

Position Paper on Sexual and Reproductive Health and Rights 2019 (The Madrid Declaration)

Launched in September 2019 in Madrid at the World Contraception Day event organised by the Sociedad Española de Contracepción (Spanish Society of Contraception)

SUMMARY OF THE MAIN POINTS IN ENGLISH

1. Evidence-based medicine and respecting human rights, including SRH rights, should be at the forefront when planning and implementing SRH policies.
2. Sexual and reproductive rights constitute fundamental human rights. Human rights of particular relevance are the rights to health, to life, to freedom from torture and other ill-treatment, to privacy and to equality and non-discrimination.
3. Contraception saves lives, improves health and is highly cost-effective. Availability of contraception must be made more equitable throughout Europe. A wide range of contraceptives must be freely available to women and men, in order to fulfil their reproductive rights.
4. Sterilisation must be freely available as a choice for those who want a highly-effective irreversible method of fertility control. It is essential that consent to sterilisation is valid and that there is no element of coercion.
5. Abortion must be accessible in a safe environment for those who request it. Medical professionals' refusals to provide abortion care on grounds of conscience must be controlled by adequate regulation, oversight and enforcement.
6. Sexually transmitted infections and HIV are widespread in Europe. More effort needs to be put into preventive measures and treatment.
7. Comprehensive, age-appropriate sexuality and reproductive health education must be provided for young people to ensure their health and wellbeing as adults.
8. Actions that reduce infertility should be promoted and services for the diagnosis and treatment of infertility must be provided.
9. Measures should be taken in the primary and secondary prevention of reproductive tract cancers.
10. There are disparities in maternal mortality rates across Europe which need addressing. There are reports from some countries of disrespectful or even abusive treatment of women during maternity care.
11. More work is needed throughout Europe on the prevention and combatting of gender-based violence. Similarly, more effort is needed in the prevention of female genital mutilation and prosecution of perpetrators.
12. Education of professionals to a basic level in the management of sexual problems, including education about sexual and reproductive rights as human rights, is needed.
13. Specific population groups, some of them marginalised and stigmatised, need particular attention. They include adolescents, LGBTQIA, migrants, people with disabilities, older people, sex workers and men.
14. The issues raised in this Paper should be widely disseminated and acted upon. Progress can be made by interdisciplinary work and forming partnerships with other organisations.

RESUMEN DE LOS PUNTOS PRINCIPALES EN ESPAÑOL

1. La medicina basada en la evidencia y el respeto de los derechos humanos, incluidos los derechos en SSR, deben estar en primera fila a la hora de planificar e implementar políticas de SSR.
2. Los derechos sexuales y reproductivos constituyen derechos humanos fundamentales. Los derechos humanos de particular importancia son los derechos a la salud, a la vida, a no sufrir tortura y otros malos tratos, a la privacidad, a la igualdad ya la no discriminación.
3. La anticoncepción salva vidas, mejora la salud y es altamente rentable. La disponibilidad de anticonceptivos debe hacerse más equitativa en toda Europa. Una amplia gama de anticonceptivos debe estar disponible libremente para mujeres y hombres, a fin de que puedan alcanzar sus objetivos en materia de derechos reproductivos.
4. La esterilización debe estar disponible libremente como una opción para aquellos que desean un método irreversible altamente efectivo de control de fertilidad. Es esencial que el consentimiento para la esterilización sea válido y que no haya ningún elemento de coerción.
5. El aborto debe ser accesible en un entorno seguro para quienes lo solicitan. La negativa de los profesionales médicos a proporcionar servicios de aborto por motivos de objeción de conciencia debe ser controlada por una regulación, supervisión y cumplimiento adecuados.
6. Las infecciones de transmisión sexual y el VIH están muy extendidos en Europa. Es necesario poner más esfuerzo en medidas preventivas y tratamiento.
7. Se debe proporcionar una educación integral, adecuada a la edad de la sexualidad y la salud reproductiva, para que los jóvenes puedan garantizar su salud y bienestar como adultos.
8. Deben promoverse acciones que reduzcan la infertilidad y se proporcionen servicios para el diagnóstico y tratamiento de la misma.
9. Se deben tomar medidas en la prevención primaria y secundaria de los cánceres del tracto reproductivo.
10. Existen disparidades en las tasas de mortalidad materna en toda Europa que deben abordarse. Hay informes de algunos países sobre el trato irrespetuoso o incluso abusivo a las mujeres durante los cuidados maternos.
11. Se necesita más trabajo en toda Europa para prevenir y combatir la violencia de género. Del mismo modo, se necesita más esfuerzo en la prevención de la mutilación genital femenina y el procesamiento de sus autores y responsables.
12. Se necesita educación a un nivel básico de profesionales en el manejo de problemas sexuales, incluida la educación sobre derechos sexuales y reproductivos como derechos humanos.
13. Hay grupos de población específicos, algunos de ellos marginados y estigmatizados, que necesitan una atención especial. Incluyen adolescentes, LGBTQIA, migrantes, personas con discapacidades, personas mayores, trabajadoras sexuales y hombres.
14. Las cuestiones planteadas en este documento deben difundirse ampliamente y ponerse en práctica. Se puede avanzar mediante el trabajo interdisciplinario y formar asociaciones con otras organizaciones.

The European Society of Contraception and Reproductive Health (ESC) is a professional membership organisation comprising people interested in contraception and reproductive health in European countries. Its aims are to improve and facilitate knowledge, carry out studies, promote the harmonisation of policies and encourage relations with other organisations in Europe and throughout the world.

The ESC wishes to make a clear and forthright declaration on where it stands in relation to sexual and reproductive health and rights (SRHR) in its broadest sense. This Madrid Declaration expands The Hague Declaration made in 2010 (<https://escrh.eu/wp-content/uploads/2017/10/TheHagueDeclaration.pdf>). The ESC has drafted this Position Paper on SRHR spurred on by the inspirational report from the Guttmacher-Lancet Commission¹ and the current threat of regression of SRHR in many countries. This Position Paper is specifically relevant to all 53 States within the World Health Organization (WHO) Europe Region (this includes the 47 States that make up the Council of Europe). Within these countries, the Paper may be of use to advocates, opinion leaders, politicians, policy-makers, service providers, public health officials and others.

The ESC took the Guttmacher-Lancet Commission's carefully crafted definitions as a basis for the scope of this Paper. The ESC also freely used the Commission report's headings, maintaining the global theme but with a focus on a European perspective. The ESC also draws on the WHO Action Plan for SRH, with its emphasis on integrating SRH into national public health strategies and developing whole-of-government and whole-of-society approaches for implementation of programmes². The ESC places its own particular emphasis on barriers to access to SRH services that have been identified and how SRH services can be adapted to the needs of marginalised groups.

In anticipation that this Paper will be read by diverse readers (healthcare professionals, social care professionals, politicians, lawyers, policy-makers etc) there is a list of abbreviations and a glossary of terms at the end of the main text.

BACKGROUND

The ESC is keen to make a contribution to ongoing discussions in European governments and civil society on SRHR. The ESC believes that the primacy of evidence-based medicine and respect for human rights should be recognised when planning and implementing SRH policies. Policy-makers should make proposals based more on factual evidence and not on political and religious viewpoints. There is already a considerable body of evidence on the positive impact of SRH; this needs further dissemination.

Although all human rights are relevant to SRHR, the Council of Europe has identified certain human rights as having key importance. These are the rights to health, to life, to freedom from torture and other ill-treatment, to privacy and to equality and non-discrimination³.

Despite progress having been made on SRHR in Europe, some people in European countries continue to face widespread denials and infringements of their SRHR³. In some countries, policies and laws relating to SRHR have been made more restrictive⁴. Harmful gender stereotypes, stigma and social norms continue as well as violence and coercive practices⁵. One of the ESC's aims is to improve and facilitate knowledge of our field of medicine. The ESC has a special responsibility to communicate up-to-date, evidence-guided information and to counter any circulating myths or misinformation. The Society also recognises that stigma is widespread in relation to those seeking SRH services and wishes to address this whenever and wherever it occurs⁶.

The ESC recognises that there are forces working against progress in SRHR and advancements in gender equality⁷. These anti-gender viewpoints oppose:

- sexual and reproductive rights, including access to comprehensive abortion care and contraception including emergency contraception as well as other new reproductive technologies
- sexuality and reproductive health education
- gender mainstreaming (realising gender equality)
- protection against gender-based violence
- same-sex marriage and adoption

In 2013, a secretive network of religious fundamentalists called Agenda Europe was established; its manifesto is titled 'Restoring the Natural Order'⁸. Agenda Europe holds annual 'summits' attended by about 100 – 150 anti-SRR activists from around Europe. It is opposed not only to abortion but to all forms of contraception. The ESC feels that all those concerned with and responsible for the health of Europe's population must take a stand to ensure that the availability and access to SRH information, education and services is not undermined or curtailed.

As well as specific organisations threatening SRHR, in many countries there is an oppressive effect of the criminal law. Criminal laws governing adultery, same-sex relations, drug use, abortion, sex work, and HIV transmission, exposure and non-disclosure seek to curtail and punish deeply personal decisions and choices about an individual's life and body and they can have a negative impact on SRHR⁹. To give an example, where police can make use of criminal laws to arrest or harass sex workers, sex workers are driven underground and are less likely to seek the health care they need and have a right to access. This makes it harder for health workers to reach them.

Definition of sexual and reproductive health and rights

Sexual and reproductive health (SRH) is a state of physical, emotional, mental and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity¹⁰. Sexual and reproductive rights constitute fundamental human rights¹¹. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust and communication in the promotion of self-esteem and overall wellbeing¹. All individuals, regardless of sex, age, gender, sexual orientation, gender identity, socio-economic status, ethnicity, cultural background and legal status², have a right to autonomy and to make decisions governing their bodies and to access services that support that right. Achievement of SRH relies on the realisation of sexual and reproductive rights (SRR), which are based on the human rights of all individuals to:

- have their bodily integrity, privacy and personal autonomy respected
- freely define their own sexuality, including sexual orientation and gender identity and expression
- decide whether and when to be sexually active
- choose their sexual partners
- have safe and pleasurable sexual experiences
- decide whether, when and whom to marry
- decide on the number and spacing of their children
- have access, over the course of their lives, to the information, education, resources, services and support necessary to achieve all the above, free from discrimination, coercion, exploitation and violence

More specifically, sexual and reproductive rights (SRR) are outlined by the UN Committee on Economic, Social and Cultural Rights General Comment No. 22¹². The broad extent of these rights is laid out in Box 1.

Box 1 The right to sexual and reproductive health

- Elements of the right to sexual and reproductive health:
 - **Availability:** functioning public health and health care facilities, goods, services and programmes in sufficient quantity
 - **Accessibility:** non-discrimination, physical accessibility, economic accessibility (affordability), information accessibility
 - **Acceptability:** respectful of medical ethics and culturally appropriate, sensitive to age and gender
 - **Quality:** scientifically and medically appropriate
- Special topics of broad application:
 - Non-discrimination and equality
 - Equality between women and men, and a gender perspective
 - Intersectional discrimination (against marginalised groups)

Source: UN Economic and Social Council. General comment No. 22 (2016) on the right to sexual and reproductive health

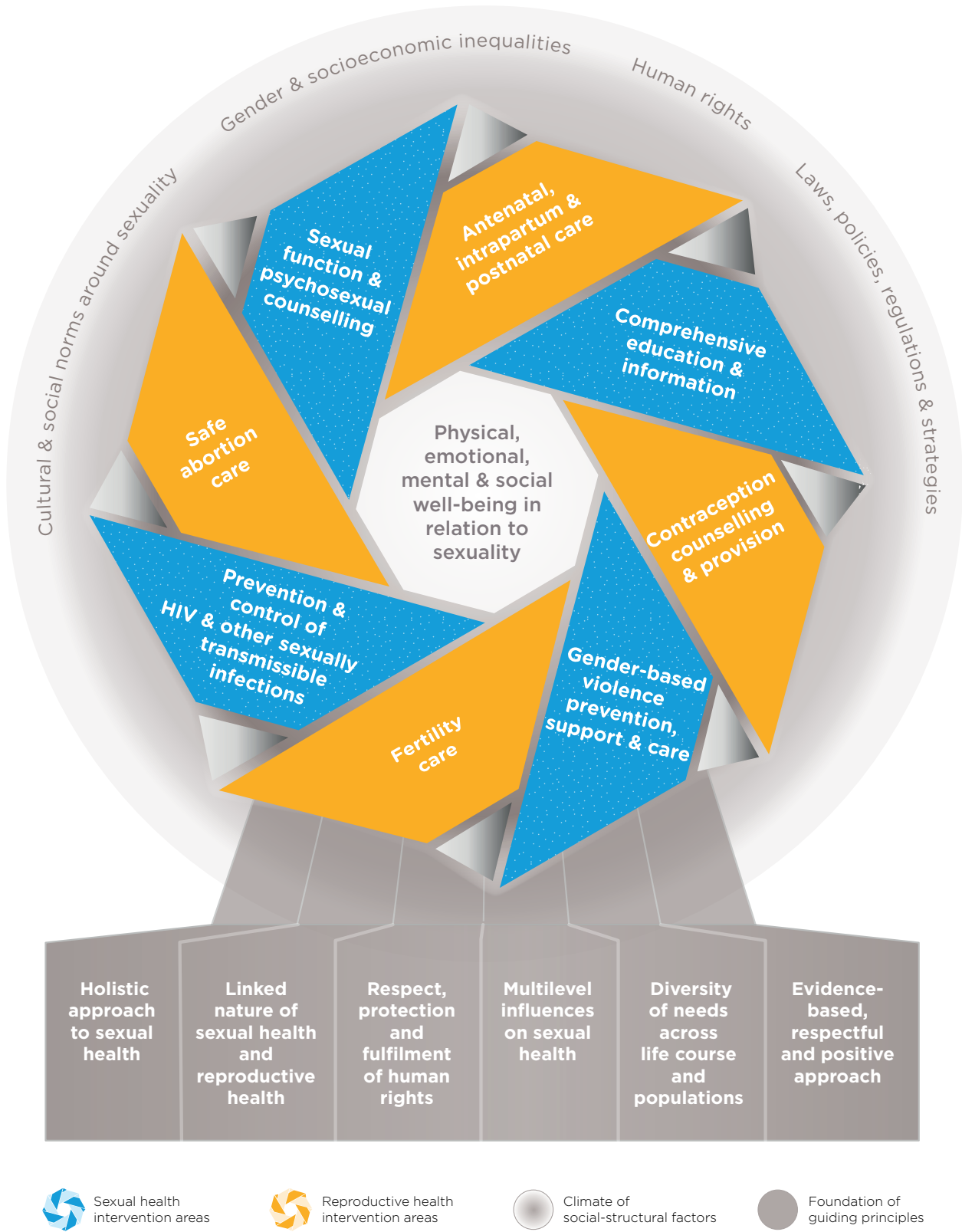
SRH services

Essential SRH services must meet public health and human rights standards, including the 'Availability, Accessibility, Acceptability and Quality' framework of the right to health¹. The services should include interventions that come under the umbrella of the WHO rosette¹³ (Figure 1):

- accurate information and counselling on SRH, including evidence-based, comprehensive sexuality and reproductive health education (CSRE)
- information, counselling and care related to sexual wellbeing, function and satisfaction
- prevention, detection and management of sexual and gender-based coercion and violence
- counselling and services for a range of safe and effective modern contraceptive methods, with a defined minimum number and type of methods, including postpartum and postabortion contraception
- safe and effective antenatal, childbirth and postnatal care, including emergency obstetrics and neonatal care
- safe and effective abortion services and care, including treatment of complications of unsafe abortion and incomplete abortion and including postabortion contraception
- information and counselling for and prevention, management and treatment of infertility
- prevention, detection and treatment of sexually transmitted infections (STIs), including HIV and reproductive tract infections
- prevention, detection and management of reproductive tract cancers

Figure 1^a

Framework for operationalizing sexual health and its linkages to reproductive health



^a Reprinted from: WHO. Sexual health and its linkages to reproductive health: an operational approach. Geneva: World Health Organization, 2017: page 5 http://www.who.int/reproductivehealth/publications/sexual_health/sh-linkages-rh/en/

SPECIFIC AREAS OF CONSIDERATION

The ESC emphasises that the specific areas of consideration mentioned below cannot be selected in a piecemeal fashion. As they are so inextricably linked, they have to be addressed in an integrated way, as shown in Figure 1. Multifaceted solutions and approaches are needed, not simplistic ones. A theme throughout the different sections of this Paper is the need for teaching basic knowledge about human sexuality and essential skills of counselling^b as an integral part of the curricula of training programmes for professionals. This education should not be reserved for specialists but should also be for all those working in primary care and social care.

Contraception

Contraceptives should be freely accessible to those who wish to use them. Contraceptives allow individuals and couples to choose if and when to have children. Because of the risks associated with pregnancy, they also save many women's lives and so promote children's wellbeing¹⁴. For example, it is estimated that in 2008 in Russia, 3,304 maternal deaths were averted by use of contraception. Contraception also offers important health benefits¹⁵. Nevertheless, there is room for improvement; in Europe there is an average unmet need^c for contraception among women aged 15 – 49 years who are married/in a union of 9% (ranging from 4% in France to 21% in Montenegro)¹⁶.

Contraception is highly cost-effective, especially if a longer-term perspective is taken. It is estimated from calculations in England that for every €1 spent on contraception provided free of charge there are savings of €9 over a 10-year period¹⁷.

The WHO Model List of Essential Medicines¹⁸ contains a wide range of contraceptives. One of the main barriers related to access to contraception is their relatively high cost and/or very limited choice. In some European countries, contraceptives are not subsidised under public health insurance schemes and so are only available to the financially privileged. In Slovakia, this is due to legal provisions that prohibit such subsidies³. Some countries, realising the favourable cost-effectiveness of contraception to the State as well as the public health benefits, allow citizens free (or heavily subsidised) access to contraception. According to a recent analysis, only seven European countries offer excellent general reimbursement schemes for contraceptives¹⁹. The Contraception Atlas of government policies on access to contraception, now published in three successive years, shows encouraging improvements in Albania, Andorra, Finland and Greece; however, both Poland and Kosovo showed a deterioration¹⁹.

Intrauterine contraception (IUC), pills and condoms are widely used throughout Europe²⁰. However, there are wide geographical variations in uptake and barriers to use by young women. It is notable that uptake of both implants and injectables is low, when both these methods are more effective than pills and condoms. So-called 'first-tier' reversible methods (implants and IUC) should be widely available²¹. There are widespread barriers to the uptake of contraception: these include lack of availability of the full range of contraceptive methods and misinformation²², hostile chauvinistic policies, gender inequality and social oppression²³. Industry backing for the development of male contraceptive methods has been virtually abandoned²⁴. Men's motivation to use contraception can be underestimated and trials of male methods are ongoing.

Following a European Commission 'implementing decision' in 2015, most European countries have deregulated emergency contraception (EC) pills so that they are available in pharmacies without the need for a prescription²⁵. Hungary and Poland are the only countries within the EU that have not followed the path of deregulation (Poland did deregulate EC for a time but then reversed the decision).

^b Counselling is defined in a broad sense to include information provision and support; the ESC does not believe any counselling should be mandatory.

^c It is acknowledged that unmet need data make assumptions about women considered to be infertile and duration of postpartum amenorrhoea and so will inevitably include some individuals who do not want or need contraception.

It is gratifying that Malta has had the benefit of emergency contraception (EC) since 2016, although it took a judicial review brought by the Women's Rights Foundation to achieve this. Regulators and pharmacists' professional bodies need to agree a practical way of ensuring that women are not refused EC on grounds of conscience²⁶.

In summary, there is strong evidence that contraception saves lives, improves health and is highly cost-effective. The ESC believes that availability of contraception must be made more equitable throughout Europe. A wide range of contraceptives must be freely available to women and men, in order to fulfil their reproductive rights.

Sterilisation

Sterilisation prevalence in Europe is very variable, mostly due to cultural differences; also, the data are incomplete. Only six countries have a combined female/male sterilisation prevalence greater than 10%. Turkey has the highest known female sterilisation prevalence and the UK the highest known vasectomy prevalence in Europe²⁰. The trend in delaying first birth has resulted in some reduction in requests for sterilisation.

Sterilisation should only be performed after a process of prior, full and informed consent²⁷. Although sterilisation should be freely available as a choice, it is essential that consent is valid and that there is no element of coercion²⁸. The ESC is concerned about instances of forced and coercive sterilisation of Roma women that have continued into the 21st century in three central^d European countries^{29,30}.

The ESC deplores the violation of the rights of people with disabilities and SRH choices on their behalf being made by third parties, especially in relation to sterilisation³¹. The ESC endorses the progressive laws in countries such as Germany, Ireland and Sweden which follow a supported decision-making model for those with disabilities that affect their mental capacity^{31,32}.

The ESC would also draw attention to the involuntary removal of gonads among two groups of people³³. The first of these is those undergoing gender reassignment, many of whom are not given the opportunity to preserve their reproductive potential. The second is those born intersex who do not get the chance to delay having radical surgery according to the gender assigned to them by a third party until they are able to give their own consent.

Abortion

Contraception itself and its use by human beings can fail. Unintended pregnancy is all too common. Abortion will always be an important option for regulating fertility. Where safe abortion is readily accessible and available, abortion-related morbidity and mortality is low. It is impossible to achieve low maternal mortality rates without access to safe abortion³⁴. Denial of abortion has significant negative psychosocial and physical impacts on women³⁵.

Legislation on abortion tends to lag behind societal attitudes and practice, and medical progress³⁶. Many, if not most, laws are over-medicalised and unnecessarily restrictive, for example requirements for abortions to be performed in specially-registered premises and for two doctors' signatures. In some European countries, interpretation of the law is unclear and requires official guidance. In some countries, abortion is stigmatised and remains outside mainstream healthcare; when this happens, providers are not usually trained to the standard expected in public healthcare.

^d In this Paper, central Europe is taken to comprise the Czech Republic, Hungary, Poland and Slovakia

A large majority of countries in Europe have liberalised their abortion laws, allowing abortion at the request of a woman or pregnant person, for reasons of distress or on broad socio-economic grounds. However, most laws maintain restrictive gestational limits and lack clarity on providing abortion on health grounds^{3,37}. In a small number of jurisdictions there are highly restrictive laws that forbid access to abortion except in extremely limited circumstances. However, criminalising and restricting access to abortion has been clearly shown not to reduce the incidence of abortion, but merely to transfer abortions from the safety of oversight by healthcare services into an unsafe, clandestine setting³⁸. Alternatively, women are forced to travel to another country (if they have the necessary funds and travel permits).

There are some positive signs of progress on abortion access. Abortion has recently been decriminalised and permitted at a woman's request up to 12 weeks' gestation in Cyprus and up to 14 weeks in the Isle of Man. The Republic of Ireland liberalised its abortion law at the end of 2018 and swiftly introduced a primary care-led medical abortion service, alleviating cross-border travel for women after years of hardship. The speed of introduction of the service in Ireland mimicked that in Portugal but the model in Portugal is very different, with providers being almost entirely gynaecologists³⁹.

In a few European countries, however, access to legal, safe abortion continues to be very restricted as a result of a range of barriers. Such restrictive laws have a broad range of adverse physical, financial and psychosocial impacts on women and a 'chilling' effect on doctors³. Northern Ireland has an archaic law and an unsupportive Executive meaning that abortion is almost completely unavailable⁴⁰. The situation in Poland is particularly worrying; abortion is severely restricted and stigmatised⁴¹. The European Court of Human Rights (ECtHR) found in a case of a 14-year old who had been raped that her rights to privacy and bodily integrity had been violated by Polish authorities³. Physicians, generally, are too fearful of the consequences of speaking out in religious/political debates within Poland⁴². The ESC notes with concern that a number of European countries have third-party authorisation, mandatory waiting periods and biased counselling requirements in their abortion regulations^{3,43}.

In a few countries, medical professionals' refusals to provide abortion care on grounds of conscience is out of control due to inadequate regulation, oversight and enforcement; this impedes access to abortion which is legally permitted (see relevant country concluding observations by clicking on the 'Human rights by country' tab at <https://www.ohchr.org/en/hrbodies/cedaw/pages/cedawindex.aspx>). Refusals of care are not permissible in emergency situations or by institutions; they are only valid in relation to direct provision of care and, in such instances, referral must be made to an alternative willing and capable provider³. The ESC believes that where a country permits refusals of care on grounds of conscience, objector status should be made public, that in all parts of a country there must be adequate numbers of healthcare professionals who provide abortion care and that governments must take a number of measures to ensure that women's access to legal abortion care is not undermined⁴⁴. Examples of countries that can accommodate objectors while still assuring women have access to abortion services are Norway, Great Britain and Portugal⁴⁵.

Mifepristone, together with misoprostol, plays a fundamental role in delivering medical abortion, a safe and convenient alternative to surgical abortion. Both drugs are on the WHO List of Essential Medicines¹⁸. In 10 European countries, mifepristone is not licensed/marketed. In Hungary, mifepristone is not available, despite being licensed. Outdated methods are still used in some countries for second-trimester abortion. Many women are making recourse to internet-based medical abortion services. Despite the importance of the benefits that medical abortion can provide, surgical abortion should remain available as an option so that choices are not limited.

The ESC believes it is unacceptable that unsafe abortion continues within Europe. For example, it is estimated that 14% of the abortions performed in central and eastern Europe are unsafe³⁸. Outdated methods are still being used by some providers with poor skills and training; national health systems must provide WHO-recommended methods. Women requesting abortion are sometimes treated with a lack of respect and postabortion counselling may be of poor quality. Lack of evidence-based practice, unskilled providers and lack of drug availability also affect the care of women with incomplete abortion.

STI and HIV prevention and care

Reproductive control often leads to non-use of condoms or contraceptive sabotage where a woman desires such use but is unable to influence the situation⁴⁶. Unfortunately, there is a link between gender-based violence (GBV) and the transmission of STIs and HIV. Young people, a particularly vulnerable group, often do not know where to obtain condoms and may not be able to afford them and have inadequate knowledge of the transmission of STIs. Older people too have vulnerabilities in this respect; statistics show a rise in STIs in older women and men.

The ESC is a strong advocate of innovative contraceptive methods but is also very conscious that barrier method use needs to be maintained. Evidence from Europe shows that dual protection is rarely employed by couples⁴⁷. The ESC supports programmes that promote condom use.

STIs are not notifiable in all European countries, so the picture relating to their incidence is incomplete. Nordic countries and the UK have the highest chlamydia notification rates, most likely as a result of high quality surveillance and laboratory services⁴⁸. The UK has the highest number of reported cases of gonorrhoea infection; multidrug antimicrobial resistance is now becoming a problem⁴⁹. Germany, Spain and the UK see the highest reported number of new syphilis cases.

New HIV infections are on the rise in Europe as a whole: during 2016, it is estimated that 221,000 people were newly infected⁵⁰. One quarter of all people living with HIV in Europe are unaware of their status, while half are diagnosed at a late stage of infection⁵⁰. Treatment coverage with antiretroviral therapy is as low as 28% in the central and eastern part of Europe. WHO recommends that all those diagnosed with HIV initiate antiretroviral therapy immediately, regardless of their CD4 cell count. However, in 2016, one third of European countries were not following this policy.

HIV pre-exposure prophylaxis (PrEP) became available in France in 2015, since followed by five other European countries⁵¹; however, overall very few of those at risk have access to PrEP and those that do often have to pay for it. Effort is being put into making PrEP more affordable⁵².

The ESC believes much more can be done to curb the spread of HIV in Europe, especially in the central and eastern parts. Young people from key populations are particularly at risk and have benefitted from services from non-governmental organisations⁵³.

Comprehensive sexuality and reproductive health education for young people

Comprehensive sexuality and reproductive health education^e (CSRE) is an age-appropriate, lifelong process which starts from birth. CSRE in schools is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality⁵⁴. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to realise their health, wellbeing and dignity; develop respectful social and sexual relationships; consider how their choices affect their own wellbeing and that of others; and understand and ensure the protection of their rights throughout their lives. CSRE must be accurate, scientifically sound and culturally sensitive; respect the principle of non-discrimination and promote diversity; address gender norms and promote tolerance and respect³.

Regrettably, ideological opposition to CSRE remains widespread in Europe, the main argument being that it encourages sex at younger ages⁵⁵. International research clearly shows that this argument is false; it is also borne out by the examples of the Netherlands, Switzerland and Finland, all of which are countries with long-standing CSRE programmes and which also have the lowest proportion of those with a sexual debut by age 15 years⁵⁶.

^e Terminology differs widely. The term chosen for this Paper reflects a much broader scope than sex education.

The ESC maintains that lack of CSRE is 'prolonging the ignorance' of young people. Ultra-conservative groups are spreading misinformation about gender; they attack the teaching of awareness and respect for gender identity and sexual orientation, sexual pleasure and sexual rights. They exploit existing taboos and promote smear campaigns that deny young people better access to CSRE in schools, deliberately thwarting efforts to change harmful social norms around gender and to tackle gender-based violence (GBV), including violence against lesbian, gay, bisexual, trans, queer, intersex and asexual (LGBTQIA) young people. This means that time and resources are wasted on ideological debate instead of taking positive and constructive measures to improve CSRE. New generations are thus growing up in the digital age without precious life skills, left with inadequate knowledge of SRHR and vulnerable to homophobic and transphobic bullying.

The ESC fully supports evidence-based⁵⁴, proven methodologies for delivering CSRE so that CSRE is demystified and becomes mainstream, along with all other key school subjects. The Federal Centre for Health Education and WHO have developed standards for CSRE⁵⁷. These have been translated into 13 languages and are widely used. IPPF has also developed guidance on delivering CSRE^{58,59}.

In 21 out of 25 countries that took part in a Europe-wide survey, there is a legal framework for CSRE⁵⁶. In 11 of the countries CSRE is mandatory and ensures that topics proven to have a positive effect on young people's social/emotional self-care skills are covered. The ESC notes that a recent challenge by parents of a Swiss girl that she should be exempted from lessons on relationships and sex in primary school was rejected by the ECtHR⁶⁰.

Malta has a high standard of CSRE with official guidelines issued by its Government⁶¹. Estonia is another example of a country with well-developed CSRE; there are links with youth-friendly SRH services, with school classes regularly visiting youth clinics and teachers having received teaching in CSRE as a core element of their training⁵⁶. CSRE has been shown to be cost-effective for society⁶².

Infertility

While other organisations such as the European Society of Human Reproduction & Embryology (ESHRE) take the professional lead on infertility matters in Europe, the ESC wishes to comment on accessibility to treatment and discrimination against certain groups of people. The ESC believes that to enable people to be aware of the fertility potential over their life course and make informed choices, education about fertility should be part of CSRE.

In the EU, infertility affects about 25 million citizens⁶³. The prevalence of male infertility in Europe is estimated to be 7.5%⁶⁴. The ESC supports Fertility Europe's view that those affected by infertility should be assured of access to assisted reproductive technology (ART) to enable them to try to become parents. The ESC agrees that a range of treatments should be included in the provision of basic health care and be provided to patients under public health insurance. Also, laws or regulations should be in place which protect all those involved in ART from coercion and mistreatment.

Certain groups of people are discriminated against in some countries. For example, policies and laws related to ART exclude single women or women in same-sex partnerships from accessing in-vitro fertilisation or donor-insemination services⁶⁵. Counselling about fertility preservation possibilities is also not provided or possibilities of fertility preservation are not available for women and men of fertile age who suffer from conditions or anticipate treatments which might affect their future fertility, including transgender people. Some countries also have laws prohibiting embryo cryopreservation and egg donation.

The ESC would point out that prolonged use of oral contraception tends to improve fertility⁶⁶. The ESC supports the promotion of actions that reduce infertility such as the prevention of obesity, minimising unsafe abortion and the prevention and early treatment of STIs and postpartum infections. The ESC would want to protect the diagnosis and treatment of

infertility as part of basic healthcare services. All individuals, including children, with conditions where the disease or treatment can interfere with fertility should be counselled about the possibilities and limits of the technologies available to preserve reproductive potential⁶⁷.

Reproductive tract cancers

In this Paper we focus mainly on cervical cancer to illustrate the current situation. There are national screening programmes for cervical and breast cancer. The ESC wishes to draw particular attention to reproductive cancer prevention in women.

The ESC points out the seldom-publicised, but highly significant, contribution that hormonal contraception makes toward prevention of some reproductive cancers. Combined oral contraception^f, especially if taken for prolonged periods of time, has been shown to have a highly significant protective effect against endometrial and ovarian cancer⁶⁸.

The incidence of cervical cancer in European countries ranges from 3.6 cases per 100,000 women per year to 28.6 per 100,000, with the highest incidence in central and eastern Europe⁶⁹. Cervical cancer ranks as the seventh most frequent cancer and the eleventh leading cause of cancer mortality among women in Europe. Based on 2012 figures, there were more than 58,000 new cases per year and more than 24,000 deaths from cervical cancer. Mortality rates from cervical cancer vary widely between countries, with an undue burden in central and eastern Europe⁷⁰.

In countries that have screening programmes and HPV vaccination, cervical cancer is rare. Primary prevention by human papillomavirus (HPV) vaccination of girls and boys and secondary prevention by population screening programmes using cervical cytology and HPV testing backed up by colposcopy both reduce the incidence of cervical cancer. It has been shown in Scotland that administration of bivalent vaccine to girls results in an 89% reduction in preinvasive cervical disease⁷¹. HPV vaccination is routinely given in 33 out of 53 countries in the WHO European region⁷²; in the remaining 20 countries women are more vulnerable to the development of cervical cancer. A traditional approach has been school-based female-only programmes⁷³. Recently, the UK and the Republic of Ireland have announced that boys will also be offered HPV vaccination; the ESC supports this development.

Obstetric care

Whilst other organisations such as the European Board and College of Obstetrics and Gynaecology (EBCOG) take the professional lead on obstetric matters in Europe, the ESC wishes to comment on certain issues. In particular, the ESC wishes to draw attention to inequalities among and abuse of women in maternity care facilities.

There are common trends in Europe in relation to childbirth. Among these are rising caesarean section rates and low breastfeeding rates⁷⁴. Also, there is extreme variation in the numbers of teenage deliveries and the risks associated with teenage births.

Between 2000 and 2015, the average maternal mortality rate in Europe decreased from 33 to 16 per 100,000 live births. Of major concern is that the country with the highest mortality has a rate 25 times that of the lowest⁷⁵. Also, within some countries there are disparities, with higher maternal mortality rates among women in rural areas, those of low socio-economic status and those from ethnic minority groups. Undocumented migrants in some countries are not entitled to non-emergency healthcare³.

^f And, almost certainly, combined hormonal contraception administered by other routes

The ESC is extremely concerned to hear reports of physical and verbal abuse by healthcare staff, suturing of birth injuries without adequate pain relief, failure to safeguard women's privacy during labour and deprivation of food and water during childbirth⁷⁶. In some countries concerns have been raised about use of medication or procedures to speed up labour and thus reduce associated costs for staff and hospital facilities³. In some central and eastern European countries there has been discrimination against Roma women, including apartheid-style segregation in maternity wards³. Not only do these actions in maternity departments fail to respect women's dignity but some of them represent cruel, inhuman or degrading treatment.

Gender-based control and violence

Reproductive control/coercion by others is a subject that has not been publicised much in Europe. Indeed, a recent review found no studies from Europe⁴⁶. In many intimate relationships, coercive control of one partner by the other is the dominant feature rather than physical violence. This control extends to contraception and also to the outcomes of a pregnancy. With respect to contraceptive use, condoms may be surreptitiously removed (stealthing) or other methods being used sabotaged⁴⁶.

GBV is any act of violence that is inflicted upon an individual because of their gender or sexual orientation¹. The violence can take different forms: physical, sexual or psychological (emotional). It encompasses harmful practices such as child marriage, sex trafficking, honour killings, female genital mutilation (FGM) and sexual harassment and abuse. GBV is perpetrated more often against women than men. It is also perpetrated against gay and transgender people. Violence against women undermines their core fundamental rights, including dignity, access to justice and gender equality. In the past, the extent of this violence has been grossly underestimated. An EU-wide survey of violence against women showed a prevalence since the age of 15 years of physical and/or sexual violence of 33% (range of each of the 28 countries 19 – 52%)⁷⁷. Five per cent of the women surveyed had been raped since the age of 15.

A staggering 43% of EU women have experienced psychological abuse by a partner; this fundamentally undermines a woman's autonomy. Coercive control is a crime in some countries. Violence against women perpetrated under coercive control differs from other forms of violence as it involves more serious forms of violence and has a bigger impact in terms of its varied consequences⁷⁸. Countries where women indicated lower levels of coercive control are shown to score higher on a measure of gender equality. Laws on GBV vary in Europe. Most European countries have now criminalised marital rape. In May 2018, Sweden became the tenth European country to recognise in law that sex without consent is rape.

GBV is often not handled well in clinical practice due to time constraints, lack of knowledge or harmful regulations that require reporting to the police. People experiencing GBV themselves know their situation and whether or not it would be a realistic option to go to the police at the time in question.

Female genital mutilation (FGM) is an abhorrent practice and can never be justified⁷⁹. It is estimated that, each year, 180,000 girls and women in Europe are at risk of FGM⁸⁰. FGM is a crime in the EU. In some countries, it is possible to prosecute the practice even when the cutting has been performed in another jurisdiction. Efforts to effectively curb the number of women and girls subjected to this practice have so far not succeeded⁸¹. The European Institute for Gender Equality (EIGE) is currently conducting a study to estimate the risk to girls of FGM in six EU Member States. France, however, leads the way in the number of prosecutions for FGM.

Sexual violence against men and boys exists but is rarely talked about⁸². It is thus becoming an increasing taboo.

The ESC supports the European Agency for Fundamental Rights' recommendations that, as a minimum, countries should review their legislation to ensure it is in line with the Council of Europe's Convention on preventing and combating violence against women and domestic violence (Istanbul Convention) and the EU Victims' Directive. The ESC recommends that countries ratify the Istanbul Convention. There should be no difference in the way that cases of rape are dealt with, whether survivors are married or unmarried. The heightened vulnerability to violence during a pregnancy needs to be more widely acknowledged and acted upon. GBV is extensively under-reported by survivors. The ESC believes that reporting rates to the police need to be increased and people must be reassured that, if they report GBV, their case will be dealt with professionally and they will receive specialist support.

Sexual health and wellbeing

Sexual health is a fundamental part of overall health and wellbeing. This underlying principle is sometimes forgotten in medical care and by professionals dealing with prevention. The focus often lies predominantly on treatment and prevention of harm; there is little room for the discussion of pleasure. The ESC is aware of the importance of understanding the variety of sexual practices and being able to help people with difficulties which may be overt or covert. Many healthcare professionals, psychologists and teachers have difficulty communicating with their patients/clients/students about sexual matters and feel at a loss as to how to give advice. In some countries there are trained sexologists/psychosexual professionals; in other countries such professionals are sorely lacking. However, 'intensive sexual therapy' is needed by perhaps only 5% of those with sexual problems; otherwise more general support, understanding and sensitive handling is sufficient. Even education to this basic level of care is lacking in many countries.

Legislation and programmes affecting people's sexual lives should be based on well-conducted population-based research on sexual behaviour and guided by human rights, not on decision-makers' personal beliefs, opinions or religious dogmas. In some countries there is a long tradition of research (Finland, Sweden, France, UK etc) and data are available; in many countries research is lacking. As an example, the British NATSAL survey has shed light on the specifics of people's sexual lives. The most recent survey, conducted in 2010-2012, showed that⁸³:

- almost 1 in 6 people have had a health condition in the previous year that affected their sex lives
- half of sexually-active women report sexual difficulties lasting 3 or more months in the previous year

The ESC supports efforts to educate practitioners in the basics of managing sexual problems and supports continuous research on all aspects of human sexuality.

POPULATION GROUPS WITH UNIQUE/SPECIFIC NEEDS

Specific population groups have unique needs; many of these groups are marginalised and prone to discrimination. Traditional SRH services may not meet their needs. Representatives of marginalised communities must be consulted on appropriate provision of SRH services.

When considering any group, it is important that doctor/nurse/patient work in partnership. The role of the patient and the interaction with their healthcare professional is now seen as central to ensuring productive clinical consultations and improved health outcomes⁸⁴.

Adolescents

Children and young people have a right to learn about the issues that affect them. In the UK, 24% of girls had not heard about menstrual periods before they experienced them and the respective figure for boys and wet dreams was 38%⁸⁵. Quality, age-appropriate education can help young people understand the changes that are happening to their bodies and make informed choices. As already mentioned, adolescents need CSRE in school; 10 – 14 years is a critically important age as it marks a key transition between childhood and older adolescence. A focus on important concepts such as respect and bodily autonomy can contribute to keeping children safe by helping them to recognise and report abuse. CSRE should include the risks of the internet and mobile phone use. ‘Sexting’ has landed many young people in highly distressing situations⁸⁶.

Youth friendly services should serve to adequately diagnose and treat STIs and empower young people who are sexually active to have sex safely. Acquisition of STIs and teenage pregnancy can undermine this. Gender inequality influences sexual behaviour. In many settings, adolescent girls and young women have disproportionately low levels of power or control over their sexual relationships compared to boys and young men.

Rates of first sexual intercourse for girls are highest in northern⁹ Europe and relatively low in southern and western Europe. Experience of sexual intercourse as reported by 15-year-olds varies considerably across countries, from 12% in Slovakia to 38% in Bulgaria and Denmark⁸⁷. Use of condoms by 15-year olds at last intercourse is less than 35% in Nordic countries⁸⁸. Pregnancies among young women vary widely across the European Region, ranging from about 12 per 1000 women aged 15–19 in Italy to about 59 per 1000 in Bulgaria. Lower levels of teenage pregnancy are found in western Europe, while moderate rates (40–60 per 1000) are found in central and eastern Europe⁸⁹.

The ESC has a long tradition of championing young people’s SRH and rights and will continue to be actively involved in this work.

Non-conforming sexual orientations and gender identities

The International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA)-Europe ranks countries in terms of how their laws and policies impact on LGBTQIA people. The scores range from 91% to 4.7%^{90,91}. LGBTQIA face discrimination in many European countries, including in the area of healthcare⁹². The ESC applauds the backing LGBTQIA people receive from the EU and acknowledges the difficulties WHO European Region has as some Member States decline to engage with LGBTQIA issues.

Clinicians need to be versed in adolescent sexual development, the process of ‘coming out’ and susceptibility to victimisation. Sexual orientation and gender identity need to be viewed as dynamic constructs. Adolescent and adult individuals may be genderqueer or gender fluid. Individual clinicians and services as a whole need to be comfortable with communicating with and managing a diversity of LGBTQIA people.

The ESC fully endorses the Yogyakarta Principles Plus 10 on sexual orientation, gender identity, gender expression and sex characteristics⁹³. The ESC notes that the ECtHR ruled in 2017 that the requirement to undergo sterilisation or treatment involving a very high probability of sterility in order to change entries on birth certificates was in breach of the right to respect for private and family life⁹⁴.

⁹ In this Paper northern Europe is defined as Iceland, the UK, Scandinavian and the Baltic countries

Migrant populations

People flee from violence, war, hunger, extreme poverty, because of their sexual orientation/gender identity or from the consequences of climate breakdown or other natural disasters⁹⁵. This section is divided into two parts^h. The first considers those people migrating internationally who are fleeing their own country because they are at risk of serious human rights violations and persecution there. The second considers long-term immigrants who are permanently resident in a new country.

One third of all migrants in the world live in Europe (9% of the total population)⁹⁶. Data on migrants in Europe is sparse. Undocumented migrants living in transit camps, squats and informal settlements across Europe have little access to SRH services³. Migrants' health generally and SRH in particular appear to be given a low priority throughout much of Europe⁹⁷.

a) Refugees/asylum seekers

Humanitarian crises affect women disproportionately, increasing their risk of suffering GBV (particularly intimate partner violence, rape, and sexual harassment at the hands of governmental or non-governmental actors, sexual slavery, forced pregnancies, child marriage and trafficking in human beings) and placing them in situations of greater vulnerability in relation to STIs, unwanted pregnancies, high-risk pregnancies, and maternal morbidity and mortality. Large numbers of refugees and migrants have entered the EU by crossing the Aegean Sea from Turkey to Greece. The 2016 EU-Turkey agreement has been challenged in a complaint to the European Ombudsperson as infringing women's human rights⁹⁸. SRH services for such women in Europe has been inadequate or completely lacking⁹⁹; they should include emergency contraception, HIV post-exposure prophylaxis and safe abortion. There has often been no privacy for women and insanitary conditions in the makeshift accommodation provided.

Sexual violence against men has been described in relation to many different armed conflicts¹⁰⁰. It has been noted that there is a lack of vocabulary in the English language to describe the types of sexual harm inflicted on men. The plight of unaccompanied boys arriving in Greece and Italy from the Middle East and Southern Asia has been reported on¹⁰¹. The aftermath of sexual violence against men and boys is both physical and mental but survivors may be extremely reluctant to seek help.

The ESC is committed to working with partners to address the SRHR needs of displaced people, particularly in European countries that have borders along the north Mediterranean coast.

b) Long-term immigrants

Immigration from countries outside Europe into Europe has been considerable over the years. For example, 23% of Swedish citizens are now first and second-generation immigrants. The largest numbers of immigrants in Europe come from Asia, followed by Africa. The needs of migrant populations for SRH services must be better understood, especially so that services can be respectful in terms of language, culture and religion. For example, one aspect that needs to be considered is long-term migrants who migrated as children or adolescents may have received conflicting messages from the two cultures they were exposed to at this critical time in their development.

^h This paper does not consider internally displaced persons, migrating within their own country.

People with disabilities

Women with disabilities have been viewed by society in general and by their relatives more specifically to be asexual and unfit to live with a partner and/or be a mother and have been subjected to strict and repressive control of their sexual needs¹⁰². As a result of the limited access and control adolescents and women with disabilities have over their own sexuality, they are vulnerable to sexual exploitation, violence, unwanted pregnancies and STIs.

The ESC is greatly concerned to hear of reports of forced contraception, sterilisation (mentioned in the section on sterilisation above) and abortion among women with disabilities³. Legal capacity and guardianship laws and arrangements may limit the ability of women with disabilities to make informed decisions in respect of their SRH³. Violence, stigma and stereotypes undermine the SRR of people with disabilities; practical and financial barriers and failures to ensure reasonable accommodation obstruct their ability to exercise sexual relationships and access to SRH care and information. The ESC supports services that are welcoming to people with disabilities and take the time to listen to them, use appropriate techniques to impart information and address their specific needs.

Older people

Sexual function and activity may decline as people age but being intimate and giving and receiving pleasure remain important. Comorbidity is more common and other factors such as prescribed medications, life cycle changes and relationship changes can all affect sexual function and satisfaction¹⁰³. Culture, religion and education can influence sexual function, as can financial limitations on both health service provision and access to the various treatment opportunities. A study in four European countries showed that sustained sexual interest and sexual enjoyment are linked to a good quality of life as people age¹⁰⁴. A 2017 ECtHR case concerning a 50-year old Portuguese woman upheld her right to a sex-life and addressed the harmful stereotype that women's sexuality is inherently linked with reproduction and becomes less important with increasing age³.

The ESC is fully supportive of SRH services for both women and men that encourage open discussion of sexual functioning without any discrimination on the basis of age. Specialists' basic training should include education on how different comorbidities may affect sexuality and how to address this when providing treatment. It must be recognised that in many countries these services will be provided almost entirely within primary care.

Sex workers

Female sex workers are vulnerable on a number of counts: the most frequently cited of these are violence (from clients, police and sex industry organisers), stigmatisation and social exclusion. Sex workers should be included more in drawing up and participating in health programmes¹⁰⁵. One factor working against sex workers' proper access to SRH services is fragmented SRH services requiring multiple visits to different sites.

Criminalisation and mandatory STI testing reduce access to services. For instance, in Austria in order to work legally, sex workers must undergo weekly STI tests and quarterly HIV tests at State-run facilities. Failure to comply with these regulations can result in fines, loss of registration or, in the case of migrants, deportation.

Male sex workers face double stigmatisation because of their work and perceived deviation from norms of masculinity¹⁰⁶. SRH programmes designed for men who have sex with men (MSM) often do not meet the needs of male sex workers who labour under harmful stereotyping. It is even less likely that SRH services will address the needs of transgender sex workers.

Community empowerment is a model that has had considerable success¹⁰⁶. For instance, in Germany a sex-worker led organisation collaborated with healthcare professionals and ran the 'Red Stiletto Shoe' campaign in 2017 to increase sex workers' awareness of, and access to, SRH services. Professionals offering comprehensive SRH services tailored to the needs of sex workers identify themselves by putting a red stiletto shoe symbol at reception in their premises.

Many sex workers experience GBV but are unable to report such crimes due to fear of prosecution, criminal sanction or deportation³. Outreach services are needed to attend to sex workers' SRH needs. An example of good practice is the drop-in centre in Skopje, Macedonia¹⁰⁷.

The ESC supports governments and policy-makers that are active in breaking down structural barriers that exclude sex workers from public health systems.

Men

European countries should adopt policies that meet the specific needs of all population groups. The ESC believes it is appropriate that women's health and rights have been prioritised because of long-standing subordination and relegation to an inferior societal status. However, this has resulted in a relative neglect of men's health. The SRH needs of men and boys are often unmet due to factors that include a lack of service availability, poor health-seeking behaviour among men, SRH facilities not being seen as 'male friendly' spaces and a lack of agreed standards for delivering SRH clinical and preventative services to men and adolescent boys⁸².

The Republic of Ireland is the only WHO Europe Member State to have a national men's health policy. A WHO European Region men's health initiative has been started⁶⁴. The ESC endorses the SRH service package for men produced by the IPPF and UNFPA⁸².

CONCLUSIONS / RECOMMENDATIONS

The ESC would emphasise the broad range of components of SRHR extending through disciplines that include medicine, psychology, social work, social policy, education, law and others. It is vital that progress is made through interdisciplinary working. This should include non-governmental organisations as well as official government departments. Working in partnerships can accomplish far more than would be possible when working alone.

The ESC would stress the crucial value of accurate data to inform decisions about SRHR. The ESC is committed to supporting continuous, reliable data collection and budgets to underpin this.

All people should have equal, unfettered access to quality SRH information and services. All people are entitled to full respect for and protection and fulfilment of their SRHR. The ESC is particularly concerned about the lack of access to SRH services of marginalised groups. Those providing SRH services must embrace the wide diversity of service users and make services for everyone more accessible, appropriate and welcoming. Sufficient budgetary provision must be made for SRH; any austerity measures and cutbacks that affect SRH must be ended.

The ESC will disseminate this Position Paper and its findings throughout Europe. Although the ESC is a professional body which eschews party politics, the Society feels compelled to state its opinion in light of the appearance of anti-gender views and publicity; if these were to become more influential, they would undermine our organisation's aims. The ESC hopes that politicians, policy-makers, public health specialists, educationalists and healthcare professionals will make good use of this Paper, including the varied and rich evidence cited, to design and introduce SRHR programmes tailored to their local situation.

SRHR needs to be included in the curricula of training for nursing, midwifery, medicine and allied professions. The ESC will ensure that this Paper is distributed throughout European universities and other educational establishments. Those involved in SRHR education, including web-based learning, can use this document as a resource.

It is important that SRH remains mainstream and is seen as part of what is considered essential healthcare so that peoples' SRHR is met and respected. The ESC will ensure that this Paper is seen by all European Health Ministries. Through our links with the World Health Organization, we will make our views and recommendations known in the 53 States included in the WHO Europe Region.

There is already a large body of evidence that has been built up on SRHR. This needs to be disseminated more widely and more thoroughly. The ESC, through its website and in collaboration with its journal *The European Journal of Contraception and Reproductive Health Care* and its educational activities intends to ensure that this is done.

Authorship

The first draft of this Position Paper was written by Prof Sam Rowlands. Further drafts were written with input from the ESC Executive Committee, ESC Expert Groups and several other individuals and organisations. Advanced drafts were further developed with the support of Dr Kai Haldre. The following provided peer review: Ms Toni Belfield, Prof Kristina Gemzell-Danielsson, Prof Andrew Horne, Dr Brooke Ronald Johnson Jr, Dr Antonella Lavelanet, Dr Olga Loeber, Ms Cristina Puig Borràs and Dr Simone Reuter. The ESC acknowledges and thanks all those who contributed to this document.

List of abbreviations

- ART Assisted reproductive technology
- CSRE Comprehensive sexuality and reproductive health education
- EBCOG European Board and College of Obstetrics and Gynaecology
- EC Emergency contraception
- ECtHR European Court of Human Rights
- ECDC European Centre for Disease Prevention and Control
- ECEC European Consortium for Emergency Contraception
- EDF European Disability Forum
- EIGE European Institute for Gender Equality
- EPF European Parliamentary Forum for Sexual and Reproductive Rights
(formerly European Parliamentary Forum on Population and Development)
- ESHRE European Society of Human Reproduction and Embryology
- FGM Female genital mutilation
- FRA European Agency for Fundamental Rights
- GBV Gender-based violence
- HIV Human immunodeficiency virus
- HPV Human papillomavirus
- ILGA International Lesbian, Gay, Bisexual, Trans and Intersex Association
- IPPF International Planned Parenthood Federation
- IUC Intrauterine contraception (devices and systems)
- LGBTQIA Lesbian, gay, bisexual, transgender, queer, intersex and asexual
- MSM Men who have sex with men
- NATSAL National Survey of Sexual Attitudes and Lifestyles (Britain)
- NSWP Global Network of Sex Work Projects
- PrEP HIV pre-exposure prophylaxis
- SRH(R) Sexual and reproductive health (and rights)
- SRR Sexual and reproductive rights
- UN United Nations
- UNESCO UN Educational, Scientific and Cultural Organization
- WHO World Health Organization

Glossary of terms

- Asylum-seeker Refugee who has not so far been legally recognised as such
- Cisgender People whose gender identity matches their sex assigned at birth
- Gender Socially constructed characteristics of women and men, such as norms, roles and relationships of and between groups of women and men
- Gender binary Classification of gender into two distinct, opposite and disconnected forms of masculine and feminine
- Gender identity A person's internal, personal sense of being male, female, genderqueer, etc
- Genderqueer Gender identity that falls outside the gender binary and cisnormativity (gender fluid also used)
- Gonad Ovary and testis
- Homophobia Dislike of or prejudice against homosexual people
- Homosexual People attracted to those of the same gender (gay/lesbian)
- Immigrant A person who has migrated to another country who is not a refugee
- Intersectionality The overlap of social identities contributing to the specific type of oppression and discrimination experienced by an individual or group
- Intersex Born with a reproductive or sexual anatomy that does not fit the typical definitions of female or male
- Marginalised Made to feel unimportant
- Rape Performing a penetrative sex act without consent
- Refugee A person who has fled their own country because they are at risk of serious human rights violations
- Refusal on grounds of conscience The refusal to perform a legal role or responsibility because of moral, religious or other personal beliefs
- Sex 1) Biological sex including anatomy of reproductive system and secondary sexual characteristics
2) Sexual intercourse
- Sexual debut First sexual activity
- Sexual orientation Who a person is attracted to
- Social norm An unwritten rule about how to behave
- Stereotype A widely held but fixed and oversimplified image or idea of a particular type of person
- Stigma A social process that taints an individual and confers on them an inferior status
- Transgender (trans) People whose gender identity does not match their sex assigned at birth
- Transphobia Dislike of or prejudice against transgender people

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