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Innovative approaches to sexual and reproductive health and rights

Report[1]
Committee on Equality and Non-Discrimination
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Summary

Sexual and reproductive health and rights (SRHR), which are related to bodily autonomy and self-determination in sexuality and reproduction, are particularly relevant to gender equality but concern every individual. Access to these rights should be ensured without discrimination based on any ground. This objective should be high in the priorities of legislators and policy makers. Innovation in science and technology, in areas such as communication and online medical consultation and prescription, facilitates the implementation of this policy priority.

Progress is still needed to address the gender bias that has historically affected the world of technology and design, with negative consequences for women particularly as regards healthcare. Measures should also be taken to prevent and counter reproductive coercion, or behaviour that interferes with a person's reproductive autonomy.

Legislation and policies on sexual and reproductive health and rights should be inspired by a positive vision of sexuality and a change of mentality is needed to free women and the population at large by the constraints of traditional patriarchy. Comprehensive sexuality education is a particularly useful tool to that end and should be part of school curricula at all levels.

[1] Reference to Committee: Doc. 15248, reference 4579 of 28 May 2021.

A. Draft resolution[2]

1. Sexual and reproductive health and rights (SRHR) are the rights related to planning one's own family, the ability to have a satisfying and safe sex life, and the freedom to decide if, when, and how often to have children. These rights are particularly relevant to women's empowerment and gender equality. Lacking or insufficient access to sexual and reproductive healthcare affects women first and foremost: the consequences of inadequate care, which include unwanted pregnancies and health risks when abortion is denied, are largely borne by them.

2. Nevertheless, sexual and reproductive health and rights concern every individual, irrespective of their sex, sexual orientation, gender identity, gender expression and sex characteristics, or their age. The Assembly believes that access to sexual and reproductive healthcare should be granted to all without discrimination based on any ground. They are relevant to multiple human rights, including: the right to life; freedom from torture and ill-treatment; health; privacy; education; equality and non-discrimination.

3. Legislators, policy makers and all those who are committed to upholding human rights and equality should place a high priority on sexual and reproductive health and rights. Progress in this area is needed and is made possible by a variety of advances and innovations in areas including technology and design, social sciences, information technology, communication and media, medicine, with substantial progress in healthcare provided remotely and through digital means, and in new insights and approaches towards male contraception.

4. Furthermore, legislators and policy makers should, should strongly support and promote research and further innovation in these areas.

5. The Parliamentary Assembly underlines that sexuality is a central aspect of human life that is related to physical and mental health, well-being, and interpersonal connection. Gender roles and boundaries imposed by patriarchal cultures, particularly on women, ultimately have a negative effect on the entire population. Legislation and policies on sexual and reproductive health and rights should be inspired by a positive vision of sexuality and should aim to preserve and promote self-determination and bodily autonomy for everyone without discrimination based on any ground, notably sex, sexual orientation, gender identity, gender expression and sex characteristics. An intersectional approach to preventing, detecting and countering discrimination is particularly needed in this context.

6. The Assembly highlights that sexual and reproductive health and rights are not only relevant to young people or people of fertile age. Adequate sexual healthcare should be provided to everyone, acknowledging the importance of sexual health throughout life.

7. Advances in technology have made access to sexual healthcare easier and safer in recent years, with an increased use of telemedicine practices, such as consultations and prescriptions via the internet and mobile devices, online and at-home testing for sexually transmitted diseases, telemedicine for early medical abortion, artificial intelligence applied to screening and counselling. The Covid-19 pandemic and the measures adopted to contain its spread have contributed to this process. This should be supported and embedded into policies and guidelines with a view to ensuring adequate and equal access to this type of healthcare to all those who need it.

8. The Parliamentary Assembly believes that to achieve progress towards gender equality, a shift in culture and attitudes on contraception is needed. Women largely bear this burden, and planned contraception has historically been seen solely as women's responsibility. The expected emergence in the foreseeable future of new male contraceptive methods, with topical, oral and injectable contraceptives currently undergoing clinical trials, will allow for increased sharing of responsibility between women and men. Research in this area should be strongly encouraged and supported, including financially. Meanwhile, all modern contraceptive methods, including long-acting reversible contraceptives (LARCs) should be provided by public health services and made easily available to all those who may need them.

9. The Assembly reiterates that comprehensive sexuality education is crucial to young people's preparation to life. Age-appropriate, medically accurate and evidence-based sexuality education should be a mandatory part of school curriculums at all levels, and accessible to all young people including outside of schools, also thanks to digital technologies. Comprehensive sexuality education should cover issues including contraception and the prevention of sexually transmitted infections; gender equality, gender norms and stereotypes; prevention of and protection from sexual, gender-based and domestic violence; sexual orientation and gender identity and expression; self-determination and consent in relationships; and personal interaction. As a necessary tool to learn how to practice one's self-determination and bodily autonomy, and to make informed choices on one's sexuality, comprehensive sexuality education is a right that should be recognised to all.

[2] Draft resolution adopted unanimously by the Committee on 23 January 2023.

10. In the light of these considerations, the Assembly calls on Council of Europe member and Observer States, as well as on all States whose parliaments enjoy Partner for Democracy status to:

10.1. promote scientific research in areas related to sexuality and reproduction, including contraception, with a view to making available innovative contraceptive methods, including for men;

10.2. encourage and support gender-sensitive medical research and practices;

10.3. promote data collection with a view to expanding and improving sexual and reproductive healthcare services and better understanding of the needs of women and girls and the rest of the population in this area; to this end, promote the adoption of internationally recognized standard definitions and data collection methods to ensure that data are accurate and comparable;

10.4. prevent and combat period poverty, or difficult access to menstrual products due to lack of economic resources, and give access to safe and hygienic menstrual products by ensuring that the menstrual protection of choice is available and affordable to all those who need it;

10.5. prevent and combat reproductive coercion, intended as interference with a person's autonomous decision-making with regards to reproductive health; sanction and consider criminalising relevant behaviour, such as contraception sabotage, physical coercion or psychological pressure to become pregnant, as well as controlling the outcome of a pregnancy (pressure to continue, or to terminate, a pregnancy);

10.6. ensure that gynaecological and reproductive healthcare guidelines and recommendations take into account the needs of all patients, irrespective of their sex, sexual orientation, gender identity, gender expression and sex characteristics, and that they are inclusive of transgender and non-binary persons;

10.7. provide healthcare professionals with up-to date training on sexual and reproductive healthcare, including on relevant scientific and technological innovation and inclusive healthcare, taking into account the specific needs of persons with disabilities, LGBTI people and older people; promote and support research to improve medical knowledge in these areas;

10.8. strengthen cooperation with civil society organisations and other stakeholders active in the area of sexual and reproductive health and rights, and support their research, data collection, information and awareness raising activities;

10.9. provide access to sexual and reproductive healthcare to the population of rural areas and ensure fair geographic distribution of relevant infrastructure;

10.10. promote awareness of the notion of co-responsibility of women and men in matters of fertility and integrate it in relevant legislation and policies;

10.11. ensure access to comprehensive sexuality education by making evidence-based, age-appropriate sexuality education mandatory and part of school curricula at all levels and using digital technologies to provide comprehensive sexuality education;

10.12. conduct awareness-raising, information and education activities, including online, targeting the general public in the same areas covered by comprehensive sexuality education in schools;

10.13. raise public, political and corporate awareness of the impact of gender bias and other forms of inequality on our health and wellbeing, individually and collectively;

10.14. promote applied research and development in public organisations, non-profit organisations and businesses to ensure that the design, production and promotion of objects, spaces and systems used in health care, education, work spaces and other areas of daily life address the inequalities caused by gender bias, by accommodating the diverse needs of women and all individuals irrespective of their sex, sexual orientation, gender identity, gender expression and sex characteristics;

10.15. encourage the revision of design, architecture and engineering curricula to ensure that students and teachers are fully aware of the negative impact of gender bias, and are equipped to develop design projects that are as diverse and inclusive as possible, in particular in a gender perspective;

10.16. make available detailed, accurate, evidence-based information on sexual and reproductive health and rights to the general public through online platforms managed by public health authorities, which should include information on where and how to obtain sexual and reproductive healthcare, including in rural areas;

10.17. encourage media, both traditional and online, including social media, to convey accurate, evidence-based information on sexuality and gender issues, including contraception, abortion, consent, and sexual and gender-based violence;

10.18. encourage and support the implementation of innovative technologies to improve access to sexual and reproductive healthcare, such as telemedicine and self-testing kits for sexually transmitted infections, as well as self-managed medical abortion;

10.19. support research and evaluation of new and existing approaches to sexual and reproductive health and rights, in order to identify best practices and inform future policy and program development;

10.20. act to eliminate stigma and discrimination related to sexual and reproductive health and rights, and promote a culture of respect and inclusivity, by inspiring legislation and policies to such culture, and through public education campaigns.

11. The Parliamentary Assembly considers that the forthcoming Council of Europe Gender Equality Strategy should include bodily autonomy and sexual and reproductive health and rights among its priorities.

B. Explanatory memorandum, by Ms Petra Stienen, Rapporteur

1. Introduction

1. Imagine if we had to choose one thing that would improve everyone's life quality. I believe that for many people, that would be ensuring the ability to make free, autonomous and well-informed choices about their sexuality and their family life. Sexual and reproductive health and rights (SRHR) are the human rights related precisely to that: planning one's own family, the ability to have a satisfying and safe sex life, and the freedom to decide if, when, and how often to have children. These rights are particularly linked to gender equality issues and are often dealt with from the perspective of women's empowerment. They nevertheless concern every individual, irrespective of their age, gender, sexual orientation or gender identity.

2. Current national legal frameworks aiming to guarantee SRHR lead to health outcomes which disproportionally affect women who are young, poor, living in rural areas or in vulnerable situations and who, for diverse reasons, suffer discrimination in access to contraception, safe and legal abortion, cervical cancer prevention, protection from gender-based violence and access to comprehensive sexuality education. All these factors prevent women's full enjoyment of their rights, dignity and integrity.

3. Sexual and reproductive health and rights are relevant to everyone. However, up to now women have been the first concerned by the shortcomings of policies and legislation in this area: the consequences of the lack of access to SRHR, including unwanted pregnancies and health risks when abortion is denied, are largely borne by them. I believe that there should be a change in attitudes and mentalities, both concerning upholding SRHR and assuming responsibilities. Taking the example of contraception alone, the management of planned contraception has been seen solely as a woman's responsibility for far too long. Recently, this state of affairs has been challenged in some forums and male contraception methods have been discussed. Further research on these methods should be strongly encouraged.

4. Several developments at international level make this report timely and relevant. In 2019, the global community reaffirmed the 1994 International Conference on Population and Development (ICPD) Programme of Action, adopted at the Nairobi Summit. At European level, the ten-year anniversary of the Istanbul Convention is being celebrated. At national level, while there has been an improvement in the enforcement of SRHR, this area has become more controversial and polarising, making it difficult to consolidate the progress achieved and increasing the risk of setbacks in legislation and policies.

5. The Covid-19 pandemic has had an impact on this area. In particular, it has highlighted the need to address shortcomings in access to SRHR and to identify good and innovative practices which successfully guarantee access to relevant services.

6. This report covers several areas of SRHR where innovation is taking place, such as design and technology, medicine (with a focus on pharmacology and the promising developments in male contraception), "e-health" (healthcare services provided electronically via the internet) and communication.

7. I believe that the concept of sexual and reproductive health and rights should be interpreted in wide terms and not limited to long established issues such as contraception, interruption of pregnancy, sexually transmitted diseases and sexuality education. An intersectional approach to this matter helps us identify additional aspects, such as the challenges that transgender people face and, in addition to the right to self-determination in sexuality and reproduction, should lead us to include in this area, the right to self-determination in gender identity and bodily autonomy.

8. I personally believe that a shift in culture and attitudes, rather than merely in legislation and policies, is needed. We should not forget that sexuality is an important and ubiquitous aspect of human life and one that is linked to physical and mental well-being, pleasure, communication, and interpersonal connection. It is in this positive light that we should assess and improve the regulations on sexual and reproductive health and rights. Patriarchal values still perpetuate rules and boundaries that have been set a long time ago to target first and foremost women. It is important to underline that these rules and boundaries ultimately affected the entire population. Such arbitrary rules have progressively fallen and have been replaced by the recognition of personal freedom and a right to self-determination in many places. This freedom is too often threatened by "reproductive coercion", a relatively new term that is currently used to refer to any behaviour that interferes with the autonomous decision-making of a person, with regards to reproductive health. Guaranteeing and further expanding freedom, rights and care for all, without discrimination, should be our top priority as a way to respect human rights for all.

2. Time for a change: innovative approaches to SRHR

9. Remarkable progress has been achieved in gender equality in the last decades, with an increase in women's participation in the economy, in public and political life, and stronger action to prevent and combat violence against women. It is now time to step up our efforts and improve substantially the access to sexual

and reproductive rights. This requires an innovative approach and increased attention to innovation in various areas. These include communication, information and awareness raising, education and, crucially, science, technology and design.

2.1. "Together for yes": the Irish example on campaigning for abortion

10. Using accurate, precise language is important when dealing with sexual and reproductive health and rights, an area too often plagued by insufficient or incorrect information. A remarkable example of innovative communication in this area is the campaign Together For Yes, which contributed substantially to repealing the 8th Amendment and the consequent legalisation of abortion in Ireland by referendum in May 2018. The unequivocal result of the vote (66% for Yes) was, in the words of the organisers of the campaign, "a seismic shift in the struggle between the forces of religious, moral and cultural conservatism and those of social liberalism in public policy".

11. Aware of the important achievements of their work, the co-directors of the initiative commissioned a review of the campaign in order to share their strategy and working methods.[3] Crucially, one of the goals of the campaign as presented in the review was to "put forward robust fact and evidence-based arguments to counter scaremongering and misinformation". Setting up an evidence-based campaign meant relying mainly on case studies demonstrating the harms of the criminalisation of abortion, and on technical, medical and legal expertise. Communication was based on three main axes: "Firstly, setting the tone as informative, reasoned, calm, and non-confrontational to assure a cautious public that the campaign would not engage in the kind of bitter and divisive debate the public was used to. Secondly, to centre abortion as a necessary part of women's healthcare. Lastly, to shift the traditional emphasis of the debate from 'choice' to 'needs'; from 'rights' to 'healthcare', and from "judgement" to "empathy and compassion".

12. On 1 June 2022, while in Dublin for the PACE Standing Committee meeting, I met with Ailbhe Smyth. Ms Smyth was one of the founders of Together For Yes, and therefore the best person to tell me more about the campaign and the reasons of its success. It is now clear to me that a series of factors contributed to it, one of which was time: the process leading to the referendum started in 2012, after the death of a 31-year-old woman, Savita Halappanavar, who had been denied medical care due to the lack of clear guidelines on abortion, and it lasted for 6 years until the referendum was actually held in 2018. Meanwhile, the referendum on equal marriage had marked a radical change in Irish society and politics.

13. When in 2017 it became clear that the government would call a referendum, a broadly based coalition was formed, which included not only feminist movements but also left-wing and other socially progressive political forces. Anti-choice forces, on the contrary, were fragmented and worked separately. The Catholic Church, which had unsuccessfully opposed marriage equality in 2015, failed again to have an impact on the outcome of the referendum. In the wake of several scandals, particularly on child abuse cases and on the Magdalene laundries, the credibility of the Church had waned.

14. "Together for yes" chose to engage as little as possible with their opponents, and rather to talk to directly to the electorate. They gave voices to those that people trusted the most: doctors and women who had had an abortion. Real stories of women, who had often had to travel abroad to obtain abortion care, were an important part of the campaign, as they helped to persuade the electorate. Telling their story was the beginning of healing for their entire country. The experience of the campaign confirmed that story telling matters. At the same time, it requires protection for those who share their story: it is crucial to prevent secondary victimisation.

15. To sum up, crucial elements of the successful 2018 campaign in Ireland were a long-term strategy, clear messages based on real-life experience and on scientific knowledge, and broad coalition building. These elements, and particularly the evidence-based approach and the priority given to scientific and technical knowledge remain an important legacy of this campaign and a lesson to learn for all those who intend to promote the access to sexual and reproductive health and rights.

2.2. The right to sexual wellbeing and pleasure

16. Promoting sexual and reproductive health requires a positive approach, free from patriarchal values dictating the role of women and men within family and in society. It also means acknowledging that every individual has a right to self-determination, sexual wellbeing, and pleasure. As the World Health Organisation states, "sexual health, when viewed affirmatively, requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence".[4]

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[3] "Learning from the 2018 Together for Yes Campaign", review commissioned by the campaign committee, 2018.
[4] www.who.int/health-topics/sexual-health#tab=tab_1 (accessed 17 January 2023).

17. I had an insightful meeting with Lisa de Pagter, an advocacy officer at Dutch foundation Rutgers and a board member of Seksueel Welzijn Nederland (Sexual Wellbeing the Netherlands), an organisation founded by the late Ellen Laan, a highly respected figure in this area in the Netherlands. Rutgers has worked with young people on sexuality for more than 50 years. In their own words, "sexual and reproductive health and rights encompasses both physical, mental and social wellbeing. It is about the individual, their relationships and wider society. It is about pleasurable sexual relationships, self-esteem, trust and communication." I can only subscribe to this understanding of the concept of SRHR. This organisation carries out programmes in different regions of the world in areas including contraception and safe abortion, sexual and gender-based violence, as well as sexuality education. Among their programmes I would like to mention is "Dance4Life", which works with young people worldwide on unsafe sex ("the fastest growing health risk"), using the power of dance and music to enable young people to empower themselves by discussing openly and learning about sexual health.

18. Together with Lisa de Pagter, I met Nienke Helder, a young designer who works on sexual wellbeing. She is the creator of "Sexual Healing", a research project aiming to innovate the approach to overcoming "sexual dysfunctions" faced by women as a consequence of traumatic experiences. She observed that "while sex life is a highly personal thing, the treatment of trauma-induced female sexual problems such as pelvic muscle blockage is often clinical, focuses on physical issues, and takes penetration as its ultimate goal". Nienke Helder's project, developed in cooperation with medical and paramedical experts and women who have experienced traumas, focuses on designing a therapy from the point of view of finding pleasure. The project is based on a set of sensory objects to be used by women "to explore what feels good to help relieve fear and pain and (re)gain a sense of security about what their bodies enjoy".[5]

2.3. A new term for an age-old threat: "reproductive coercion"

19. I consider it important, particularly for all those who support human rights and fundamental freedoms, to apply the notion of "reproductive coercion" to behaviour that interferes with the autonomous decision-making of a person with regards to reproductive health, whether in the form of contraception sabotage (for instance removing or damaging a condom, or a contraceptive patch), coercion or pressure to become pregnant, or controlling the outcome of a pregnancy (for instance, pressure to continue or to terminate a pregnancy).[6] Reproductive coercion was first defined and analysed around a decade ago and is closely related to gender-based violence, as "one of many forms of power and control exercised by an abusive partner".[7] It is far from a marginal problem: a study published in 2019 in the BMJ Sexual and Reproductive Health journal revealed that one in four women at sexual health clinics reported coercion over their reproductive lives, including "contraceptive sabotage".[8]

20. This type of coercion may be exercised at many levels: by individuals, often within an intimate partner relationship, by family members or religious leaders but also at medical level and at State level, through legislation and policies unduly limiting the enjoyment of sexual and reproductive rights and thus the individuals' reproductive freedom. I wonder if we should not draw a parallel between the concept of reproductive coercion perpetrated by individuals, particularly in the setting of an intimate relationship, and the undue limitations on people's reproductive freedom deriving from legislation and policies that hinder the access to sexual and reproductive healthcare, thus limiting the enjoyment of relevant rights. The behaviour may be different, but the ultimate impact on individual freedom is similar.

21. Preventing and sanctioning reproductive coercion should be part of legislation and policies on gender-based violence. Whether it manifests itself as physical violence or in other forms, such coercion is a limitation of personal freedom, mainly targeting women, that may have a seriously harmful impact and must not be ignored or underestimated.

2.4. Ehealth: making access to SRHR easier and safer thanks to Internet

22. Technological innovation in the area of sexual and reproductive healthcare is making sexual and reproductive healthcare more easily accessible and safer through eHealth, which is the use of Information Technology tools, such as computers, communications satellites and patients' monitors for healthcare. Mobile health or mHealth is part of eHealth and refers more specifically to the use of portable devices, particularly mobile phones, in this area.

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[5] www.nienkehelder.com/sexual-healing (accessed 17 January 2023).
[6] Karen Trister Grace and Jocelyn C. Anderson, "Reproductive Coercion: A Systematic Review", *Trauma, Violence, & Abuse*, Vol. 19, Issue 4, October 2018.
[7] Ibid.
[8] Sam Rowlands, Susan Walker, "Reproductive control by others: means, perpetrators and effects", *BMJ Sexual and Reproductive Health*, Vol 45-1, 2019.

23. The World Health Organization (WHO) fully supports eHealth. In 2005, the World Health Assembly urged member States to consider developing and implementing eHealth to promote equitable and affordable healthcare access for their citizens[9] and in 2013 it adopted a resolution on eHealth standardisation encouraging member States to establish a national eHealth strategy. In 2019, the WHO released its first guidelines on eHealth interventions. More precisely, it made recommendations on 10 ways countries can use digital health technology, accessible via mobile phones, tablets, and computers, to improve people's health and essential services. The guidelines included, among others, using mobile devices to send notifications of births and deaths, and telemedicine to allow people living in remote areas to access health services by using new technology tools (mobile phones, web portals etc). It also stressed the importance of training healthcare providers to adapt to digital technology tools and to use them efficiently.[10] In its resolution of 26 May 2018 on digital health, the World Health Assembly urges member States to "assess their use of digital technologies for health at the national and subnational levels", and "to consider how digital technologies could be integrated into existing health systems infrastructure." It also proposes "to strengthen public health resilience, to improve the digital skills of all citizens and to develop legislation and/or data protection policies around issues such as data access, sharing etc and to communicate these on a voluntary basis to the WHO."[11]

24. In addition, the WHO, in collaboration with the International Telecommunications Union (ITU) and the Regional Ministry of Health of Andalucia (Spain), created the European mHealth Innovation Hub,[12] a mechanism which aims to help countries to integrate the use of mHealth in national healthcare services.

25. The tools provided by eHealth include:

- public platforms with reliable information and resources regarding sexual and reproductive health issues to counteract misinformation and disinformation such as the "foetal heartbeat at 6 weeks" myth;

- online consultation and counselling that would ensure confidentiality on sexual and reproductive health related issues;

- online and at-home testing for sexually transmitted infections (STIs) for people that cannot or do not want to visit clinics for testing;

- the potential use of artificial intelligence (AI) to screen for STIs and to provide anonymous medical advice to help overcome the barrier of embarrassment;

- at-home testing of fertility for women and men to increase their reproductive autonomy;13

- the promotion of new technologies (online prescription) that allow early medical abortions.[14]

26. As concerns public information platforms, according to the findings of civil society organisation European Parliamentarian Forum for Sexual and Reproductive Rights (EPF), several European governments provide online information on SRHR. EPF has listed these countries and rated the quality and accessibility of such information in the Contraception Policy Atlas Europe, which is updated yearly. The 2022 edition of the Atlas shows that only 18 European countries (39%) provide governmental websites, of which 16 may be considered of good quality.[15] These include Austria, Belgium and Norway. As EPF representative Marina Davidashvili explained to me, "we believe that in the era of fake news and young people looking out for information online, governments have the responsibility to provide high quality and evidence-based information to the people on their SRHR". It is therefore important that every government responds to its role and ensures that citizens are properly informed regarding SRHR.

27. Applications in the area of sexual and reproductive healthcare are beneficial for several reasons: first of all, they contain a wealth of information that is easily accessible to anyone, not only via computer but in most cases also via a smartphone. Information is generally presented clearly and structured in categories, which

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[9] Cohen, JK, WHO releases first digital health guidelines, *Modern Healthcare*, 19 April 2019. See also WHO releases first guideline on digital health interventions, World Health Organization, News release, 17 April 2019.
[10] Dinerstein, C, WHO's Guidelines For Digital Healthcare Have More Regulatory Obstacles, Than Technical, American Council on Science and Health, 1 May 2019.
[11] Resolution WHA71.7 (2018), 71st World Health Assembly, 26 May 2018. See also National eHealth Strategy Toolkit, World Health Organization, 2012.
[12] European mhealth hub (mhealth-hub.org) (accessed 17 January 2023).
[13] "Reproductive autonomy" is the ability of an individual to reproduce, which can avoid misunderstanding and stigmatisation of either sex.
[14] Porter Erlank C, Lord J, Church K, "Acceptability of no-test medical abortion provided via telemedicine during Covid-19: analysis of patient-reported outcomes", *BMJ Sexual & Reproductive Health*, 2021;47:261-268
[15] European Contraception Policy Atlas, EPF (epfweb.org) (accessed 17 January 2023).

makes it easier for users to find the answers to their queries. Some users find books and other traditional forms of publications overwhelming, especially when they need to solve a specific doubt. "The smartphone approach is particularly promising given the many challenges of providing a quality sexual health education for young people of either gender in many countries and regions. About half of the world's population now has a smartphone and those numbers continue to grow".[16] In addition, many of the available apps can be used free of charge and function also without an internet connection. Lastly, and particularly important, users access the applications anonymously.[17] This creates a less intimidating environment, as most young people are hesitant to refer to a family member or even a doctor to solve their questions on sexuality.

28. Applications cannot substitute a doctor's appointment, but they can provide information that may both help users to address a specific situation and, more generally, educate them about their body, their sexual health and reproduction. In this context, it is useful to present some of these applications and explain their functioning:

- Ovia Fertility and Cycle Tracker[18] is a fertility tracker application. It allows women to narrow down their ovulation day and figure out their cycles, as it includes an ovulation calendar and another calendar to track the different events during the cycle. The app also provides thematic articles on fertility and conception. Users can save data for offline use and export it to an Excel file too. Users can introduce information on their period, mood, intercourse, basal temperature, blood pressure, and so on. The information is processed by the app and presented in multiple ways, providing for a personalised navigation.

- My Sex Doctor is a sexual health and information app which was created "for people who didn't get the sex education they could have used."[19] It provides information on a range of issues such as puberty (a category "what's happening to my body" refers to changes happening at puberty age), abortion, menstruation, relationships and more. The app can be used without an Internet connection, which makes it even more accessible. Users' reviews praise among other things the app's structure, as its various sections such as "Topics", "Dictionary" or "Symptom checker" clearly categorise the content helping users to find their way to the information they need.

- Girl Talk is an American application designed specifically for younger users. It was originally created by gynaecologist Lynae Brayboy to help in preventing unwanted pregnancies. Its four guiding principles are: trusted sexual health information, visually appealing graphics, compatibility with iPhones, and age-appropriate, straightforward content. The content was adapted from various sources, including the Department of Health and Human Services' Office of Adolescent Health, Planned Parenthood. The information provided covers topics including anatomy and physiology, sexuality and relationships, contraception, sexually transmitted infections, and body image. Researchers praised this app as beneficial: "the reported usefulness of Girl Talk as a sexual health application increased significantly and knowledge improved most in topics such as anatomy and physiology and STI prevention. Although most participants (76.5%) stated that they had been previously exposed to sexual health information, 94.1% of participants stated that Girl Talk provided new information than outlined in health class."[20]

- Bedsider[21] is a birth control reminder application. In other words, this application reminds users through notifications to take the contraceptive pill, to switch the ring monthly, to replace the patch weekly, or to take the Depo Provera injection (progesterone, a hormone used to prevent ovulation) depending on which contraceptive method each user has chosen. There is an option to snooze the reminder for up to six hours. If this period is exceeded, the application sends a message mentioning the use of a backup birth control method. The notifications sent are humorous, making the procedure appealing to the user. The application can also be set to remind of medical appointments or help to find emergency contraception.

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[16] Morgan, K, "Girl Talk": Smartphone app teaches girls about sexual health, Elsevier, 9 October 2017.
[17] Brayboy, L M et al, The use of technology in the sexual health education especially among minority adolescent girls in the United States, *Current Opinion in Obstetrics and Gynaecology*, October 2018, Volume 30, Issue 5, pp305-309.
[18] Ovia Fertility app review – appPicker, Ovia Fertility & Cycle Tracker – appPicker.
[19] Kane, B, My Sex Doctor: There's an app for everything, *Southern News*, 18 October 2013.
[20] Brayboy, L M *et al*, The use of technology in the sexual health education especially among minority adolescent girls in the United States, *Current Opinion in Obstetrics and Gynaecology*, October 2018, Volume 30, Issue 5, pp305-309. See also Morgan, K, "Girl Talk": Smartphone app teaches girls about sexual health, Elsevier, 9 October 2017.
[21] Stacey, D, Bedsider's Birth Control Reminder App, *verywellhealth*, 21 June 2020. See also: Better Sexual Health? There's an App for That, Women's Aid Center, 16 November 2018.

- an example of an application created in Africa is InfoAdoJeunes,[22] made available in 2020 by the Association Togolaise pour le Bien Etre Familiale (ATBEF), the IIPF Member Association in Togo, to provide information on sexual and reproductive health to young people. In the early times of the COVID-19 pandemic, the application proved popular with its target public, as young people are accustomed to using mobile phones to obtain information. The application is evidence-based and accurate, uses simple language and has a colourful layout, making navigation easy and amusing. It contains eight navigation options, namely: Comprehensive Sexual Education (CSE), the menstrual cycle, contraception, teleconsultation, web TV, games and quizzes, a chat forum, and a tab where users can ask an expert a question. Conceived in the pandemic era, the app provides services such as teleconsultation, for people who have no access to hospitals and healthcare services.

29. It is worth noting that sexual and reproductive applications, while beneficial at many levels, may expose their users to some danger in connection with the highly personal information they collect. In the United States, in the wake of the overturning of the Supreme Court's Roe v. Wade decision which may lead to banning or severely restricting access to abortion in much of the country, some experts and activists invited women to delete all menstrual apps, as the information they contain may be incriminating.[23] Even applications tracing people's movements could be used by investigators if States pass legislation forbidding women to travel where abortion is legal.[24] While the alert was triggered with regard to recent developments in the United States, we should remain vigilant to the situation in Europe as well. Public authorities should refrain from using personal and medical information for purposes of reproductive coercion, and prevent and sanction any such misuse, perpetrated by any individual or organisation.

30. Besides mobile apps, I would like to mention a website named Pussypedia[25] whose aim is to combat misinformation on key issues of women's life and to provide accurate and coherent information. In addition to women's anatomy and sexual and reproductive health, Pussypedia includes articles on social issues, covering among other things trans, intersex and nonbinary bodies and stereotypes connected to patriarchy. The articles are written by a community of people all over the world in a simple and appealing language. The website is full of illustrations and colours and is linked to a book, which it aims to constantly update. While it differs from mobile apps, this website is part of the more general phenomenon that sees online technology used to grant easy access to information on sexual and reproductive health and rights, combined with multi-theme analysis.

3. Male contraception: state of play

31. Traditionally, the burden of contraception has always fallen on women. Some women spend several decades of her life trying to avoid pregnancy. This "fertility work" may be viewed as one of the many aspects of women's unpaid work. In this sense, it eventually contributes to gender inequality.[26] Fertility work encompasses not only the physical burdens of contraception, including a long list of side effects, but also the financial and mental burden of it.[27] Overall, female contraceptive methods tend to be more expensive than male methods mainly because most require at least one visit to a doctor while some require a renewable prescription.[28] Additionally, due to the hormonal nature of various female contraceptive methods, they produce more serious side effects than male methods. As a result, almost 50 percent of women discontinue the use of hormonal contraception after 1 year because of adverse side effects.[29]

32. The development of new male contraceptive methods would not only alleviate the burden of contraception on women but would also give men reproductive autonomy. At present, effective male contraceptive options are limited to condoms and vasectomy. Worldwide, none of these methods account for more than 7% of contraceptive use as most men rely on female compliance with contraceptives.[30] The reason men bear so little responsibility for birth control lies heavily in outdated gender norms such as the idea that women should be the primary caretakers of children.[31] The feminisation of contraceptive use began well before the invention of the female birth control pill, but the rapid popularity of the pill led to a real shift and men were

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[22] The New Mobile App That's Helping Improve Young People's Sexual and Reproductive Health in Togo, Blog, International Planned Parenthood Federation (IPPF), Africa Region, 27 April 2020 (accessed 10 January 2023).
[23] Waheed, J "Here's how period tracking apps have responded to the overturning of Roe v Wade, after people are urged to delete their data", *Glamour Magazine*, 5 July 2022.
[24] Hill, K, "Deleting Your Period Tracker Won't Protect You", *The New York Times*, 30 June 2022.
[25] www.pussypedia.net/about (accessed 10 January 2023)
[26] Kimport, K, "More than a physical burden: Women's mental and emotional work in preventing pregnancy", *The Journal of Sex Research*, 55.9 (2018): 1096-1105.
[27] Bertotti, A M, "Gendered divisions of fertility work: Socioeconomic predictors of female versus male sterilization." *Journal of Marriage and Family* 75.1 (2013): 13-25.
[28] Campo-Engelstein, L "Contraceptive justice: why we need a male pill." *AMA Journal of Ethics* 14.2 (2012): 146-151.
[29] ibid.
[30] Glasier, Anna. "Acceptability of contraception for men: a review." *Contraception* 82.5 (2010): 453-456.
[31] Campo-Engelstein, L "Contraceptive justice: why we need a male pill." *AMA Journal of Ethics* 14.2 (2012): 146-151.

essentially absolved from contraceptive decisions.[32] Nevertheless, a shared responsibility model would be much more effective in preventing unwanted pregnancies as one woman can only get pregnant once within nine months while a man can cause a much higher number of pregnancies in a year.

33. Even though the research to develop hormonal male contraception started at the same time as the development of female hormonal contraceptive methods, the availability of a long-acting and reversible method of hormonal male contraception remains an unfulfilled need.[33] An important number of studies on hormonal male contraception have been terminated early due to the appearance of side effects such as mood disorders and decreased libido, while women on hormonal birth control have been enduring such side effects for decades.[34]

34. On the bright side, hormonal male contraceptive pills exist that have been proven to be highly effective and safe to use in recent years.[35.]Studies show that an experimental male oral contraceptive is successful in decreasing sperm production with the help of a modified testosterone that has the combined actions of androgen and progesterone, while preserving libido.[36] Although there are some concerns around the acceptability of a hormonal male contraceptive, surveys suggest that a hormonal contraceptive method would be welcomed by a large percentage of men and most women in stable relationships would trust their partner to use it.[37] However, women in casual relationships had less trust that their male partners would use the male pill effectively.[38] Studies also show that even under conservative assumptions, the introduction of a hormonal male contraception could contribute to averting unwanted pregnancies and the impact would be especially great in settings where current use of contraception is low.[39]

35. As regards the current development of non-hormonal methods of male contraception, these could potentially be more appealing to men as they do not impact levels of testosterone or sexual function.[40] The non-hormonal methods in development are promising but extensive testing is required before human safety studies can be performed to determine their efficacy for the prevention of unintended pregnancies.[41] In the last few decades, the pharmaceutical industry has abandoned most of its investments in the field of male contraception, leaving only non-profit organisations and public entities to work on the subject.[42] While the work of these organisations and entities is promising, interest from big pharmaceutical companies could ensure that a new male contraceptive is available on the market sooner. However, these companies will only become interested in the development of a new male contraceptive once it has been proved that a wide market for the product exists.

36. Several studies indicate that men show significant interest in using new methods of male contraception in order to share the responsibility of birth control and to gain reproductive autonomy.[43] However, an initial positive attitude towards male contraceptive methods is not enough. Once these new methods are available on the general market, there should be promotional campaigns targeting not only men but also their female partners in order to gain trust in efficiency.[44] Moreover, to prepare for the release of a new male contraceptive method, public policy is needed. Not only the health care system but also the educational system and local communities should be involved in the introduction of a new male contraception, especially within marginalized populations.[45] Health care facilities should include male contraception in primary care so that health care providers can educate their male patients about these options.[46] Governments should also generate policies

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[32] ibid.
[33] Reynolds-Wright, JJ, and Anderson, RA. "Male contraception: where are we going and where have we been?." *BMJ sexual & reproductive health* 45.4 (2019): 236-242.
[34] Behre, HM, et al. "Efficacy and safety of an injectable combination hormonal contraceptive for men." *The Journal of Clinical Endocrinology & Metabolism* 101.12 (2016): 4779-4788.
[35] Thirumalai, A, et al. "Effects of 28 days of oral dimethandrolone undecanoate in healthy men: a prototype male pill", *The Journal of Clinical Endocrinology & Metabolism* 104.2 (2019): 423-432.
[36] ibid.
[37] Amory, JK. "Male contraception", *Fertility and sterility* 106.6 (2016): 1303-1309.
[38] Eberhardt, J; Van Wersch, A; and Meikle, N. "Attitudes towards the male contraceptive pill in men and women in casual and stable sexual relationships." *BMJ Sexual & Reproductive Health* 35.3 (2009): 161-165.
[39] Dorman, E, et al. "Modeling the impact of novel male contraceptive methods on reductions in unintended pregnancies in Nigeria, South Africa, and the United States." *Contraception 97.1* (2018): 62-69.
[40] Soufir, Jean-Claude. "Hormonal, chemical and thermal inhibition of spermatogenesis: contribution of French teams to international data with the aim of developing male contraception in France." *Basic and clinical andrology* 27.1 (2017): 3.
[41] Amory, JK.
[42] Serfaty, David. "A Plea for male contraception." (2015): 75-76.
[43] Glasier, Anna. "Acceptability of contraception for men: a review." *Contraception* 82.5 (2010): 453-456.
[44] Eberhardt, Judith, Anna Van Wersch, and Neil Meikle.
[45] Plana, Olivia. "Male contraception: research, new methods, and implications for marginalized populations." *American journal of men's health* 11.4 (2017): 1182-1189.
[46] ibid.

requiring public insurance programs to expand their coverage to include contraception for men in order to make male contraception more accessible.[47]

4. Sexual and reproductive health and rights for all: overcoming gender, gender identity and age limits

37. An innovative approach to sexual and reproductive health and rights that I deem important to adopt is an inclusive one that is not limited to girls and women in reproductive age, but rather extends to everyone, irrespective of their age, gender, gender identity and gender expression.

38. Experts and activists are increasingly aware that traditional policies on sexual and reproductive health and rights are too limited in scope, and that large shares of the population face exclusion from this area. Too few legislators and policy makers are familiar with such approach, as I often notice when meeting with them. Therefore, I consider it as part of my mission, as rapporteur for this report and in my professional and political work, to advocate for access to sexual and reproductive health and rights to be guaranteed to everyone.

39. A sign of the gradually increasing awareness of and support to this principle is the *Statement on sexual and reproductive health and rights of the ageing population*[48] approved in November 2017 by the International Medical Advisory Panel (IMAP). The statement aims to provide sexual and reproductive rights organisations with the latest evidence and it underlines the importance of addressing the sexual and reproductive health and rights (SRHR) needs of the ageing population. This includes ensuring access to appropriate, rights-based, stigma-free sexual and reproductive health information and services, and other health services. The statement also provides practical guidance on how to offer services without compromising the needs of the ageing population.

40. Among civil society organisations, Canada-based GRAN, or Grandmothers Advocacy Network, is a good example of inclusive activism. While focusing on "grandmothers, vulnerable children and youth in sub-Saharan Africa", their work and recommendations may inspire European actors as well. "SRHR is not only a health issue but also a human rights issue, a gender equality issue, and an age discrimination issue", reads GRAN's background paper "Older Women: Sexual and Reproductive Health and Rights (SRHR)"[49]. Their analysis is clear: "the sexual health of women beyond reproductive age in sub-Saharan Africa (SSA) and around the world is almost always overlooked in policies and programs, healthcare, research, academic discourse, and in the media. Older women are absent from official records and are invisible to policy-makers and organizations providing development assistance. As a result, older women are often denied basic services and protection of their sexual and reproductive health and rights". They explain that the sexual health of women aged over fifty is disregarded for reasons including ageism (prejudice and discrimination based on age, with the misconception that sexual health is irrelevant because older people do not engage in sex after the end of reproductive life) and the traditional focus on maternal and child health.

41. It is unreasonable to neglect the health needs and rights of women after the age of fertility, as they face specific health challenges, including a higher risk to developing non-infectious diseases, such as breast and cervical cancer, which can affect sexual functioning both physically and psychologically. The stereotypical thinking, widespread among healthcare professionals and policymakers, and the misconception that ageing women do not have sexual health needs, makes tackling the issues I mentioned more difficult.

42. A 2020 editorial of the Reproductive Health review is entitled "Leaving no one behind" also includes taking the elderly along concerning their sexual and reproductive health and rights".[50] I can only agree with this stance, given that the article refers not only to women but also to men. It explains that when older people engage with the health systems to discuss and seek help regarding SRHR, it becomes clear that these health systems are not designed to meet their needs or address their issues. It confirms that health workers are often described as holding stereotypical, prejudiced and discriminatory attitudes against older people based on their age. Changing this situation should be a priority for policy makers. The same article adds that "in the World report on ageing and health published in 2015, healthy ageing is defined as "the process of developing and maintaining the functional ability that enables wellbeing in older age" […] However, to realise true healthy ageing, SRH and rights issues cannot be ignored". I would like to highlight that the current decade (2020–2030) was declared as the decade of healthy ageing.

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[47] ibid.
[48] IPPF, *IMAP Statement on on sexual and reproductive health and rights of the ageing population*, February 2018.
[49] Grandmothers Advocacy Network, *Older Women: Sexual and Reproductive Health and Rights (SRHR)*, Ottawa, at www.grandmothersadvocacy.org.
[50] Banke-Thomas, A., Olorunsaiye, C.Z. & Yaya, S. " 'Leaving no one behind' also includes taking the elderly along concerning their sexual and reproductive health and rights: a new focus for *Reproductive Health*", *Reproductive Health* **17**, Article number 101 (2020), 20 June 2020.

43. Everyone should be able to count on age-friendly healthcare, affordable medicines and long-term care that acknowledges the importance of sexual health throughout life. Attention should be paid to ensuring that everyone, irrespective of their age, and particularly people that are more vulnerable to discrimination, including persons with disabilities and LGBTI people, may enjoy their sexual and reproductive rights. The specific issues of women past the age of reproduction and of older men should be given greater visibility and attention, and they should be addressed in compliance with relevant human rights standards and obligations. An additional recommendation is inspired by the 2014 article *Sexual and reproductive health and rights of older men and women: addressing a policy blind spot* published by Isabella Aboderin of Bristol University. Professor Aboderin writes that growing attention has been paid to older persons since the turn of the century, fuelled by increasing awareness of the rapid ageing of populations, but only in relation to health issues in general, not to sexual and reproductive health. She also finds that this policy lacuna is the result of a lack of data and scientific evidence in this area. A few years later, the situation has only partly improved. Therefore, further research is still needed to prepare adequate policy responses to the challenges we are discussing.

44. As an article published on the October 2021 issue of Frontiers in Reproductive Health explains, "Sexual and reproductive healthcare is often conceptualized as "women's" or "men's" health services, which may be excluding many people from seeking care […]. Health care professionals should be sensitive and understand how gender, as opposed to sex assigned at birth, can directly affect clinical practice". [51] Transgender and non-binary people, with their specific sexual and reproductive health needs, "are often excluded from gynecological and reproductive practices, as current guidelines and recommendations in this area exist within a gender binary, heteronormative system, catering care to those who identify as heterosexual and cisgender". The article adds that one of the main barriers to quality care for transgender people is the lack of adequate clinician training. Addressing this shortcoming should be an absolute priority.

45. On a separate but closely related note, I would like to add that even the concept of bodily autonomy, which is a crucial aspect of sexual and reproductive health and rights, should be interpreted in a wider, inclusive sense. Generation Equality Forum, co-hosted by France and Mexico in 2021, promoted bodily autonomy as a central element of gender equality policies. I can only welcome this progress and the increasing political support for this right. I would like to add that the concept of bodily autonomy is also relevant to the rights oftransgender people. It should be made clear that bodily autonomy includes the power and agency to self-determine one's gender identity.

5. Design: an agent of change and a tool to promote gender equality

46. Design is an important part of our everyday life and, as emerged from the hearing held by the Committee on Equality and Non-Discrimination on 10 October 2022 with experts Alice Rawsthorn and Jimena Acosta, it is not only a matter of appearance, of making our living environment more aesthetically pleasing. In fact, it is an agent of change, intertwined with social, economic, scientific and cultural developments, and may be used as a powerful tool to alleviate inequalities, including those based on gender, and to improve healthcare. In spite of such positive potential, until now design has often aggravated gender inequality, mainly due the dominance of cis-gender men in its ranks. As Caroline Criado-Perez writes in the important book "Invisible women", we live in "a world designed by men", and for men: most smartphones are too big for the average woman's hand (and pockets), voice recognition is 70% more likely to understand a male voice and, crucially, women are misdiagnosed more often them men due to the impact of a supposedly gender-neutral approach to designing medical instruments, which is actually based on men's characteristics and functioning. Gender inequality has an impact not only on medicine but also on technology and even on venture capital funding.

47. In the realm of sexual and reproductive healthcare, the negative impact is particularly clear. However, there are positive changes: egregious cases of discrimination are now more likely to be called out, and books, art exhibitions and cultural projects have raised awareness of this issue. The influence of senior women and non-binary people in hi-tech and other industries is leading to increasingly successful and inclusive design, and financial investors are becoming aware of the commercial potential of sexual healthcare innovation. Positive developments include telemedicine tools that were first used during the early phases of the Covid pandemic. New products have been launched, such as the Elvie breast pump that is more discreet than traditional ones and allows women to express milk while carrying out their normal activity. Menstrual plugs developed in Malaysia are an example of innovative tools created to tackle period poverty by replacing tampons.

48. As Ms Rawsthorn highlighted, design's contribution to addressing complex challenges includes not only pursuing good design, but also avoiding bad design, by anticipating the negative impact of badly designed

[51] Claire E. Lunde, Rebecca Spigel, Catherine M. Gordon and Christine B. Sieberg, "Beyond the Binary: Sexual and Reproductive Health Considerations for Transgender and Gender Expansive Adolescents", *Frontiers in Reproductive Health*, Vol. 3, 6 October 2021.

tools. Artificial intelligence is has a role to play in this respect and is being used, among other things, in diagnosing sexually transmitted diseases.

49. Women's contribution to design has increased in recent decades, although, as Ms Acosta underlined, many of the tools they designed (props for menstruation, contraceptives, breastmilk devices) are still not mentioned in most design books. Innovation never stopped: pregnancy tests, for instance, would take two hours to deliver a result in the 1960s, 30 minutes since 1985 with the introduction of Clear Blue, and now only three minutes with the latest digital version of the test. Women's health apps such as Flo and Ovia collect various types of data on fertility, ovulation and even predict menopause.

50. I can only agree with Ms Acosta, who points out that while innovation increasingly hacks the system towards equality, the system itself remains based on women's oppression. This is why in Latin America gender equality movements such as La Marea Verde often refer to the need to innovate in the area of sexual and reproductive health and rights. Existing power structures need to be redesigned, they say, to reach reproductive justice and "co-liberation", a concept based on the idea that "none of us is free if some of us are not".

6. Spain: where there's political will, there's a way

51. The fact-finding visit I conducted to Spain on 28 – 29 September 2022 proved timely and fruitful. I chose Spain mainly due to the considerable progress the country has achieved in gender equality legislation and policies in the last decades. In the 2000s, awareness of outstanding gender inequalities and a strong political will to address them led Spanish governments to initiate and implement ambitious legislation, including the Organic law on gender-based violence (2004) and the Organic law on real equality between women and men (2007). I believe that this is an important example for other Council of Europe member States, including those in the Mediterranean region and other countries of Catholic tradition, where the usual examples from Northern Europe may feel less relevant or less applicable to the local context.

52. On a different but related note, the 2005 reform introducing same-sex marriage was another sign that Spanish legislators and policy makers did not hesitate to challenge traditional patriarchal values, their priority being promoting equality across the board. The current Spanish government, especially the Minister of Equality, Ms Irene Montero, whom it was a real pleasure to meet, shows the same determination in pushing forward a gender equality and LGBTI-inclusive agenda. A few days before I went to Spain, Minister Montero stated that the new legislation on abortion and the "Trans Law" reforming gender recognition were top priorities and she "demanded" they be adopted before the end of 2022.

53. Ms Gloria Lopez, an journalist from AMECO-Press (the Spanish Association of Women Media Professionals) with whom I met in Madrid, confirmed that the draft bill to reform the legislation on sexual and reproductive health and rights and abortion was important news, in view of the challenges faced today including regulations varying across autonomous regions, the impact of years of budget cuts, and widespread conscientious objection. In addition, it provided for sexuality education in schools, which was currently lacking or insufficient. Progress in this area has triggered a backlash from conservative forces including the Catholic Church, which has some influence on education, and the most conservative politicians. The far-right Vox party,in particular, has an agenda of promoting the traditional patriarchal values that Spanish society has to a large extent abandoned. An example of the criticism that feminists face includes the reaction to a march they held on 8 March, International Women Day, in 2020. Those were the early days of the Covid-19 pandemic, and the event was harshly criticised by many ultraconservatives as being a "super spreader". Around the same date, Vox held another large public event, which however raised no criticism.

54. The start of my visit coincided with International Safe Abortion Day, a commemoration that is widely marked in Spain. I could feel the effect of this special day on the spirit and motivation of many of my interlocutors, both among civil society representatives and the authorities. I was honoured to have the opportunity to speak at the annual event organised in Madrid by the Ministry of Equality to mark this day, together with Spanish women's rights activists, experts and media personalities.

55. I held a meeting with Ms Carmen Calvo Poyato, Chairperson, and other members of the Committee on Equality of the Congreso de los Diputados. I am grateful to our Spanish colleagues as a large number of them joined the meeting, representing all political groups. This of course is also a sign of their interest in sexual and reproductive health and rights issues. Our conversation confirmed that gender equality enjoys wide support across the political spectrum (with the exception of the far-right) and politicians from all the main parties share a pride in the progress achieved by their country in this area. They underlined that Spain had pioneered areas including the fight against gender-based violence, precisely thanks to such consensual support. The 2004 Organic law against gender violence was voted by all political parties, and in 2017 a "State Pact against

gender-based violence"[52] renewed the shared commitment to preventing and combating violence against women.

56. The meeting with Minister of Equality Irene Montero also proved very fruitful. A smart politician with an ambitious agenda, whom I consider a powerful ally, Ms Montero clarified that progress in gender equality does not happen in a void – the cultural landscape and the values generally accepted by the population largely contribute to defining it. That is why men have an important role to play. Ms Montero used the term 'co-responsibility' in this context, a term I find very inclusive and useful. The same applies to media, which have a profound influence on people's mindsets. For the same reason, Ms Montero also highlighted the importance of comprehensive sexuality education in schools, which was often opposed not only by far-right forces but also by mainstream conservative politicians.

57. A vibrant civil society active in promoting gender equality and countering gender-based violence is another feature of today's Spain and its close cooperation with public authorities is a major pre-condition for achieving real progress in these areas. In Madrid I met with *SEDRA – Federación de planificación familial*, in their youth counselling centre in the heart of Madrid. This organisation carries out a multitude of activities, including advocacy to impact public policies and legislation on sexual and reproductive health and rights, and providing assistance to the population to complement the services provided by the public sector. Youth is the main target of such work, with a focus on providing information on issues ranging from contraception to sexually transmitted diseases but also sexuality and relationships. In Spain, like in many other countries, sexuality education is lacking or insufficient, and young people seek information on sexuality from Internet sources that are not necessarily reliable and through pornography, which is not meant to be educational or even accurate, and is often misleading. My interlocutors at SEDRA found that sexuality education was often too limited, as schools were hesitant to tackle subjects other than contraception and infections, and that it started too late, with students being 14 years old and older. While the youth counselling centre endeavoured to help by providing accurate information, they were unable to reach the entire youth population in the way that public education could. Moreover, a majority of their users were girls, as boys and young men seemed to find it more embarrassing to seek information or believed they did not need it. The outcome of this conversation confirmed once again the importance of comprehensive sexuality education, which can be complemented but no replaced by other services. I also had the opportunity to meet the management of Madrid Salud (Madrid Health) a programme of the Municipality of Madrid that provides assistance and counselling in the area of sexual and reproductive rights to all residents, irrespective of their age, gender and status. I was impressed by their motivation and commitment, buoyed by the awareness of how much their services are needed by the population and by the respect their work gained. It appears that, irrespective of which political group is in power at local level, Madrid Salud manages to continue its activities. The gender perspective and feminist approach Madrid Salud follows also struck me positively. I can only admire their commitment to equality and their sex-positive attitude and support their ambition to safeguard access to sexuality healthcare and information and remove the barriers that certain individuals and groups face. They explained that their goal was to promote a healthy, enjoyable sexuality for the citizens of Madrid in all their diversity. Programmes like this are extremely valuable as they develop a perfect knowledge of the population they serve, with its needs and the challenges it faces.

58. While my fact-finding visit to Spain was held entirely in Madrid, I had the opportunity to exchange in writing with representatives of the Generalitat de Catalunya (government of the autonomous community of Catalonia). Sexual and reproductive health and rights seem to be very high in the priorities of this government, which identified gender equality among the core elements of its plans, established a Ministry of Equality and Feminisms (*Departament d'Igualtat i Feminismes*) and adopted a National Strategy for Sexual and Reproductive Rights.

59. According to the information the Catalonian authorities provided to me, voluntary termination of pregnancy is considered as a right and is covered by the Catalan public health system, both in the medical and the surgical form. It is interesting to note that the number of clinics and hospitals that practice abortions has increased in the past year. This sounds like an extremely positive development, against a backdrop of declining abortion care infrastructure in most European countries.

60. It is also positive that an in December 2022 the Ministry of Equality and Feminisms adopted an Action plan to support human rights defenders, which covers anti-abortion harassment and violence among other things. More generally, the government of Catalonia is currently taking (pro)active action against "anti-gender" groups attempting to unduly limit women's rights. In this context, criminal proceedings were brought against an anti-abortion campaign instigated by an international anti-choice platform (40 days for life) that gathered

[52] In Spain, a *Pacto de Estado* or "State Pact" is an agreement between political parties of opposed orientation to guide policies of particular importance in the long term, irrespective of which political group is in power. Regional authorities were also involved in the process. See for example: Government of Spain, Ministry for Equality, *Delegación del Gobierno contra la Violencia de Género – Pacto de Estado contra la Violencia de Género* at www.violenciagenero.igualdad.gob.es.

around three abortion centres in the city of Barcelona. Also, in November 2022, a bus that had been riding in various Spanish cities displaying transphobic messages was stopped at the initiative of the Ministry of Equality and escorted out of Catalonia. The organisation behind this bus (Hazte Oír) is now facing administrative sanctions.

61. The government of Catalonia appears to tackle different forms of discrimination with strong determination and a particularly advanced and inclusive approach. In addition to the priority attached to sexual and reproductive healthcare and the particular focus on the "rights", I would like to highlight that attention is paid to the situation of transgender people. I also found it interesting that forthcoming activities of the Ministry of Equality and Feminisms include an Action Plan to Combat Aesthetic Pressure, which seeks to tackle the growing impact of aesthetic pressure on women, particularly on girls and teenagers.

7. Communicating on gender equality. How to tell an inclusive story in times of an ultra-conservative backlash?

62. The promotion of innovative approaches to sexual and reproductive rights and improving everyone's access to them faces an insidious challenge, namely the backlash against women's rights from ultraconservative forces at global level. These movements, often of extremist religious inspiration, refer to a supposed "gender ideology" that allegedly threatens the "natural order" – 'natural' meaning 'traditional and patriarchal' – and oppose progressive stances both on gender equality and on equal rights for LGBTI people. Anti-gender tendencies increasingly infiltrate politics and institutions, with far-right parties and movements embracing the misrepresentation and disinformation on gender equality for political gain. Research carried out by civil society organisations and individual experts has shown that the ultraconservative campaign against human rights in the area of sexuality and reproduction is based on a precise strategy. According to the publication "Restoring the natural order", published in 2018 by the European Parliamentary Forum for Sexual and Reproductive Rights (EPF), the first visible targets of this campaign were abortion and same-sex marriage (leading to actual bans in several Central and Eastern European countries), but the strategy secretly aimed to target also contraception, in-vitro fertilisation and divorce.

63. During the preparation of this report I met with fellow parliamentarians who used an anti-gender rhetoric, which led me to wonder how to best react to it with a view to neutralising it. The arguments used by ultraconservative politicians are repetitive and almost predictable. One has the impression that a practical handbook is circulated to provide them with a limited set of speaking points. Typical features of this rhetoric are the use of pseudo-scientific arguments and of a legal language echoing that used in human rights. The "foetal heartbeat" at six weeks of pregnancy used by anti-choice campaigners is a good example of a pseudo-scientific argument. Science says that there is no actual heart at that stage, and no audible beat. Moreover, before the eighth week of pregnancy the correct term is not foetus, but rather embryo. The same applies to the concept that "life begins at fertilisation", with the alleged creation of a unique DNA at that stage. "This statement is commonly offered by religious organizations and is often cited as the basis for so-called personhood amendments, but the assertion that it is scientifically sound is incorrect", writes fertility doctor Richard J.Paulson[53]. Both pseudo-legal and pseudo-scientific arguments are intended to confuse and convince the less educated or more malleable sections of the public. The temptation to just disengage, not listen and not reply is strong. Indeed, there is no point in trying to convince anti-gender campaigners that the arguments they use are fallacious: they probably know already. However, it is important not to leave their stances unchallenged. As politicians supporting human rights and gender equality, we have an obligation to dispel those myths and misrepresentations since our audience, our electorate and the public in general, may believe them and in good faith make their political choices accordingly. Communicating wisely, with a view to achieving progress in access to sexual and reproductive health and rights, implies targeting the "movable middle", those who are not bound to an ideological choice and are ready to accept the more convincing option in a political debate.

64. It is also important to adapt the style of communication used to its target. Some audiences may be used to a feminist perspective, some other may have an approach based on human rights and fundamental freedom more broadly. Some concepts, such as the need to respect everyone's right to self-determination, are non-negotiable and should be understood by any audience. I discussed this topic with several interlocutors, both to seek new ideas and to share my views on it. In Spain, civil society representatives pointed out that the far right has unduly appropriated the idea of family. Indeed, why should the love and support and all the positive things we associate with family belong exclusively to a political group? However, in this case, as in others, it is not useful to follow the anti-gender tendency into their territory. It is more useful to prioritise the concept of

[53] Richard J.Paulson, "The unscientific nature of the concept that "human life begins at fertilization," and why it matters", *Fertility and Sterility*,Vol 107, Issue 3, pp566-567, 1 March 2017.

individual rights and freedoms, the freedom to make choices on one's own life, including when and how to start a family.

8. Conclusions

65. Gender equality is far from achieved, in Europe and beyond, and progress in women's rights – like human rights in general – can never be taken for granted. In fact, today more than ever, the achievements of the last few decades are threatened by a global backlash. We observe, in the political debate of most Council of Europe member States and in the legislation and policies of some of them, insidious attempts to control people's self-determination in sexuality and reproduction. Women's bodies, in particular, have become the object of a cultural and political dispute, in a global political landscape characterised by an upsurge of populist and ultraconservative forces that promote a revival of patriarchy.

66. The patriarchal attempts to control people's sexuality and reproductive choices should be countered effectively. Women's self-determination in matters of reproduction has been increasingly threatened by legislation and policies in Council of Europe member States and beyond. The same applies to self-determination of one's gender identity, a power that should be recognised in the perspective of preventing and combating discrimination against transgender people. Our societies feature a diversity of ideas, aspirations and lifestyles which should be recognised and embraced. Rather than erasing differences, we should embrace and celebrate them.

67. Throughout the preparation of this report, the exchanges I had with experts, civil society organisations, fellow politicians in parliament and government positions, not to mention the exchanges within the Committee on Equality and Non-Discrimination, confirmed my opinion that much can and should be done to improve everyone's access to sexual and reproductive health and rights.

68. Close cooperation with civil society organisations is crucial in achieving progress in this area. It is also of the utmost importance to inform, raise awareness and educate the public, as many of the issues at stake are not adequately known, and traditional misconceptions are today combined with deliberate disinformation spread by some. The most important condition for rapid and substantial progress, however, is political will. Legislators and policy makers who are committed to upholding human rights and equality should place a high priority on sexual and reproductive health and rights. Progress is needed and is possible, thanks to a variety of tools and innovations, as presented in this report.