia 2017*, 2, (2017).

<https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=5&ved=0ahUKEwiD5ou5yoyYAhVRwmMKHachBsMQFghSMAQ&url=https%3A%2F%2Fwww.stat.ee%2Fpopulation&usq=AOvVaw2JV63nIm3ufPyRG0qAZij6> (last visited 12 Dec. 2017).

¹⁷ *Id.* at 4-10.

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ International Monetary Fund, *IMF Executive Board Concludes 2016 Article IV Consultation with the Republic of Estonia*, Press Release No. 17/10 (2017). <https://www.imf.org/en/Publications/CR/Issues/2017/01/13/Republic-of-Estonia-Selected-Issues-44525> (last visited 11 Dec. 2017).

²¹ The World Bank, *Estonia*, Country Profile Data, (2017). <https://data.worldbank.org/country/estonia> (last visited 11 Dec. 2017).

Estonia amounted to 270.3 million euros in 2016.²² 38% of R&D expenditure came from the 2016 State Budget.²³ UNESCO reported that, from 2006 – 2015, the government consistently provided 44.5% - 46.4% of the State's Gross Domestic Expenditure on R&D (GERD).²⁴ Estonia's business R&D expenditure is on an upward trend “suggesting new potential for better innovation performance.”²⁵

14. Estonia's research, development and innovation strategy “Knowledge-Based Estonia 2007-2013” launched the Estonian Biotechnology Programme (EBP). EBP is a research and development program designed to contribute to the development of biotechnology in Estonia. EBP highlighted biotechnology “as the strategic key technology that has a potentially significant impact on Estonian economy.”²⁶ Agriculture (plant and animal breeding technologies) and the healthcare industry (therapeutic products, diagnostics, and drug discovery technologies) are among the biotechnological applications with the highest potential.²⁷

15. Estonia's agricultural field incorporates animal breeding which “started with the crossing of chosen parents and the selection of the offspring.”²⁸ Because animal reproductive medicine (such as *in vitro* fertilization) continue to advance the field, the “most important biotechnology techniques include: [DNA] marker assisted selection, cloning and the production of the transgenic animals.”²⁹ Notably, the EBP recognizes that “the greatest part of the transgenic animal research for the commercial use is in the field of human medicine, for the production of drugs.”³⁰ According to the EBP, Estonia's potential for future progress and implementation existed in the following products and services: artificial insemination stations, import & export of the semen of genetically improved breeds, as well as semen and embryo banks of the Estonian breeds.³¹ Estonia's reproductive medicine research projects “are concerned with the development of the fertility monitoring tests, reproductive

²² See Statistics Estonia, *Expenditure on research and development decreased last year*, News Release No. 128, (2017), <https://www.stat.ee/news-release-2017-128> (last visited 11 Dec. 2017).

²³ *Id.*

²⁴ UNESCO, *Science, Technology and Innovation: Expenditure on R&D*, Institute for Statistics, (2017). <http://uis.unesco.org/en/country/EE?theme=science-technology-and-innovation> (last visited 11 Dec. 2017).

²⁵ European Commission, *Country Report Estonia 2017*, Communication from the Commission of the European Parliament, the Council, the European Central Bank and the Eurogroup, 2, (2017). <https://ec.europa.eu/info/sites/info/files/2017-european-semester-country-report-estonia-en.pdf> (last visited 11 Dec. 2017).

²⁶ Estonian Biotechnology Programme, *Feasibility study for an Estonian biotechnology programme: Final Report*, 3, (2010). https://www.mkm.ee/sites/default/files/inno_13.pdf (last visited 11 Dec. 2017).

²⁷ *Id.*

²⁸ *Id.* at 21.

²⁹ *Id.*

³⁰ *Id.*

³¹ *Id.* at 23.

pathologies and cloning technologies [including]: bull semen fertility tests, development of the laboratory test packages for the [artificial insemination] industry; evaluation of the affectivity of automatic estrus detection systems; development of the cytological tests for the diagnosis of uterine inflammatory conditions; embryo transfer, *in vitro* embryo production, [and] embryo viability testing.”³² Within this field, Estonia leads research on the diagnostic tests and cattle cloning and is competent in diagnostics, genetics, and bioinformatics.³³

16. The EBP notes that the demand for human *in vitro* fertilization (IVF) treatment has risen over the past three decades.³⁴ It consequently recognizes the “opportunity to increase the size of the IVF market by including homosexual couples and single mothers.”³⁵ According to the EBP, “[a]most two-thirds of [ovary stimulation] cycles are still performed with fresh, as opposed to frozen embryos.”³⁶ While techniques of preserving embryos continue to improve, country-specific regulation against cryopreservation is a perceived threat to this [global] market.³⁷ Additionally, reproductive medicine must balance new treatment guidelines with the safety of the procedure, pregnancy rates, and the number of cycles required to occur in order for the IVF to be successful.³⁸ While reproductive medicine is a narrower subset of therapeutic development, the EBP realizes its capability of attracting mid-size pharmaceutical companies such as Organon and Feering and even larger pharmaceutical companies such as Merck Serono and Sanofi-Aventis.³⁹ Ultimately, the EBP emphasizes the “niche opportunity around reproductive medicine to explore further under a [regional] market” that includes Estonia, the Baltic countries, and proximal Russia.⁴⁰

17. In 2009, the EBP prioritized the country’s biomedicine sector to “increase the capacity of export and business development,” “enter into cooperation agreements with international MBA programmes, which would allow biotechnology thematic modules to be passed by distance learning or in short study stints abroad,” and “to make this study opportunity available to the heads of biotechnology companies.”⁴¹ The EBP identified Estonia’s strengths in biomedicine including two

³² *Id.* at 24.

³³ *Id.*

³⁴ *Id.* at 66.

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.* at 68.

⁴⁰ *Id.* at 72.

⁴¹ Estonian Biotechnology Programme, *Approved by the resolution of the BTP steering committee meeting, 7 Dec. 2009*, 18, (2009). <https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=7&cad=rja&uact=8&ved=0ahUKEwjXsbzMpojYAhVKw2MKHR1bB->

state-of-the-art international research centres engaged in industry-leading research – the State-of-the-art centre for transfer medicine (virology, immunology, clinic metabolomics, molecular pathology etc.) and the State-of-the-art centre for genomics – and two Competence Centres that are engaged in industrial research proceeding from the Estonian companies’ interests – Competence Centre for Reproductive Medicine and Biology Technology (human fertility medicine diagnostics, reproductive technologies) and Competence Centre for Cancer Research (development of cancer drugs, development and implementation of technologies for the early diagnosis of cancer and prognosis).⁴² It also recognized three leading universities: Tallinn University of Technology, the University of Tartu’s Institute of Molecular and Cellular Biology and Tartu University Hospital, and the Estonian University of Life Sciences.⁴³ Furthermore, as another strength, it acknowledged that Estonia is home to “researchers recognized on a high international level and their research groups.”⁴⁴

18. The EBP, however, also identified three weakness areas: small number of patent applications and specific patent knowledge, lack of venture capital targeted at biomedicine, and small size of companies and limited material resources.⁴⁵

19. Despite its size, Estonia maintains a well-established economy, continued investment in research and development, and a renowned presence in the fields of biomedicine and biotechnology. Yet, its unseized opportunities in fields such as human embryonic stem cell research, artificial reproductive technologies, and reproductive medicines hinder its development. Because of Estonia’s reluctance to pursue such scientific fields, it is unable to adequately take the steps “necessary for the conservation, the development and the diffusion of science and culture.”⁴⁶

20. Although this Committee as well as the Committee on Elimination of Discrimination against Women persistently urges Estonia to address accessibility to contraception among rural women and teenagers, Estonia’s country report remains silent on these issues. In addition to the *in vitro* fertilization market – which was identified by the EBP as an opportunity to extend the benefits of science to homosexual couples and single mothers – Estonia may look to surrogacy as another

[oQFghOMAY&url=https%3A%2F%2Frio.jrc.ec.europa.eu%2Fen%2Ffile%2F8351%2Fdownload%3Ftoken%3D9F0mthY&usg=AOvVaw2WpA-yimz0hROcyJw7R7Dv](https://www.frio.jrc.ec.europa.eu/file/F8351/download?token=3D9F0mthY&usg=AOvVaw2WpA-yimz0hROcyJw7R7Dv) (last visited 12 Dec. 2017).

⁴² *Id.* at 19-20.

⁴³ *Id.* at 20.

⁴⁴ *Id.*

⁴⁵ *See Id.* (citing Ernst & Young, *Feasibility Study for an Estonian Biotechnology Programme*, (2009)).

⁴⁶ ICESCR. Art. 15, para 2. (“The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for the conservation, the development and the diffusion of science and culture.”).

method of ensuring the rights to family, health and science for homosexual couples and women unable to bear children.

21. This Report is a tool for this Honorable Committee to employ in identifying gaps in Estonia's attempt to fulfill its obligations under the Covenant, specifically the protected human right to "take part in cultural life [and] enjoy the benefits of scientific progress and its applications" under Article 15 of the Covenant.⁴⁷

RESEARCH WITH HUMAN EMBRYONIC STEM CELLS (hESC)

Research with human embryonic stem cells (hESC) in Estonia

22. In comparison to other countries that have adopted public policies on embryonic, stem cell, and cloning research, Estonia is relatively intermediate on the spectrum of public policies.⁴⁸ Estonia's adopted policies allow research on human gametes, embryos, and supernumerary embryos as well as the procurement of hESC lines. Human embryonic research, however, is only permitted when approved by one of the two Committees of Bioethics: the Tallinn Medical Research Ethics Committee at the National Institute for Health Development and the Ethics Review Committee on Human Research of the University of Tartu.⁴⁹ Yet, Estonia lacks any specific law that regulates the research on human stem cells.

23. Estonia's "Procurement, Handling and Transplantation of Cells, Tissues and Organs Act" (Rakkude, kudede ja elundite hankimise, käitlemise ja siirdamise seadus) establishes a "transplantation infrastructure" in which a "national system of procurement, handling and transplantation of cells, tissues and organs" is created.⁵⁰ The infrastructure consists of a transplantation council, national transplantation agency, transplantation centres, the procurers and handlers of cells, tissues and organs, the Estonian Health Insurance Fund, the State Agency of Medicines, the Health

⁴⁷ ICESCR. Art. 15, para 1, subsection (a)-(b). ("1. The States Parties to the present Covenant recognize the right of everyone: (a) To take part in cultural life; (b) To enjoy the benefits of scientific progress and its applications.")

⁴⁸ Rosario M. Isasi and Bartha M. Knopper, *Beyond the permissibility of embryonic and stem cell research: substantive requirements and procedural safeguards*, Human Reproduction, Vol. 21, Issue 10, 2474-2481, (1 Oct. 2006). <https://doi.org/10.1093/humrep/del235> (last visited 11 Dec. 2017).

⁴⁹ Tiina Titma, *Regulation of stem cell research in Estonia, Euro Stem Cell, Policy & Regulation*, EuroStemCell, Policy & Regulation, <https://www.eurostemcell.org/regulation-stem-cell-research-estonia> (last visited 13 Dec. 2017).

⁵⁰ *Procurement, Handling and Transplantation of Cells, Tissues and Organs Act*, RI I, 26 Feb. 2015, Art. 5, para. 1, (29 Jan. 2015). ("The transplantation infrastructure means the national system of procurement, handling and transplantation of cells, tissues and organs, the purpose of which is to ensure the procurement, handling and transplantation of cells, tissues and organs according to the established legislation.") <https://www.riigiteataja.ee/en/eli/ee/520032017006/consolide/current> (last visited 12 Dec. 2017).

Board, and the Ministry of Social Affairs.⁵¹ Under the Act, “the transplantation of cells, tissues and organs means the implantation of cells, tissues and organs removed from a donor for therapeutic purposes.”⁵² The Act “applies to the cells, tissues and organs which are removed from a living or deceased human donor and are or are not processed *in vitro* and which are intended for human use.”⁵³ Additionally, it does not regulate “the use of cells, tissues and organs in scientific research used for purposes other than medical use on human beings.”⁵⁴

24. The “Artificial Insemination and Embryo Protection Act” (hereafter “Embryo Protection Act”) is the controlling domestic legislation on the use of human embryos for scientific research in Estonia. Estonia is party to the “Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine” (hereafter “Convention for the Protection of Human Rights and Dignity”), which addresses the creation of human embryos. Finally, Estonia prohibits the cloning of human beings pursuant to the “Additional Protocol to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, on the Prohibition of Cloning Human Beings” (hereafter “Additional Protocol”).

25. The Embryo Protection Act (Kunstliku viljastamise ja embrüokaitse seadus) is Estonia’s key domestic legislation that regulates the use of human embryos for scientific research.⁵⁵ Under this Act, an “embryo” means a “[human] embryo in its early stage of development from the time of fertilization of the ovum.”⁵⁶ The Act permits an individual to voluntarily donate his sperm or her ova for the purposes of using the gametes for artificial insemination.⁵⁷

⁵¹ *Id.*, art. 5, para. 2. (“The transplantation infrastructure shall be composed of: 1) transplantation council; 2) national transplantation agency; 3) transplantation centres; 4) the procurers and handlers of cells, tissues and organs; 5) Estonian Health Insurance Fund; 6) State Agency of Medicines; 7) Health Board; 8) Ministry of Social Affairs.

⁵² *Id.*, art. 2, para. 3. (“For the purposes of this Act, the transplantation of cells, tissues and organs means the implantation of cells, tissues and organs removed from a donor for therapeutic purposes.”).

⁵³ *Id.*, art. 1, para. 2. (“This Act applies to the cells, tissues and organs which are removed from a living or deceased human donor (hereinafter donor) and are or are not processed *in vitro* and which are intended for human use.”).

⁵⁴ *Id.*, art. 1, para. 3, subsection 4. (“the use of cells, tissues and organs in scientific research if used for purposes other than medical use on human beings.”).

⁵⁵ *Artificial Insemination and Embryo Protection Act* (Kunstliku viljastamise ja embrüokaitse seadus) [hereafter Embryo Protection Act], No. RT I 1997, 51, 824, Elektrooniline Riigi Teataja, (E.I.F. 17 July 1997). <https://www.rigiteataja.ee/en/eli/530102013057/consolide> (last visited 11 Dec. 2017).

⁵⁶ *Id.*, art. 3. (“Embryo” means an embryo in its early stage of development from the time of fertilisation of the ovum. For the purposes of this Act, “embryo” means a human embryo unless otherwise provided by this Act.”)

⁵⁷ *Id.*, art. 3¹. (“A donor of artificial insemination is a person who voluntarily surrenders his gametes to artificial insemination. Unless otherwise provided by this Act, both ova and sperm donors are considered as donors.”)

26. Chapter 4 of the Act, *Protection of Embryos Created in Vitro*, explicitly states that “[a]n ovum shall be fertilized *in vitro* only with the aim of transferring the ovum to a woman.”⁵⁸ Embryos must be preserved fourteen days after fertilization of the ovum.⁵⁹ Such embryos cannot be preserved or used after the fourteen days.⁶⁰

27. Embryos that are “created *in vitro* must be frozen and preserved in frozen form for up to seven years.”⁶¹ But if a frozen embryo is not transferred to a woman within those seven years, “the embryo shall be used for scientific research or destroyed.”⁶²

28. The Embryo Protection Act prescribes three sorts of donated embryos that may be used for scientific research: embryos that were not transferred to a woman for the purposes of ensuring the success of an artificial insemination or of protecting the health of the child or mother⁶³; embryos intended to be transferred to a woman who has declared her consent to artificial insemination void⁶⁴; and embryos frozen for more than seven years.⁶⁵ Additionally, “[t]he consent of the person who donated the gametes is necessary for using an embryo for scientific research.”⁶⁶

29. The Embryo Protection Act prohibits selecting a sperm for artificial fertilization on the basis of the sex chromosome contained therein without the purpose of avoiding transmission of a serious sex-related inheritable disease to the child;⁶⁷ the creation of an embryo with genetic information identical to that of the embryo, fetus or living or dead person;⁶⁸ the fusion of human

⁵⁸ *Id.*, Art. 29 (“Purpose of in vitro fertilization of ova”, “An ovum shall be fertilised in vitro only with the aim of transferring the ovum to a woman.”).

⁵⁹ *Id.*, Art. 34. (“An embryo may be preserved or used on the grounds prescribed in § 31 or 32 of this Act within fourteen days after fertilisation of the ovum. Preservation or use of embryos after expiry of the specified term is prohibited. The time during which the embryo is frozen pursuant to § 30 of this Act shall not be included in such term.”).

⁶⁰ *Id.*

⁶¹ *Id.*, art. 30, para. 1. (“Embryos created in vitro shall be frozen and preserved in frozen form for up to seven years.”).

⁶² *Id.*, art. 30, para. 2. (“If an embryo is not transferred to a woman within the term specified in subsection (1) of this section, the embryo shall be used for scientific research or destroyed.”).

⁶³ *Id.*, art. 32, para. 1. (“Embryos which, in order to ensure the success of the artificial insemination or to protect the health of the child or the mother, are not transferred to a woman, and embryos which have remained unused due to circumstances specified in subsection 4 (3) or 30 (2) of this Act may be used for scientific research.”).

⁶⁴ *Id.*, art. 4, para. 3. (“A woman has the right to refuse to undergo artificial insemination until it is carried out and declare her consent void.”).

⁶⁵ *Id.*, art. 30, para. 2. (“If an embryo is not transferred to a woman within the term specified in subsection (1) of this section, the embryo shall be used for scientific research or destroyed.”).

⁶⁶ *Id.*, art. 32, para. 2. (“The consent of the persons who donated the gametes is necessary for using an embryo for scientific research.”).

⁶⁷ *Id.*, art. 35, para. 1. (“It is prohibited to perform the following acts in connection with artificial insemination of a woman: (1) artificial fertilisation of an ovum with a sperm which has been selected on the basis of the sex chromosome contained therein, except in the cases where a gamete is selected in order to avoid transmission of a serious sex-related inheritable disease to the child.”).

⁶⁸ *Id.*, art. 35, para. 2. (“It is prohibited to perform the following acts in connection with artificial insemination of a woman: (2) creation, by way of substitution of the nucleus of a fertilised ovum by a somatic cell of another embryo,

embryos with different genetic information;⁶⁹ and the creation of an embryo capable of developing by fertilization of a human gamete with an animal gamete.⁷⁰ This Act, thus, prohibits the creation and cloning of human embryos.

30. The Embryo Protection Act follows the “14th Day” Rule. Scientifically, an embryo does not develop until 10-12 days after fertilization.⁷¹ Numerous states have acknowledged this scientific fact when regulating research on embryos.⁷² To date, Canada, the United States, Iceland, the United Kingdom, Spain, Sweden, Denmark, Netherlands, Slovenia, Switzerland,⁷³ China, India, Japan, South Korea, Singapore, Australia, and New Zealand allow research on zygotes, blastocysts and even embryos up to the 14th day after fertilization.⁷⁴ About 30 years ago, the “14th day rule” was adopted as an acceptable compromise between those who believe “human life” begins at fertilization, and those who believe the early stages of development do not yet constitute a “human life.”⁷⁵ Since then, it is widely considered to be an acceptable balance between the moral imperatives of religious beliefs and the need to advance science.⁷⁶ Moreover, recent developments have raised the question of further extending the possibility of researching on embryos beyond 14 days. Until 2016, culturing human embryos *in vitro* never exceeded nine-days.⁷⁷ In 2016, human embryos were sustained in-vitro for 12-13 days.⁷⁸

foetus or living or dead person, of an embryo with genetic information identical to that of the embryo, foetus or living or dead person.”).

⁶⁹ *Id.*, art. 35, para. 3. (“It is prohibited to perform the following acts in connection with artificial insemination of a woman: (3) fusion of embryos with different genetic information in order to create a cell fusion if at least one of the embryos is a human embryo, or fusion of a human embryo with a cell which contains genetic information different from that of the cells of the embryo and which may develop further together with the embryo.”).

⁷⁰ *Id.*, art. 35, para. 4. (“It is prohibited to perform the following acts in connection with artificial insemination of a woman: (4) creation of an embryo capable of developing by fertilisation of a human ovum with animal sperm or animal ovum with human sperm.”).

⁷¹ Haywood L. Brown, *Stages of Development of the Fetus*, Merck Manual, <https://www.merckmanuals.com/home/women-s-health-issues/normal-pregnancy/stages-of-development-of-the-fetus> (last visited 7 Dec. 2017).

⁷² Insoo Hyun, Amy Wilkerson & Josephine Johnston, *Embryology Policy: Revisit the 14-day Rule*, NATURE, (May 4, 2016), <http://www.nature.com/news/embryology-policy-revisit-the-14-day-rule-1.19838> (last visited 7 Dec. 2017) (explaining that these states have either codified the 14-day rule into law or have specified it in scientific guidelines).

⁷³ Marc Kaplan, *Call to Re-Examine “14 Day Rule” Limiting In-Vitro Human Embryo Research*, Case Western Reserve University of Medicine (May 4, 2016), http://casemed.case.edu/cwrumed360/news-releases/release.cfm?news_id=302 (last visited 7 Dec. 2017) (stating that Switzerland restricts human-embryo research at seven days).

⁷⁴ *See id.* (explaining that the “14-day rule” limits in vitro human-embryo research to the period before “the earliest point at which an embryo’s biological individuation is assured”).

⁷⁵ *Id.*

⁷⁶ John Harris, *It’s time to Extend the 14-day Limit for Embryo Research*, The Guardian (May 6, 2016), <https://www.theguardian.com/commentisfree/2016/may/06/extend-14-day-limit-embryo-research> (last visited 13 Dec. 2017).

⁷⁷ *Id.*

⁷⁸ Kaplan, *supra* note 20.

31. Estonia also ratified the “Convention for the Protection of Human Rights and Dignity”, which entered into force on 1 June 2002 for Estonia.⁷⁹ §15 states a “General rule” for scientific research: “Scientific research in the field of biology and medicine shall be carried out freely, subject to the provisions of this Convention and the other legal provisions ensuring the protection of the human being.”⁸⁰ §18 prohibits the creation of human embryos for research purposes.⁸¹

32. Estonia subsequently ratified the “Additional Protocol to the Convention for the Protection of Human Rights and Dignity of the Human Being”, which also came into force on 1 June 2002 for Estonia.⁸² The scope of the Additional Protocol is exclusively that of cloning human beings. Article 1 prohibits “any intervention seeking to create a human being genetically identical to another human being, whether living or dead,” and defines “the term human being ‘genetically identical’ to another human being means a human being shared with another the same nuclear gene set.”⁸³

33. Non-compliance with the Embryo Protection Act, the Convention for the Protection of Human Rights and Dignity, and the Additional Protocol results in pecuniary punishment or imprisonment for both individuals and legal persons.⁸⁴

⁷⁹ Committee on Bioethics, Council of Europe, CDB/INF (2015) 1 REV (4 June 2015), <https://rm.coe.int/1680490348> (last visited 12 Dec. 2017).

⁸⁰ *Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine*, [hereinafter Convention for the Protection of Human Rights and Dignity] 4 Apr. 1997, European Treaty Series No. 164, entered into force on 12 Jan. 1999 [hereafter Convention for the Protection of Human Rights and Dignity], Art. 15.

⁸¹ *Id.*, Art. 18, para. 2. (“The creation of human embryos for research purposes is prohibited.”), <https://rm.coe.int/168007cf98> (last visited 11 Dec. 2017).

⁸² *Additional Protocol to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, on the Prohibition of Cloning Human Beings* [hereinafter Additional Protocol], 1 Dec. 1998, European Treaty Series No. 168, (E.I.F. 3 Jan. 2001), <https://rm.coe.int/168007f2ca> (last visited 11 Dec. 2017).

⁸³ *Id.*, art. 1.

⁸⁴ Organisation for Economic Co-Operation and Development, *Estonia – Information on residency for tax purposes*, General Part of the Civil Code Act § 24, Section II – Criteria for Entities to be considered a tax resident, (“A legal person is a tax resident in Estonia if it is established pursuant to Estonian law. European public limited companies (SE) and European associations (SCE) whose seat is registered in Estonia are also residents. A legal person is either a legal person in private law or a legal person in public law. (<https://www.riigiteataja.ee/en/eli/528032014002/consolide>); According to General Part of the Civil Code Act § 25 legal persons in private law in Estonia are the following: public limited company (aktsiaselts, AS), private limited company (osühing, OÜ) but there are also general partnership (täisühing, TÜ), limited partnership (usaldusühing, UÜ) and commercial association (tulundusühistu). Legal provisions can be found in the Commercial Code <https://www.riigiteataja.ee/en/eli/525032015007/consolide>. Non-profit associations (mittetulundusühing) and foundations (sihtasutus) are also Estonian residents. Legal provisions can be found in the Non-profit associations Act <https://www.riigiteataja.ee/en/eli/529012015009/consolide> and the Foundations Act <https://www.riigiteataja.ee/en/eli/529012015010/consolide>.”), <https://www.oecd.org/tax/automatic-exchange/crs-implementation-and-assistance/tax-residency/Estonia-Tax-Residency.pdf> (last visited 12 Dec. 2017).

34. Estonia's Penal Code, Chapter 9 *Offenses Against the Person*, Division 5 *Illegal Treatment of Embryo or Foetus* frames the enforcement of the regulations set forth in the Embryo Protection Act.⁸⁵ §130, *Prohibited acts with embryo*, punishes the act of human cloning or creating a human hybrid or human chimera by a pecuniary punishment or with three years' imprisonment.⁸⁶

35. Estonia's policy on the research of hESC follows the subsidiarity principle where "research on embryos should only be conducted if no suitable alternatives exist."⁸⁷ This is demonstrated by the requirement that any human gamete donated⁸⁸, embryo created⁸⁹, or ovum fertilized *in vitro*⁹⁰ must be intended for the transferring to a woman consenting to *in vitro* fertilization. An embryo may be used for scientific research only in the cases where an embryo was not transferred in order to protect the health of the mother or child⁹¹, where a woman declares her consent to *in vitro* fertilization void⁹², or where a frozen embryo is preserved longer than seven years.⁹³

36. The term "suitable alternatives", derived from the subsidiarity principle, implies that stem cell research operates within a moral hierarchy. In other words, "research should be first be done on animal material; [then] adult stem cells should be used before embryonic stem cells; [next] affected or at-risk embryos should be used before healthy embryos; and supernumerary embryos should be used before research embryos are created."⁹⁴ This hierarchy is demonstrated by Estonia's robust investment in animal reproductive medicine and research on cattle cloning, diagnostics, genetics and

⁸⁵ Estonia Penal Code, Chapter 9 *Offenses Against the Person*, Division 5, *Illegal Treatment of Embryo or Foetus*, RT I, 23 Dec. 2014, (E.I.F. 1 Jan. 2015), <https://www.rigiteataja.ee/en/eli/ee/522012015002/consolide/current> (last visited 12 Dec. 2017).

⁸⁶ *Id.*, Art. 130. ("Prohibited acts with embryo: (1) Human cloning or creating a human hybrid or human chimera is punishable by a pecuniary punishment or up to three years' imprisonment. (2) The same act, if committed by a legal person, is punishable by a pecuniary punishment.").

⁸⁷ Guido Pennings and André Van Steirteghem, *The subsidiarity principle in the context of embryonic stem cell research*, Human Reproduction, Vol. 19, Issue 5, 1060–1064, (1 May 2004), <https://doi.org/10.1093/humrep/deh142> (last visited 11 Dec. 2017).

⁸⁸ Embryo Protection Act, Art. 3(1). ("A donor for artificial insemination (hereinafter donor) is a person who voluntarily donates his or her gametes for the purposes of artificial insemination. Unless otherwise provided by this Act, sperm donors and ovum donors are both deemed to be donors.").

⁸⁹ *Id.*, Art. 31. ("An embryo preserved *in vitro* shall be used: (1) for transfer to a woman pursuant to the procedure prescribed in this Act.").

⁹⁰ *Id.*, Art. 29. ("An ovum shall be fertilised *in vitro* only with the aim of transferring the ovum to a woman.").

⁹¹ *Id.*, Art. 32, para. 1. ("Embryos which, in order to ensure the success of the artificial insemination or to protect the health of the child or the mother, are not transferred to a woman, and embryos which have remained unused due to circumstances specified in subsection 4 (3) or 30 (2) of this Act may be used for scientific research.").

⁹² *Id.*, Art. 4, para. 3. ("A woman has the right to refuse to undergo artificial insemination until it is carried out and declare her consent void.").

⁹³ *Id.*, Art. 30. ("(1) Embryos created *in vitro* shall be frozen and preserved in frozen form for up to seven years; (2) If an embryo is not transferred to a woman within the term specified in subsection (1) of this section, the embryo shall be used for scientific research or destroyed.").

⁹⁴ Guido Pennings and André Van Steirteghem, *The subsidiarity principle in the context of embryonic stem cell research*.

bioinformatics.⁹⁵ Estonia law permits adult stem cells, tissues, and organs to be donated, transplanted, and used for therapeutic purposes.⁹⁶ In addition, Estonia law allows “research on pluripotent stem cells derived from somatic cells only if the human stem cells are used in scientific research with the final purpose of medical use on human beings.”⁹⁷ Only cryopreserved, supernumerary embryos that have exhausted their use to be transferred to a woman may be used for scientific research.⁹⁸ Furthermore Estonia, alongside any other country that has ratified the Convention for the Protection of Human Rights and Dignity, is prohibited from creating embryos specifically for research.⁹⁹

37. In its communication to a European citizens’ initiative called “One of Us” which “concerns the juridical protection of the dignity, the right to life and of the integrity of every human being from conception,” the European Commission highlighted the benefits of hESC.¹⁰⁰ “Human embryonic stem cell (hESC) research has the potential to contribute to the next generation of healthcare by offering treatments or possible cures for untreatable and/or life-threatening diseases . . . Embryonic stem cells are unique because they can form any of the cells of the body and scientists use this feature to make new cells that can be transplanted into patients to replace damaged or diseased tissue. In addition, studies of embryonic stem cells enable biologists to understand how our tissues develop and maintain themselves, and stem cells are also used to screen new drugs to decrease their risk of toxicity and to advance pharmaceutical research. Embryonic stem cells are cell lines capable of producing an infinite number of identical cells which can be frozen, stored and shipped to other laboratories for further culture and experimentation . . . Induced pluripotent stem cells (iPSC), are adult, specialised cells that have been genetically reprogrammed . . . Induced pluripotent stem cells have many similar properties to embryonic stem cells and research continues to make progress; however, these cells cannot yet be produced to clinical standard or be treated as natural cells.”

38. Notwithstanding the incredible benefit derived from research utilizing hESC and iPSC, the Commission’s conclusion aligns with the subsidiarity principle and implies that such research outweighs currently outweighs any ethical dilemma. “The Commission agrees with Opinion 22 of the

⁹⁵ *Supra* ¶ 14.

⁹⁶ *Supra* ¶ 21.

⁹⁷ Tiina Titma, Regulation of stem cell research in Estonia, Euro Stem Cell, Policy & Regulation, <https://www.eurostemcell.org/regulation-stem-cell-research-estonia> (last visited 13 Dec. 2017).

⁹⁸ *Supra* ¶ 24.

⁹⁹ *Convention for the Protection of Human Rights and Dignity*, Art. 18, para. 2. (“The creation of human embryos for research purposes is prohibited.”), <https://rm.coe.int/168007cf98> (last visited 11 Dec. 2017).

¹⁰⁰ Communication from the Commission on the European Citizens’ Initiative “One of us”, COM/2014/0355, Doc. 52014DC0355, (28 May 2014), <http://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX:52014DC0355> (site visited 12 Dec. 2017).

European Group on Ethics and New Technologies that ‘should alternatives to hESCs with the same potential as embryo-derived stem cells be found in the future, the implications of such developments for both scientific and ethical aspects of the hESC-based research projects ought to be taken into account as soon as possible’. This means that once fully equivalent alternatives to hESCs are available, the Commission will explore their full deployment and potential and will revert to the European Group on Ethics and New Technologies for an Opinion in the light of results of hESC research and of scientific advances in alternatives to hESC.”

Analysis: To What Extent are Estonia’s Laws and Practices with regard to hESC Compatible with the Covenant?

39. Although Estonia’s performance under the Covenant when it comes to research on human embryonic stem cells is far from abysmal, it still falls short in certain aspects. Article 15(1) of the Covenant mandates that all States which are party to CESCR must recognize the right of everyone “to take part in cultural life; to enjoy the benefits of scientific progress and its applications; and to benefit from the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.”¹⁰¹ The benefits of scientific progress include access to health, medicine, technology, education and training.¹⁰² It implies that society has the right to advance knowledge and understanding which provides an empirical basis for implementing laws, policies, and programs.¹⁰³

40. According to the 2009 “Venice Statement on the Right to Enjoy the Benefits of Scientific Progress and its Applications” (“Venice Statement”), a document adopted by a group of experts convened under the aegis of UNESCO, States have a duty “to respect the freedoms indispensable for scientific research and creative activity, such as the freedom of thought, to hold opinions without interference, and to seek, receive, and impart information and ideas of all kinds.”¹⁰⁴

41. In her *Report of the Special Rapporteur in the field of cultural rights*, Farida Shaheed identified four general obligations under “the right to enjoy the benefits of scientific progress and its

¹⁰¹ International Covenant on the Economic, Social and Cultural Rights. Art. 15.
<http://www.ohchr.org/Documents/ProfessionalInterest/cescr.pdf> (last visited 12 Dec. 2017).

¹⁰² AAAS Science and Human Rights Coalition, *Defining the Right to Enjoy the Benefits of Scientific Progress and Its Applications: American Scientists’ Perspectives* (Report prepared by Margaret Weigers Vitullo and Jessica Wyndham), DOI: 10.1126/srhl.aaa0028, (October 2013),
https://www.aaas.org/sites/default/files/content_files/UNReportAAAS.pdf (last visited 12 Dec. 2017).

¹⁰³ *Id.* at 2-3.

¹⁰⁴ UNESCO, *Venice Statement: The Right to Enjoy the Benefits of Scientific Progress and its Applications*, ¶ 14 (Jul. 16-17, 2009),
<http://unesdoc.unesco.org/images/0018/001855/185558e.pdf> (last visited Aug. 30, 2017).

applications.” (1) access to the benefits of science by everyone, without discrimination; (2) opportunities for all to contribute to the scientific enterprise and freedom indispensable for scientific research; (3) participation of individuals and communities in decision-making; and (4) an enabling environment fostering the conservation, development and diffusion of science and technology.¹⁰⁵ However, the list is not exhaustive.

42. The *Venice Statement* also highlights that, under Article 15, States have a duty to fulfill and “adopt a legal and policy framework and to establish institutions to promote the development and diffusion of science and technology in a manner consistent with fundamental human rights...to promote access to the benefits of science and its applications on a non-discriminatory basis including measures necessary to address the needs of disadvantaged and marginalized groups.”¹⁰⁶

43. Article 15(2) recites, “[t]he steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for the conservation, the development and the diffusion of science and culture.” This general obligation implicitly contains several more specific obligations: first, “conservation of science includes retaining scientific discoveries as well as the data behind them, which must be preserved in a form that allows replication of those discoveries;”¹⁰⁷ second, “development demands an explicit commitment to the development of science and technology for human benefit;”¹⁰⁸ and third, “diffusion encompasses the dissemination of scientific knowledge and application both within the scientific community and in society at large.”¹⁰⁹

44. Article 15(3) states “[t]he States Parties to the present Covenant undertake to respect the freedom indispensable for scientific research and creative activity.”¹¹⁰ Special Rapporteur Farida Shaheed emphasized that “[f]reedom of scientific research means ensuring that the scientific enterprise remains free of political and other interference, while guaranteeing the highest standards of ethical safeguards by scientific professions.”¹¹¹

¹⁰⁵ Farida Shaheed (Special Rapporteur on Cultural Rights), *The Right to Enjoy the Benefits of Scientific Progress and Its Applications*, U.N. Doc. A/HRC/20/26, para. 25, (May 14, 2012), http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session20/A-HRC-20-26_en.pdf. (last visited 14 Dec. 2017).

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* at 5.

¹⁰⁸ *Id.* at 4.

¹⁰⁹ *Id.* at 5.

¹¹⁰ International Convention on Economic, Social and Cultural Rights. Art. 15. para. 3.

¹¹¹ Farida Shaheed (Special Rapporteur on Cultural Rights), *The Right to Enjoy the Benefits of Scientific Progress and Its Applications*, U.N. Doc. A/HRC/20/26, (May 14, 2012), http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session20/A-HRC-20-26_en.pdf. (last visited 14 Dec. 2017).

45. Although Estonia's performance under the Covenant is far from abysmal, it falls short in certain aspects. Notably, Estonia is not taking the proper steps towards achieving the full realization of the Right to Science as required by Article 15(2). Estonia recognizes that biotechnology and biomedicine, more specifically hESC research and research on assisted reproductive technologies and medicine, are promising fields for investment.¹¹² Although Estonia permits research on hESC and assisted reproductive technologies, it lacks a comprehensive, legal framework to properly regulate these practices. Estonia's domestic laws regulate the creations and use of embryos as well as permit embryos to be donated and used for scientific research. Notwithstanding, Estonia has not enacted any domestic laws to specifically address the actual hESC research methods nor the prospective medicines and treatments that may result from those methods.

46. Despite the Estonian Biotechnology Programme (EBP)'s desire to pursue investments and development in the biotechnology and healthcare industries, Estonia has not assumed a leadership role in these fields. Estonia's Periodic Report to the Committee is silent on these issues entirely. Rights to Science, Health, and Family are human rights directly affected by emerging medicine, science, and technology. By recognizing the development of these rights, Estonia may fulfill its obligations under the Covenant as well as realize its full potential on the global stage.

ASSISTED REPRODUCTIVE TECHNOLOGIES (ART)

ART in Estonia

47. Although the term "assisted reproductive technologies (ART)" refers to a set of modern techniques used for addressing involuntary childlessness, it generally refers to treatments in which gametes or embryos are handled *in vitro* to establish a pregnancy.¹¹³ The process of *in vitro fertilization* (IVF) involves the fertilization of oocytes using sperm in a laboratory with the resulting embryo surgically implanted in a woman's womb.¹¹⁴ *Intracytoplasmic sperm injection* (ICSI) is the procedure in which only a single sperm is injected into the oocyte.¹¹⁵ The more common IVF

¹¹² *Supra* ¶¶ 14-17.

¹¹³ Patrick Präg and Melinda C. Mills, *Assisted Reproductive Technology in Europe: Usage and Regulation in the Context of Cross-Border Reproductive Care*, Childlessness in Europe: Contexts, Causes, and Consequences, Demographic Research Monographs, DOI 10.1007/978-3-319-44667-7_14, 289-309, (2017) https://link.springer.com/content/pdf/10.1007%2F978-3-319-44667-7_14.pdf (last visited 11 Dec. 2017).

¹¹⁴ *Id.* at 290.

¹¹⁵ *Id.*

procedure, however, transfers a cryopreserved embryo.¹¹⁶ “[A]fter a hormonal treatment, several oocytes are collected at the same time, fertilized, and frozen for later use in case the first embryo transfer fails since ART still has a relatively low success rate.”¹¹⁷ *In vitro maturation* is an alternative collection strategy entailing the collection of immature eggs from a woman that are then matured in a lab.¹¹⁸

48. “*Frozen oocyte replacement* is a technique in which oocytes are retrieved, frozen, cryopreserved, and fertilized only after they have been thawed from transfer.”¹¹⁹ This particular technique is popular, especially among working women, because it can be used to delay motherhood for any reason and gives the woman the option of having genetically related children later in life.¹²⁰ “*Preimplantation genetic diagnosis (PGD) or screening (PGS)*” allows individuals to examine “an embryo to determine whether specific genetic and structural alterations are present.”¹²¹

49. A woman may donate a fertilized oocyte to transfer to another woman’s womb. “*Egg donations*” are conducted “in cases of *surrogate motherhood* for prospective parents who are unable to carry a child.”¹²² A woman who has undergone ART may also donate or “share” any non-used frozen oocyte with other women.¹²³ This type of donation is usually referred to as “*egg sharing*”.¹²⁴

50. World-wide “...an estimated five million babies have been born with the help of assisted reproduction in the past four decades.”¹²⁵ As many European countries are considered to have “lowest-low” fertility, Europe has the largest number of ART treatments globally.¹²⁶

51. There are six fertility clinics in Estonia including three private clinics¹²⁷. Estonia permits gamete donations, egg freezing, PGS, and PGD.¹²⁸ Surrogacy, however, is prohibited and penalized.¹²⁹ In a 2010 study showing the number of ART treatments initiated by ART patients in a country, namely women between the ages of 15 and 45, Estonia places ninth out of thirty European

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ *Id.*

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *Id.*

¹²³ *Id.*

¹²⁴ *Id.*

¹²⁵ *Id.* at 289.

¹²⁶ *Id.* at 290-291.

¹²⁷ Fertility Clinics Abroad, *IVF Estonia*, last updated 27 June 2017 by Caroline Phillips, <https://www.fertilityclinicsabroad.com/ivf-abroad/ivf-estonia/> (last visited 12 Dec. 2017).

¹²⁸ *Id.*

¹²⁹ *See infra* ¶ 60.

countries.¹³⁰ Estonia followed Denmark, Belgium, Iceland, Sweden, Slovenia, Norway, Finland, and Czech Republic.¹³¹

52. In 2011, Estonia conducted 556 IVF (*in vitro fertilization*) treatment cycles, 1,184 ICSI (*Intracytoplasmic sperm injection*) treatment cycles, 582 FERs (*frozen embryo replacement*), 0 PGD (*Preimplantation genetic diagnosis*), 152 EDs (*egg donations*), 0 IVM (*in vitro maturation*), 0 FOR (*frozen oocyte replacements*).¹³² At the time, Estonia had 5 IVF clinics and IUI (*intrauterine insemination*) labs.¹³³ From the total 1740 treatment cycles (556 IVF and 1183 ICSI), 631 ART infants were birthed, constituting 4.2% of infants birthed in Estonia in 2011.¹³⁴

53. In 2015, Estonian State Agency of Medicines data shows that 2,834 ART cycle procedures occurred – a 1.8% decrease from 2014.¹³⁵ “The most used IVF method was ICSI” which constituted 41% of all ART cycles.¹³⁶ “IVF related cost formed 1.555 million euros” – 5.2% more than 2014.¹³⁷ According to Estonian Medical Birth Registry, 380 IVF children were born in 2015. In 2014, 404 IVF children were born.¹³⁸

54. In 2015, Estonians younger than 34 years of age were the largest group undergoing ART cycles at 1,319 individuals compared to 915 aged 35-39, 243 aged 40, and 357 aged 41-years and older.¹³⁹

55. Of the documented side effects occurring in 2015 due to ART, there were 7 cases that resulted in ovarian hyperstimulation syndrome.¹⁴⁰ There were no documented cases of complications

¹³⁰ Patrick Präg and Melinda C. Mills, *Assisted Reproductive Technology in Europe: Usage and Regulation in the Context of Cross-Border Reproductive Care*, Childlessness in Europe: Contexts, Causes, and Consequences, Demographic Research Monographs, DOI 10.1007/978-3-319-44667-7_14, 289-309, 292, (2017), https://link.springer.com/content/pdf/10.1007%2F978-3-319-44667-7_14.pdf (last visited 11 Dec. 2017).

¹³¹ *Id.*

¹³² M.S. Kupka, T. D'Hooghe, A.P. Ferraretti, J. de Mouzon, K. Erb, J.A. Castilla, C. Calhaz-Jorge, Ch. De Geyter, V. Goossens, *Assisted reproductive technology in Europe, 2011: results generated from European registers by ESHRE*, Human Reproduction, Volume 31, Issue 2, 233-248, (1 February 2016), <https://doi.org/10.1093/humrep/dev319> (last visited 12 Dec. 2017).

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ National Institute for Health Development (Tervise Arengu Instituut), *IVF Procedures 2015*, (20 July 2016), (<http://www.tai.ee/en/health-data/health-statistics-and-health-research-database/latest-updates/3966-ivf-procedures-2015>) (last visited 12 Dec. 2017).

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ National Institute for Health Development: Health Statistics and Health Research Database, *KV12: Number of clinical pregnancies by gamete owner and ART Method*, State Agency of Medicines, (20 July 2016), http://pxweb.tai.ee/esf/pxweb2008/Database_en/HCservices/04Diagnostics/04Diagnostics.asp (last visited 12 Dec. 2017).

¹³⁹ *Id.* (referring to table KV10: ART cycles by method and age group).

¹⁴⁰ *Id.* (referring to table KV13: ART adverse and side effects).

to oocyte retrieval, bleeding as a complication to oocyte retrieval, infections as a complication to oocyte retrieval, maternal death, nor fetal reeducations.¹⁴¹

56. Yet, Estonia still criminalizes and punishes certain acts involved with artificial assisted technologies and practices under Estonia's Penal Code, Chapter 9 *Offenses Against the Person*, Division 5 *Illegal Treatment of Embryo or Foetus*.¹⁴² §129, *Damaging of embryo or foetus*, makes the damaging or injuring of an embryo or fetus while it is in the uterus of a woman if such act results in miscarriage or the death of the embryo or fetus punishable by a pecuniary punishment or up to five years' imprisonment.¹⁴³ §130, *Prohibited acts with embryo*, punishes the act of human cloning or creating a human hybrid or human chimera by a pecuniary punishment or with three years' imprisonment.¹⁴⁴ Under §131, *Abuse of human embryo or fetus*, the *in vitro* creation of a human embryo or fetus without the intention of transferring the embryo or fetus to a woman, or outside a lawfully authorized institution, or without the corresponding lawful right, or the preservation of a human embryo or fetus in an unfrozen form longer than the term the law provides, or the performance of unauthorized transactions with an embryo or fetus are all punishable by a pecuniary punishment.¹⁴⁵

57. Notwithstanding Estonia's legalization of ART treatments and insuring IVF, the country has prohibited surrogacy. §132 of the Estonian penal code makes the “[t]ransfer of a foreign ovum, or an embryo or foetus created therefrom to a woman whose intention to give away the child after birth is known [punishable] by a pecuniary punishment.”¹⁴⁶ This is applicable to the surrogate mother, the physician who performed the IVF, and any legal person involved.¹⁴⁷ However, there is a

¹⁴¹ *Id.*

¹⁴² Estonia Penal Code, Chapter 9 *Offenses Against the Person*, Division 5, *Illegal Treatment of Embryo or Foetus*, RT I, 23 Dec. 2014, (E.I.F. 1 Jan. 2015), <https://www.riigiteataja.ee/en/eli/ee/522012015002/consolide/current> (last visited 12 Dec. 2017).

¹⁴³ *Id.*, Art. 129. (“(1) Damaging an embryo or foetus by injuring, administering a substance to or performing any other act with regard to the embryo or foetus while it is in the uterus of a woman if such act results in miscarriage or the death of the embryo or foetus is punishable by a pecuniary punishment or up to five years' imprisonment. (2) The same act, if committed by a legal person, is punishable by a pecuniary punishment.”).

¹⁴⁴ *Id.*, Art. 130. (“Prohibited acts with embryo: (1) Human cloning or creating a human hybrid or human chimera is punishable by a pecuniary punishment or up to three years' imprisonment. (2) The same act, if committed by a legal person, is punishable by a pecuniary punishment.”).

¹⁴⁵ *Id.*, Art. 131. (“(1) Creating of a human embryo or foetus in vitro without the intention to transfer the embryo or foetus to a woman, or outside an institution duly authorised by law or without the corresponding lawful right, or preserving of a human embryo or foetus in vitro in an unfrozen form for longer than the term provided by law or performance of unauthorised transactions with an embryo or foetus is punishable by a pecuniary punishment. (2) The same act, if committed by a legal person, is punishable by a pecuniary punishment.”).

¹⁴⁶ Estonia Penal Code §132 *Illegal surrogate motherhood*, RT I, 23.12.2014, (E.I.F. 1 Jan. 2015), (“(1) Transfer of a foreign ovum, or an embryo or foetus created therefrom to a woman whose intention to give away the child after birth is known is punishable by a pecuniary punishment; (2) The same act, if committed by a legal person, is punishable by a pecuniary punishment.”), <https://www.riigiteataja.ee/en/eli/522012015002/consolide> (last visited 12 Dec. 2017).

¹⁴⁷ *Id.*

discourse surrounding altruistic surrogacy which would allow for the legislation of surrogacy “while excluding it from becoming commercial and a part of human trafficking.”¹⁴⁸

58. The Artificial Insemination and Embryo Protection Act (Kunstliku viljastamise ja embrüokaitse seadus), which entered into force on 17 July 1997, is the controlling domestic legislation regulating artificial fertilization as well as the protection and the transplantation of the embryo created outside the body.¹⁴⁹ This Act recognizes artificial insemination as a part of woman’s contraception,¹⁵⁰ permits individuals to voluntarily donate ova or sperm,¹⁵¹ and allows women up to 50 years of age to exercise her own discretion and consent to artificial insemination.¹⁵² Under §5(3), artificial insemination is “prohibited if pregnancy or childbirth endangers the life or health of a woman or child, as well as other medical contraindications.”¹⁵³ Such medical indications are “identified by a competent specialist medical provider who has the right to refer the patient to the provider of specialized medical care who arranges for artificial insemination if necessary” which is then verified by a specialized medical caregiver that organizes the artificial insemination.¹⁵⁴

59. Before artificial insemination, a woman must receive medical and legal counseling performed by “the provider of specialized medical care who organizes the artificial insemination” detailing “the biological and medical nature of and the possible risks related to artificial insemination”

¹⁴⁸ The Baltic Course, International Magazine, *Estonia mulls legalizing surrogacy on certain conditions*, BC, Tallinn, (19 Oct. 2015), (citing Made Laanpere, President of the Estonian Association of Gynaecologists), <http://www.baltic-course.com/eng/legislation/?doc=111835> (last visited 12 Dec. 2017).

¹⁴⁹ *Artificial Insemination and Embryo Protection Act*, art. 1, (“This Act regulates the artificial fertilization of a woman with the sperm of a man and the transplantation of the embryo created outside the body and the protection of the embryo created outside the body.”).

¹⁵⁰ *Id.*, art. 2 (“Artificial insemination is a part of a woman’s contraception, which involves transferring sperm to a woman, or an embryo created outside her body.”)

¹⁵¹ *Id.*, art. 3, para. 1, (“A donor of artificial, insemination is a person who voluntarily surrenders his gametes to artificial insemination. Unless otherwise provided by this Act, both ova and sperm donors are considered as donors.”)

¹⁵² *Id.*, art. 4. (“(1) It is only artificially permitted to fertilize only a woman of up to 50 years of age with an active capacity at her own discretion. No one should force or influence a woman to artificially fertilize her; (2) The consent of a woman for artificial insemination shall be formalized pursuant to the procedure provided for in §16 of this Act; (3) A woman has the right to abandon artificial insemination until it is performed and to declare her consent invalid.”)

¹⁵³ *Id.*, art. 5, para. 3.

¹⁵⁴ *Id.*, art. 6, (“(1) Indications specified in § 5 of this Act shall be identified by a competent specialist medical provider who has the right to refer the patient to the provider of specialized medical care who arranges for artificial insemination if necessary. The provider of specialized medical care organizing artificial insemination verifies the indication of artificial fertilization on the basis of the documents provided to him, including the right to request additional data on the state of health of the patient from the specialist care provider who leads the patient to him and, if necessary, conducts further research; (2) An examination of indications of artificial insemination shall be documented in a document certifying the provision of health care services, which shall include a conclusion on the medical indications and contraindications of artificial insemination.”)

as well as “the legal bases and consequences of artificial insemination.”¹⁵⁵ Additionally, parties outside of the health care system are prohibited from attempting to intermediate the artificial insemination.¹⁵⁶

60. According to the Embryo Protection Act, artificial fertilization must be voluntary for the medical provider¹⁵⁷, the woman receiving the embryo¹⁵⁸, the husband if the woman is married.¹⁵⁹ If a woman has specified a particular man’s embryo, that man must also consent to the fertilization.¹⁶⁰ Consent must also be memorialized in writing.¹⁶¹

61. The Embryo Protection Act prohibits the usage of fresh donor sperm.¹⁶²

62. A woman may use the sperm of her deceased husband no later than one month after the death of her husband.¹⁶³ The same applies to the sperm of a man who is deceased and was specified beforehand by the woman.¹⁶⁴

¹⁵⁵ *Id.*, art. 10., para. 1. (“Before performing artificial insemination after having established the indications prescribed in § 5 of this Act, the provider of specialised medical care who organises the artificial insemination shall explain the biological and medical nature of and the possible risks related to artificial insemination and the legal bases and consequences of artificial insemination to the woman who wishes to undergo artificial insemination and, in the cases specified in §§ 17 and 21 of this Act, also to the man concerned.”).

¹⁵⁶ *Id.*, art. 11. (“Intermediation of artificial insemination outside the health care system is prohibited and the agreements concluded as a result of the intermediation are void.”).

¹⁵⁷ *Id.*, art. 8. (“(1) A doctor or any other health care professional shall not be required to perform or participate in the activities specified in § 2 of this Act; (2) A doctor who has commenced artificial insemination may interrupt the procedure if medical contraindications become evident.”).

¹⁵⁸ *Id.*, art. 4, para. 2. (“A woman’s consent to artificial insemination shall be recorded pursuant to the procedure provided for in § 16 of this Act.”).

¹⁵⁹ *Id.*, art. 17. (“§ 17. Husband’s consent to artificial insemination of his wife (1) In order for a married woman to undergo artificial insemination, her husband’s consent, which shall be in accordance with the consent granted by the woman pursuant to § 16 of this Act, is necessary. The husband’s consent shall set out whether he agrees to artificial insemination of his wife with his sperm even after his death; (2) The consent specified in subsection (1) of this section shall be granted in writing. The format of the consent shall be established by the Minister of Social Affairs. (2¹) If the husband has granted his consent to artificial insemination of his wife, the child is deemed to descend from him; (3) A husband has the right to declare his consent void in writing until the beginning of the procedure of artificial insemination’ (4) In the event of artificial insemination of a woman with the sperm of a man who had not granted his consent thereto or had declared his consent void, the issue of the child’s filiation shall be settled pursuant to the provisions of acknowledgement of paternity.”).

¹⁶⁰ *Id.*, art. 21, para. 1. (“Artificial insemination of an unmarried woman with the sperm of a specific man who is not married to the woman may be performed with the written consent of the man in accordance with § 17 of this Act.”).

¹⁶¹ *Id.*, art. 16, para. 1-3. (“(1) Artificial insemination of a woman shall be carried out only under the conditions prescribed in §§ 4 and 5 of this Act and with the written consent of the woman. (2) The written consent of a woman shall set out that she agrees to: 1) insemination with the sperm of her husband, any other specific man or a donor; 2) in vitro fertilisation of her ova; 3) impregnation with an embryo originating from an ovum of another woman; 4) freezing of embryos; (3) If examinations conducted on the basis of § 6 of this Act lead to a finding which confirms risk factors but does not preclude artificial insemination, the consent of the woman shall set out separately that she consents to artificial insemination even considering the risk involved.”).

¹⁶² *Id.*, art. 30, para. 1. (“Embryos created in vitro shall be frozen and preserved in frozen form for up to seven years.”).

¹⁶³ *Id.*, art. 20. (“Artificial insemination of a woman with the sperm of her husband or a man specified in § 21 of this Act later than one month after the death of the husband or man is prohibited.”).

¹⁶⁴ *Id.*

63. Individuals may donate sperm, eggs, and embryos, may choose to remain anonymous, and may be paid for his or her gamete donation.¹⁶⁵ However, “transactions with embryos are prohibited.”¹⁶⁶ “The gametes obtained from one donor may be used in order to conceive babies to be born to [no more than] six different women in Estonia.”¹⁶⁷ Up to three embryos created from the same person may be transferred to a woman over the course of one artificial insemination.¹⁶⁸ Only one man’s sperm may be used in each case of insemination.¹⁶⁹

64. Estonia provides compensation to a person insured under the Health Insurance Act for §1(1) “health care services related to *in vitro* fertilization and embryo transfer,”¹⁷⁰ §1(2) “health care services provided within 90 days before *in vitro* fertilization and embryo transfer which have been provided in connection with *in vitro* fertilization and embryo transfer,”¹⁷¹ and §1(3) “partial expenses incurred for prescription medicinal products necessary for out-patient treatment.”¹⁷²

¹⁶⁵ *Id.*, art. 25. (“(1) Any adult man of up to 40 years of age and any adult woman of up to 35 years of age (except in the case provided for in subsection 23 (3)) who is mentally and physically healthy, has consented to donate his or her gametes for the purposes of artificial insemination and has entered into a corresponding written contract for that purpose may be a gamete donor; (3) Gametes shall not be used for artificial insemination if the donor has not entered into a contract specified in subsection (1) of this section, has not undergone the required medical examination before each case of gamete donation or, in the case of sperm donation, less than six months have passed from the donation.”); art. 26. (“(1) A donor has the right to: 1) remuneration for gamete donation; 2) non-disclosure of the fact that he or she is a donor; (2) Donors are required to undergo the medical examination prescribed in § 25 of this Act; (3) A donor does not have the right to establish preconditions for the use of the gametes donated by him or her; (4) A donor does not have the right to require establishment of the identity of the mother, father or child, respectively; (5) A donor does not have the right to require that he or she be declared the mother or father of the child.”); art. 27. (“(1) The personal data of a donor shall not be disclosed upon artificial insemination, except in the case where the ovum donor is a relative of the woman who wishes to undergo artificial insemination; (2) The woman and the man who have granted their consent to artificial insemination have the right to know the following information concerning the biological and social background of the donor: 1) nationality; 2) colour; 3) education; 4) marital status; 5) whether he or she has got any children; 6) height; 7) constitution; 8) hair colour; 9) eye colour.”).

¹⁶⁶ *Id.*, art. 31, para. 3. (“Transactions with embryos are prohibited.”).

¹⁶⁷ *Id.*, art. 13. (“The gametes obtained from one donor may be used in order to conceive babies to be born to up to six different women in Estonia.”).

¹⁶⁸ *Id.*, art. 31, para. 2. (“In the course of one artificial insemination, up to three embryos created from the gametes of the same persons may be transferred to a woman.”).

¹⁶⁹ *Id.*, art. 12. (“In artificial insemination of a woman, the sperm of only one man shall be used in each case of insemination.”).

¹⁷⁰ *Id.*, art. 35¹, para. 1, subsection 1. (“The following shall be compensated to a person insured under Health Insurance Act: 1) health care services related to *in vitro* fertilisation and embryo transfer which have been entered in the list of health care services of the Estonian Health Insurance Fund.”).

¹⁷¹ *Id.*, art. 35¹, para. 1, subsection 2. (“The following shall be compensated to a person insured under Health Insurance Act: 2) health care services provided within 90 days before *in vitro* fertilisation and embryo transfer which have been provided in connection with *in vitro* fertilisation and embryo transfer.”).

¹⁷² *Id.*, art. 35¹, para. 1, subsection 3. (“The following shall be compensated to a person insured under Health Insurance Act: 3) partial expenses incurred for prescription medicinal products necessary for out-patient treatment which have been entered in the list of medicinal products of the Estonian Health Insurance Fund.”).

**Analysis: To What Extent are Estonia’s Laws and Practices with regard to ART
Compatible with the Covenant?**

65. According to Special Rapporteur Farida Shaheed, the Right to Health under Article 12 and the Right to Science under Article 15 should be enjoyed by everyone, without discrimination.¹⁷³ In fulfillment of their Covenant obligations, States, therefore, should ensure that its residents have access to the scientific and health benefits of new medicines and technologies, such as Assisted Reproductive Technology. States should also ensure its scientists maintain their right to practice and improve such technologies and medicines through practice and research. Furthermore, certain forms of ART such as IVF are medical techniques within the field of reproductive endocrinology and meet the definitions of “science” and “a benefit of scientific progress” set forth in the *Venice Statement* and the 2012 Special Rapporteur on Cultural Rights’ Report.¹⁷⁴

66. The World Health Organization (“WHO”) recognizes infertility as a disability because it intrinsically limits the major life activity of reproduction.¹⁷⁵ According to WHO, environmental factors can aid disabled people and allow them to participate in society “on an equal basis with others.”¹⁷⁶ IVF is a widely recognized and utilized treatment that effectively helps women overcome disabling fertility issues for over forty years.¹⁷⁷

67. According to this Committee’s General Comment No. 14 (2000), the right to health incorporates “[t]he right to control one’s health and body, including sexual and reproductive freedom...[and] the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.”¹⁷⁸ “Reproductive health means that women and

¹⁷³ Farida Shaheed (Special Rapporteur on Cultural Rights), *The Right to Enjoy the Benefits of Scientific Progress and Its Applications*, U.N. Doc. A/HRC/20/26, para. 24, (May 14, 2012), (explaining that the term “science” as used in the ICESCR is “knowledge that is testable and refutable, in all fields of inquiry . . . and encompassing all research”; and elaborating that “[t]he ‘benefits’ of science encompass not only scientific results and outcomes but also the scientific process, its methodologies and tools.”), http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session20/A-HRC-20-26_en.pdf. (last visited 14 Dec. 2017).

¹⁷⁴ Reproductive Medicine Associates of Connecticut, *What is a Reproductive Endocrinologist?*, <http://www.rmact.com/our-fertility-doctors/what-is-a-reproductive-endocrinologist> (last visited 14 Dec. 2017).

¹⁷⁵ WHO Infertility Definitions and Terminology, *Sexual and Reproductive Health: Infertility definitions and terminology*, <http://www.who.int/reproductivehealth/topics/infertility/definitions/en/> (last visited 14 Dec. 2017); Shorge Sato, *A Little Bit Disabled: Infertility and the Americans With Disabilities Act*, 5 N.Y.U.J. LEGIS. & PUB. POL’Y 223 (2002).

¹⁷⁶ WHO *World Report on Disability* at 4 (2011), http://whqlibdoc.who.int/publications/2011/9789240685215_eng.pdf (last visited Jan. 23, 2016).

¹⁷⁷ *Id.*

¹⁷⁸ United Nations Committee on Economic, Social, and Cultural Rights, General Comment No. 14, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social, and Cultural Rights: The Right to the Highest Attainable Standard of Health* at ¶ 8, Doc. E/C.12/2000/4 (Aug. 11, 2000).

men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth.”¹⁷⁹

68. In *Artavia Murillo et al v. Costa Rica*, the Inter-American Court of Human Rights determined that “reproductive autonomy and access to reproductive health services ... includes the right to have access to the medical technology necessary to exercise this right.”¹⁸⁰

69. In direct conflict with the definitions of the right to health and the right to science set forth by this Committee, the Special Rapporteur, WHO, and the Inter-American Court of Human Rights, Estonia continues to criminalize and penalize any act that injures or damages an embryo or fetus, while it is in a woman’s uterus, if it results in miscarriage or death of the embryo or fetus.¹⁸¹ Additionally, Estonia prohibits the entire practice of surrogacy.¹⁸² As a result, women incapable of bearing children, homosexual couples, and prospective parents finding surrogacy as the safest and most viable method of having a biological offspring are denied the medical procedure altogether. Thus, Estonia falls short in respecting, protecting, and fulfilling the Right to Family (Article 10), Right to Health (Article 12), and the Right to Science (Article 15).

ABORTION AND CONTRACEPTION (A&C)

Abortion and Contraception in Estonia

Abortion

70. On Abortion and Contraception, Estonia scores 56 out of 72 points on the Research and Self-Determination Index placing 30th out of 194 countries surveyed.¹⁸³

71. At the end of 2011, the Committee on Economic, Social and Cultural Rights (hereafter the “Committee”) issued its Concluding Observations and Recommendations on Estonia’s

¹⁷⁹ *Id.* at 20, ¶ 14, n. 12.

¹⁸⁰ I/A Court H.R., *Artavia Murillo et al. v. Costa Rica* case, Judgment of November 28, 2012, Series C, No. 257, ¶ 146, http://www.corteidh.or.cr/docs/casos/articulos/seriec_257_ing.pdf (last visited 14 Dec. 2017).

¹⁸¹ *Supra* ¶ 58.

¹⁸² *Supra* ¶ 58.

¹⁸³ World Congress for Freedom of Scientific Research, *Abortion, Research and Self-Determination Index*, (<http://www.freedomofresearch.org/issue/abortion?page=1>) (last visited 14 Dec. 2017).

obligations under the Covenant.¹⁸⁴ The Committee’s Observation expressed concern “that, while the rate of abortion has decreased, it continues to be widely practiced among adolescents, despite efforts to include sex education in the school curricula and the dissemination of information on sexual and reproductive health directed to adolescents through various media. Moreover, the Committee is concerned that unwanted pregnancy often leads teenage girls to drop out from school. The Committee also regrets that it has not been provided with information on the measures taken by the State party to raise awareness of sexual and reproductive health among the public at large. (arts. 12 and 10).”¹⁸⁵

72. The Committee’s Recommendation urged Estonia “to ensure that sexual and reproductive health services are effectively accessible to adolescents. The Committee also calls on the State party to intensify its efforts aimed at preventing teenage pregnancy and to provide the necessary support services for pregnant adolescents, including measures to enable them to continue their education. The Committee requests the State party to include in its next periodic report information on sexual and reproductive health education provided to the public.”¹⁸⁶

73. In its third periodic report submitted to the Committee, Estonia attempts to address the Committee’s concerns “that unwanted pregnancy often leads teenage girls to drop out of school.” Under the section titled “Article 13, *Education*,” Estonia states “[t]he proportion of dropouts in basic schools (Grades 1-9) in the years under review [2010-2015] was 0.9% of all students [by 2015]. Two thirds-of all dropouts are boys. The proportion of dropouts at the upper secondary school level is 1.6%. Male students comprise 50-55% of these dropouts.”¹⁸⁷ Yet, the report does not address the reasons for those dropouts nor the gender-specific obstacles abortion may impose on a pregnant teenager.

74. Pursuant to the Committee’s request to “report information on sexual and reproductive health education provided to the public, Estonia states that “[s]ince 2000, young people have been provided with reproductive health counselling and services and psychological assistance by youth counselling centres, which are funded by the Health Insurance Fund and the state. The

¹⁸⁴ Committee on Economic, Social and Cultural Rights, *Consideration of reports submitted on Economic, Social and Cultural Rights on Estonia*, E/C.12/EST/CO/2, 16 Dec. 2011, <http://uhri.ohchr.org/Document/File/15fa463f-3029-4d37-a0da-9563bbc46893/172d9c65-2e86-468f-8e2c-8109cf670748> (last visited 13 Dec. 2017).

¹⁸⁵ *Id.*, Observation ¶ 24.

¹⁸⁶ *Id.*, Recommendation ¶ 24.

¹⁸⁷ U.N. Economic and Social Council, *Third Periodic Report Submitted by Estonia under articles 16 and 17 of the Covenant, due in 2016*, UN Doc. E/C.12/EST/3, (29 Sep. 2017); U.N. Economic and Social Council, *Third Periodic Report Submitted by Estonia under articles 16 and 17 of the Covenant, due in 2016: Annex*, UN Doc. E/C.12/EST/3, (29 Sep. 2017). http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=INT%2fCESCR%2fADR%2fEST%2f228826&Lang=en (last visited 13 Dec. 2017).

Counselling centres are meant for men and women up to the age of 24. They can attend the counselling alone or as a couple. The centres also offer group work and lectures on sexual education. Gynecologists, andrologists, psychologists, midwives and social workers are employed at the centres.”¹⁸⁸ Additionally, Estonia describes “[a]n online counselling service and quality guidelines for online sexual and reproductive health counselling were developed in 2014 and 2015 within the scope of the ‘Organisation of online counselling in sexual health and development of quality guidelines for online mental and reproductive health counselling’ project, which in the future will serve as the basis for the definition and assessment of services and for the measurement of their quality.”¹⁸⁹

75. In addition to the Committee expressing concerns regarding abortion, in 2007, the Committee on the Elimination of Discrimination against Women (hereafter CEDAW) also brought attention to the issue. In its Concluding Comments on Estonia’s fulfillment under the Convention on the Elimination of All Forms of Discrimination against Women, it expressed “[concern] about the limited availability of specific information and data, including trends, about different aspects of women’s health. It is concerned that, while the abortion rate has decreased, it remains relatively high. It is also concerned about the increase in HIV-positive women in Estonia.”¹⁹⁰

76. While in the early 2000s, Estonia experienced over 10,000 reported abortions in a year’s period, by 2015 it dropped to 4,919 reported abortions.¹⁹¹

77. The “Pregnancy Abatement and Sterilization Act” (Raseduse katkestamise ja steriliseerimise seadus) “determines the conditions and procedures for termination and sterilization of pregnancy” within Estonia.¹⁹² The Act defines *termination* or *pregnancy interruption* as “the removal of an embryo or fetus from the uterine cavity by surgical or drug administration.”¹⁹³ *Sterilization* entails “the closing or cutting off the female tubes for preventing pregnancy, or the closing or cutting of the male branches of the male to prevent fertilization.”¹⁹⁴

¹⁸⁸ U.N. Economic and Social Council, *Third Periodic Report Submitted by Estonia under articles 16 and 17 of the Covenant, due in 2016*, UN Doc. E/C.12/EST/3, ¶ 162, (29 Sep. 2017).

¹⁸⁹ *Id.*, ¶ 163.

¹⁹⁰ Committee on the Elimination of Discrimination against Women, *Concluding comments of the Committee on the Elimination of Discrimination against Women: Estonia*, 10 Aug. 2007, CEDAW/C/EST/CO/4, ¶ 24. <http://uhri.ohchr.org/Document/File/e8646a30-17a7-419c-ae8a-437add254266/44ddb928-5853-42eb-95c9-d695dafaeadada> (last visited 13 Dec. 2017).

¹⁹¹ Wm. Robert Johnston, *Historical abortion statistics, Estonia*, Johnston’s Archive (24 Feb. 2017), <http://www.johnstonsarchive.net/policy/abortion/ab-estonia.html> (last visited 14 Dec. 2017).

¹⁹² Pregnancy Abatement and Sterilization Act – 25 Nov. 1998 – RT I 1998, 107, 1766 (E.I.F. 21 Dec. 1998). <https://www.riigiteataja.ee/akt/13243384> (last visited 13 Dec. 2017).

¹⁹³ *Id.*, art. 2.

¹⁹⁴ *Id.*, art. 4.

78. According to the “Pregnancy Abatement and Sterilization Act” (Raseduse katkestamise ja steriliseerimise seadus), abortion is permitted up until the 12th week of pregnancy.¹⁹⁵ Abortion may be legal up to 22 weeks, however, if “(1) the pregnancy endangers the pregnant woman’s health; (2) the unborn child may have a severe mental or physical damage to health; (3) the illness or health problem of a pregnant woman hinders the raising of a child; (4) the pregnant woman is below the age of 15; (5) the pregnant woman is over the age of 45.”¹⁹⁶ The doctor performing the abortion will decide on the admissibility of termination of pregnancy.¹⁹⁷ In cases of where the pregnancy endangers the pregnant woman’s health, the unborn child may be born with severe mental or physical damage, or the pregnant woman’s illness prevents her from raising the child, at least three doctors must agree on the admissibility of termination in writing.¹⁹⁸ Two of the three doctors must be gynecologists while the other doctor must be a medical specialist concerned with the woman’s illness or health problems.¹⁹⁹ In addition, a woman whose pregnancy has lasted for more than 12 weeks or if the woman’s medical status requires it must be admitted for hospital treatment after the abortion.²⁰⁰

79. The Act requires that abortions be performed voluntarily. Therefore, a woman must give her written consent to the procedure, and/or her legal representative must give written consent.²⁰¹ If the legal representative’s wishes conflict with the interest of the woman, the health care provider “shall proceed from the person’s own consent upon termination of pregnancy.”²⁰²

¹⁹⁵ *Id.*, art. 6, para. 1. (“Pregnancy may be interrupted if it has not lasted longer than 11 weeks.”).

¹⁹⁶ *Id.*, art. 6, para. 2, subsections 1-5. (“(2) Pregnancy which has lasted for more than 11 and up to 21 weeks may be terminated if: 1) the pregnancy endangers the pregnant woman’s health; 2) the unborn child may have a severe mental or physical damage to health; 3) the illness or health problem of a pregnant woman hinders the raising of a child; 4) the pregnant woman is below the age of 15; 5) the pregnant woman is over the age of 45.”).

¹⁹⁷ *Id.*, art. 11, para. 1. (“A doctor who terminates pregnancy shall decide on the admissibility of termination of pregnancy based on the requirements specified in sections 5 and 6 of this Act.”).

¹⁹⁸ *Id.*, art. 11, para. 2. (“The admissibility of termination of pregnancy in the cases described in clauses 6 (2) 1), 2) and 3) of this Act shall be ascertained with the decision of at least three doctors – two or more gynaecologists and a medical specialist or specialists resulting from the woman’s illness or health problems. If necessary, a social worker shall be involved in the making of a decision in addition to doctors in the cases specified in clause 6 (2) 3) of this Act. A decision on admissibility of termination of pregnancy shall be in written form and certified by all the persons making the decision with their signatures.”).

¹⁹⁹ *Id.*

²⁰⁰ *Id.*, art. 13, para. 3. (“A woman whose pregnancy is terminated shall be admitted for hospital treatment if her pregnancy has lasted for more than 12 weeks or if the woman’s medical status so requires.”).

²⁰¹ *Id.*, art. 1. (“A woman’s pregnancy may only be terminated at her own request. Nobody is allowed to force or influence a woman to terminate her pregnancy. Consent for termination of pregnancy shall be in written form.”); art. 2. (“Pregnancy of a woman with restricted active legal capacity may be terminated with her own consent or with the consent of her legal representative according to subsection 766 (4) of the Law of Obligations Act.”).

²⁰² *Id.*, art. 3. (“art. 3. (“If a woman with restricted active legal capacity does not agree to involve her legal representative with good reason in the case provided for in subsection 766 (4) of the Law of Obligations Act or if the decision of the legal representative is in conflict with the interests of the woman, the health care provided shall proceed from the person’s own consent upon termination of pregnancy.”).

80. Only gynecologists and health care providers holding the activity license of gynecology maintain the right to terminate a pregnancy.²⁰³ Gynecologists or other health care professionals cannot be forced to participate in the process of terminating a pregnancy.²⁰⁴

81. Before the abortion procedure, the Act requires that the health care professional explain to the pregnant woman “the biological and medical nature of termination of pregnancy, and the involved risks, including the potential complications”²⁰⁵ as well as “the psychological and other relevant counselling possibilities.”²⁰⁶

82. The Act also ensures that a doctor “apply measures [as determined by the Ministry of Social Affairs] preventing complications which may accompany the termination of pregnancy.”²⁰⁷ A woman also has the right within two weeks following her abortion to consult with the doctor who established the admissibility of termination of pregnancy.²⁰⁸

83. The Act also mandates the Ministry of Social Affairs to collect and process data concerning abortion for the purposes of developing national social policy within the areas of family planning, increasing the number of births, decreasing the number of abortions, and ensuring the quality of health services.²⁰⁹ The data will also be used in Estonia’s submission of reliable data to the World Health Organization.²¹⁰

84. According the 2014 UN Department of Economic and Social Affairs’ Report titled “Abortion Policies and Reproductive Health around the World,” Estonia provides the following legal

²⁰³ *Id.*, art. 7. (“Only gynaecologists shall have the right to terminate pregnancy.”); art. 9. (“Pregnancy can only be terminated by a health care provider holding the activity licence of gynaecology for the provision of health services.”).

²⁰⁴ *Id.*, art. 8. (“Gynaecologists or other health care professionals cannot be required to terminate pregnancy or participate in the process of termination of pregnancy.”).

²⁰⁵ *Id.*, art. 12, para. 1. (“Before the termination of pregnancy, the health care professional must explain to the woman who wishes to terminate her pregnancy or in the case provided for in subsection 766 (4) of the Law of Obligations Act to the legal representative the biological and medical nature of termination of pregnancy and the involved risks, including the potential complications.”).

²⁰⁶ *Id.*, art. 12, para. 1¹. (“The health care professional shall inform a pregnant woman or a woman who wishes to terminate her pregnancy or in the case provided for in subsection 766 (4) of the Law of Obligations Act her legal representative of the psychological and other relevant counselling possibilities, if necessary.”).

²⁰⁷ *Id.*, art. 14, para. 1. (“Immediately after termination of pregnancy a doctor shall apply measures preventing complications which may accompany the termination of pregnancy. The list of measures shall be established by a regulation of the minister responsible for the area.”).

²⁰⁸ *Id.*, art. 14 para. 2. (“A woman whose pregnancy was terminated shall have the right within two weeks following the termination of pregnancy to consult with the doctor having established the existence and duration of pregnancy out of turn on the conditions of emergency care.”).

²⁰⁹ *Id.*, art. 16, para 1. (“The Ministry of Social Affairs shall collect and process data concerning the termination of pregnancy for the development of national social policy in the field of family planning, increasing the number of births and decreasing the number of abortions as well as for ensuring the quality of health services and exercising supervision over the organisers of termination of pregnancy and as an obligation of a member of the World Health Organisation for the submission of reliable data comparable with other countries thereto.”).

²¹⁰ *Id.*

grounds for abortion: to save a woman’s life, to preserve a woman’s physical health, and to preserve a woman’s mental health.²¹¹ Abortion is available in the cases of rape or incest, of fetal impairment, for economic and social reasons, and even upon request through the twelfth week of pregnancy.²¹² Thereafter, a pregnant woman must undergo a consultation with doctors.²¹³ A pregnant woman must consent to an abortion, and the abortion must be performed in a hospital by a physician.²¹⁴

85. In a 2015 global study conducted by the Guttmacher Institute in New York, USA, the pregnancy rates and outcomes (births and abortions) among 15- to 19-year old adolescents and 10- to 14-year old children were examined in each state.²¹⁵ According to 2011 data, there were 1,400 pregnancies among females aged 15-19 in Estonia. 43% of those teenage pregnancies ended in abortion. Among females aged 10-14, 2012 data show that for every 1,000 females, 27 were pregnant. 77% of those pregnancies ended in abortion. The study notes that “[t]he teen pregnancy rate declined in the majority of the 16 countries with complete estimates in both the mid-1990s and 2011. The steepest annualized percentage change occurred in Estonia (4% per year).”

Contraception

86. CEDAW issued its Concluding Observations on Estonia’s obligations under the Convention on the Elimination of Discrimination against Women on 18 November 2016.²¹⁶ Its Observations noted that approximately 95% of Estonian citizens are covered by the national mandatory health insurance scheme.²¹⁷ Yet, it expressed concern with “the high rates of alcohol abuse and alcohol-related deaths among young women; the limited contraceptive coverage under the health insurance scheme; the long waiting periods for health appointments, in particular with respect to sexual and reproductive health services, especially for women in rural areas; and the limited

²¹¹ 2014 UN Department of Economic and Social Affairs, *Abortion Policies and Reproductive Health around the World*, United Nations Secretariat (2014), <http://www.un.org/en/development/desa/population/publications/pdf/policy/AbortionPoliciesReproductiveHealth.pdf> (last visited 12 Dec. 2017).

²¹² *Id.*

²¹³ *Id.*

²¹⁴ *Id.*

²¹⁵ Gilda Sedgh Sc. D., Lawrence B., Finer Ph.D., et. al., *Adolescent Pregnancy, Birth, and Abortion Rates Across Countries: Levels and Recent Trends*, *Journal of Adolescent Health*, Vol. 56, Issue 2, 223-230, (February 2015), Guttmacher Institute, New York, New York. <https://www.sciencedirect.com/science/article/pii/S1054139X14003875> (last visited 11 Dec. 2017).

²¹⁶ Committee on the Elimination on the Elimination of Discrimination against Women, *Concluding comments of the Committee on the Elimination of Discrimination against Women: Estonia*, (18 Nov. 16), CEDAW/C/EST/CO/5-6.

²¹⁷ *Id.*, ¶ 30.

accessibility for rural, older and marginalized women of the recently introduced electronic administration of health appointments.”²¹⁸

87. CEDAW’s corresponding recommendation included to “take the measures necessary to address the high rates of alcohol abuse and alcohol-related deaths among young women; ensure affordable access to sexual and reproductive health services, in particular to a comprehensive range of contraceptives, for all women and girls, including those in rural areas and those with disabilities; reduce the waiting periods for obtaining health appointments, in particular for rural women and with respect to sexual and reproductive services; and ensure that rural, older and marginalized women are not excluded from health services owing to the recent introduction of electronic administration of health appointments, by educating them on the use of such tools and ensuring adequate Internet access.”²¹⁹

88. In 2007, CEDAW wrote in its Concluding Observations on Estonia’s Covenant obligations, “The Committee reiterates its recommendation that comprehensive research be conducted into the specific health needs of women. It urges the State party to take concrete measures to enhance and monitor access to health-care services for women, including in rural areas. It requests the State party to strengthen measures aimed at the prevention of unwanted pregnancies, including by making a comprehensive range of contraceptives more widely available and without any restriction and by increasing knowledge and awareness about family planning. The Committee requests the State party to include in its next report further information on women’s health, disaggregated by age, ethnicity and urban and rural areas, and on the impact of measures it has taken to improve women’s health, as well as information on women’s access to health-care services, including family planning. The Committee recommends that the State party step up its efforts to prevent and combat HIV/AIDS and improve the dissemination of information about the risks and ways of transmission. It recommends that the State party include a gender perspective in all its policies and programmes on HIV/AIDS. It calls on the State party to ensure the effective implementation of its HIV/AIDS strategies and to provide detailed and statistical information about women and HIV/AIDS in its next report.”²²⁰

89. Condoms and emergency contraceptive pills are accessible without prescription.²²¹

²¹⁸ *Id.*

²¹⁹ *Id.*, ¶ 31.

²²⁰ Committee on the Elimination on the Elimination of Discrimination against Women, *Concluding comments of the Committee on the Elimination of Discrimination against Women: Estonia*, CEDAW/C/EST/CO/4, ¶ 25, (10 Aug. 2017).

²²¹ Department of Obstetrics and Gynecology, University of Tartu, Tartu, Estonia, “Contraceptive use among young women in Estonia: Association with contraceptive services,” *The European Journal of Contraception and Reproductive Health Care*, 2015, June 2015, DOI: 10.3109/13625187.2015.1057699, https://www.researchgate.net/publication/279066205_Contraceptive_use_among_young_women_in_Estonia_Associat

90. “The conditions and procedure for the issue of prescriptions for medicinal products and for the dispensation of medicinal products by pharmacies and the format of the prescription” Act (Ravimite väljakirjutamise ja apteekidest väljastamise tingimused ja kord ning retsepti vorm) establishes the issuance and dispensation of prescriptions for medicinal products in Estonia.²²² Hormonal contraceptive methods and intrauterine devices (IUDs) are subsidized and prescribed by doctors, nurses, and midwives.²²³ Additionally, individuals must visit a contraceptive service in order to start using one of these methods.²²⁴

91. Contraceptives available via prescription include: plastic IUDs, intravaginal contraceptives, hormonal contraceptives for systemic use such as progestogens, estrogens, emergency contraceptives, and medroxyprogesterone.²²⁵

92. Estonia has the highest rate of using intrauterine contraception (IUC) in Europe, at 35.9% of women who use contraception.²²⁶

93. Prescription contraceptives are generally subsidized by the Estonian government. “Contraceptives receive a reimbursement rate of 75%, if taken: (i) within one year after childbirth, (ii) within three months after an abortion, or (iii) in the case of medical contraindication to childbirth. If

[ion with contraceptive services](http://www.ec-ec.org/emergency-contraception-in-europe/country-by-country-information-2/estonia/); European Consortium for Emergency Contraception (ECEC) – Estonia <http://www.ec-ec.org/emergency-contraception-in-europe/country-by-country-information-2/estonia/> (last visited 12 Dec. 2017).

²²² The conditions and procedure for the issue of prescriptions for medicinal products and for the dispensation of medicinal products by pharmacies and the format of the prescription” Act (Ravimite väljakirjutamise ja apteekidest väljastamise tingimused ja kord ning retsepti vorm), RTL 2005, 23, 315, (E.I.F. 3 Jan. 2005).

<https://www.rigiteataja.ee/en/eli/ee/507092016002/consolide/current> (last visited 14 Dec. 2017).

²²³ *Id.*, art. 2, section 2, (“Medicinal products may be prescribed for medical purposes and for the purposes of treatment of other persons only by the physicians, dentists, midwives and nurses working with a family physician acting on the basis of a practice list of a family physician, who are authorised to provide health services in the Republic of Estonia in relation to the out-patient treatment of the persons treated by them.”); art. 2, section 3¹, subsection 6-7, (“Midwives, stating their position title on the prescription, are authorised to prescribe only the following medicinal products and substances: 6) ATC code G02B – contraceptives for topical use; 7) ATC code G03A– hormonal contraceptives.”); art. 2, section 3², subsection 6, (“Nurses working with a family physician acting on the basis of a practice list of a family physician, stating their position title on the prescription, are authorised to prescribe only the following medicinal products and substances: ATC code G02B, G03A and G03DA02 – hormonal contraceptives, except for initial prescription.”).

²²⁴ Department of Obstetrics and Gynecology, University of Tartu, Tartu, Estonia, “Contraceptive use among young women in Estonia: Association with contraceptive services,” *The European Journal of Contraception and Reproductive Health Care*, 2015, June 2015, DOI: 10.3109/13625187.2015.1057699, https://www.researchgate.net/publication/279066205_Contraceptive_use_among_young_women_in_Estonia_Association_with_contraceptive_services (last visited 13 Dec. 2017).

²²⁵ WHO Collaborating Centre for Drug Statistics Methodology, *ATC/DDD Index 2017*, Norwegian Institute of Public Health. https://www.whocc.no/atc_ddd_index/ (last visited 14 Dec. 2017).

²²⁶ “Worldwide use of intrauterine contraception: a review,” *Contraception*, Vol. 89, Issue 3, March 2014, pp. 162-173. <https://doi.org/10.1016/j.contraception.2013.11.011>

a contraceptive on the list of medicines reimbursed at 75% is not used for these three reasons, the contraceptive falls into the 50% reimbursement rate bracket.”²²⁷

94. Contraceptive preparations are taxed at 9% of the taxable value which is a reduction from the 20% tax rate imposed on most items.²²⁸

Analysis: To What Extent are Estonia’s Laws and Practices with regard to Abortion and Contraception Compatible with the Covenant?

95. The right to benefit from scientific progress include the right to access and undergo scientific procedures and methods that help improve health and safety. Abortion, access to affordable contraception, and education on sex and reproduction are incorporated within those rights memorialized in Article 10, Article 12, and Article 15 of the Covenant.

96. As emphasized in this Committee’s General Comment No. 14, the right to reproductive health means that individuals have the freedom to decide if and when to reproduce.²²⁹ In addition, States must ensure that their residents are informed and have access to safe, effective, affordable and acceptable methods of family planning.²³⁰

97. The Programme of Action of the International Conference on Population and Development further enshrines this well-established “right to reproductive autonomy”. “Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other relevant UN consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children”²³¹

²²⁷ Center for Reproductive Rights, *European Standards on Subsidizing Contraceptives*, www.reproductiverights.org, https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_fac_slovak_european%20standards_9%2008_WEB.pdf (last visited 13 Dec. 2017).

²²⁸ Value-Added Tax Act (Käibemaksuseadus), 10 Dec. 2003, RI I 2003, 82, 554, Art. 15(2), (E.I.F. 12 Dec. 2017), <https://www.riigiteataja.ee/en/eli/ee/514072017001/consolide/current> (last visited, 13 Dec. 2017).

²²⁹ *Supra* ¶ 69.

²³⁰ *Id.*

²³¹ Programme of Action of the International Conference on Population and Development, Cairo (1994), ¶ 7.3, U.N. A/CONF.171/13/Rev.1 (1995), http://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf (last visited 13 Dec. 2017).

98. The European Court of Human Rights, in deciding *Costa and Pavan v. Italy*, *Evans v. UK*,²³² *Dickson v. UK*,²³³ and *S.H. and Others v. Austria*,²³⁴ concluded that the decision to become or not become a parent is an “expression of private and family life,” and is therefore protected under Article 8 of the European Convention of Human Rights, which is similar to Article 10 of the Covenant.²³⁵

99. Estonia’s country report does not adequately address the gender-specific factors that affect issues this Committee has raised such as teenage pregnancy. The report is also silent on concerns expressed by CEDAW such as ensuring affordable access to sexual and reproductive health services especially for rural women and providing a comprehensive range of contraceptives in rural area; it also urged Estonia to pursue comprehensive research on the specific health needs of women.²³⁶

100. Estonia’s domestic law on abortion is moderate as it does not restrict teenage abortions nor impose extreme obstacles on women seeking abortions. Estonia does not criminalize nor penalize women, doctors, or health care providers for participating in an abortion procedure. However, the requirement for three doctors’ approval in select cases may be an arduous obstacle to overcome especially for teenagers and women living in rural areas.

²³² See ECHR *Case of Evans v. United Kingdom*, (No. 6339/05), Judgement of 4 October 2007, ¶ 7172, where the ECHR indicated that “private life [...] incorporates the right to respect for both the decisions to become and not to become a parent” and, regarding the regulation of the practice of IVF, clarified that “the right to respect for the decision to become a parent in the genetic sense, also falls within the scope of Article 8.”

<http://hudoc.echr.coe.int/webservices/content/pdf/001-72684?TID=ihgdqbxnfi>. (last visited 14 Dec. 2017).

²³³ See ECHR *Case of Dickson v. United Kingdom* (No. 44362/04), Judgement of 12 December 2007, ¶ 66 (the Court indicated, with regard to the technique of assisted reproduction that “Article 8 is applicable to the applicants’ complaints in that the refusal of artificial insemination facilities concerned their private and family lives which notions incorporate the right to respect for their decision to become genetic parents.”)

<http://hudoc.echr.coe.int/webservices/content/pdf/003-2204926-2350295?TID=ihgdqbxnfi>. (last visited 14 Dec. 2017).

²³⁴ See ECHR *Case of S.H. and others v. Austria* (No. 57813/00), Judgement of 3 November 2011, ¶ 82 (the Court referred explicitly to the right of access to assisted reproduction techniques, such as IVF, indicating that “the right of a couple to conceive a child and to make use of medically assisted procreation for that purpose is also protected by Article 8, as such a choice is an expression of private and family life.”), <http://www.ieb-eib.org/en/pdf/cedh-shothers-c-austria-20100401.pdf> (last visited 14 Dec. 2017); see also ECHR, *Case of P. and S. v. Poland* (No. 57375/08), Judgment of 30 October 2012, ¶ 96 (the ECHR indicated that, “[w]hile the Court has held that Article 8 cannot be interpreted as conferring a right to abortion, it has found that the prohibition of abortion when sought for reasons of health and/or well-being falls within the scope of the right to respect for one’s private life and accordingly of Article 8.”)

http://www.grocjusz.edu.pl/Materials/archiwum/archiwum2012/js_16.11.2012.pdf. (last visited 14 Dec. 2017).

²³⁵ *Costa and Pavan v. Italy* (No. 54270/10), Judgement of 28 August 2012, art. 8, ¶ 56-57 of the European Convention recites: “1. Everyone has the right to respect for his private and family life, his home and his correspondence. 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.” European Convention for the Protection of Human Rights and Fundamental Freedoms, 213 U.N.T.S. 222, entered into force Sept. 3, 1953, as amended by Protocols Nos 3, 5, 8, and 11 which entered into force on 21 September 1970, 20 December 1971, 1 January 1990, and 1 November 1998 respectively.

²³⁶ *Supra* ¶ 88.

101. Estonia makes contraceptives readily available over the counter or by prescription. Although contraceptives may be taxed, they may also be subsidized by the government. As expressed by CEDAW, however, contraceptives may be altogether unavailable for teenagers and adults in rural areas.

102. Until Estonia makes contraceptives accessible to all teenagers and adults, regardless of gender or geographical location, removes arduous obstacles for women seeking an abortion, addresses the causes of teenage pregnancy, and increases its investment in research on reproduction and gender-specific needs, it will not adequately meet the rights to reproductive autonomy, to family, to health, and to science.

RECOMMENDATIONS

103. We recommend that this Honorable committee include at least one of the following questions in the List of Issues it will prepare for Estonia.

i. Please explain how a lack of comprehensive, domestic legislation on human embryonic stem cell research benefits Estonia and how it can be reconciled with its Article 15 obligation to take steps towards achieving the full realization of the Right to enjoy the benefits of scientific progress and its application.

ii. Please explain how banning surrogacy respects and ensures the protected Article 10 Right to Family, the Article 12 Rights to reproductive autonomy and reproductive health, and the protected Article 15 Right to enjoy the benefits of scientific progress and its application.

iii. Please explain how penalizing individuals who could benefit from the practice of surrogacy respects and ensures the protected Article 10 Right to Family, the Article 12 Rights to reproductive autonomy and reproductive health, and the protected Article 15 Right to enjoy the benefits of scientific progress and its application.

iv. In recognizing that the Article 12 Right to health and the Article 15 Right to science must be fulfilled without discrimination, please explain how Estonia's current position on surrogacy does not discriminate against individuals who are incapable of bearing children, homosexual couples, or prospective parents finding surrogacy as the safest and most viable method of having a biological offspring.

v. Please, report on what steps Estonia has taken, or intends to take, to repealing penalties against surrogacy.

vi. Please, report on what steps Estonia has taken, or intends to take, to respect, protect, and fulfill the “right to reproductive autonomy,” especially regarding teenagers’ access to contraceptives, sexual education, and emerging science.

vii. Please, report on what steps Estonia has taken, or intends to take, to make contraception more available and affordable, especially for teenagers and for individuals residing in rural areas.