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Empowering women: promoting access to contraception in Europe

Draft report¹

Committee on Equality and Non-Discrimination

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Summary

Contraception increases women's decision-making power and autonomy, as individuals and within the household, and helps them to strike a better balance between private and work life. Access to contraception is therefore a crucial factor of women's empowerment.

One of the main barriers to contraception is its financial cost: subsidies and reimbursement should therefore be granted by public authorities by including modern contraceptives in public health insurance schemes.

Misconceptions and myths, as well as patriarchal norms and social stigma, also severely hinder access to modern contraception. Comprehensive sexuality education in school, as well as information and awareness raising activities targeting adults, are key in addressing such cultural and social barriers.

Protecting and promoting access to sexual and reproductive health and rights, including access to contraception, should be high in the list of political, equality and health priorities of European governments.

¹ Reference to Committee: Doc. 14597, Ref. 4402 of 12 October 2018.

A. Draft resolution²

1. Access to modern contraception is crucial to women's empowerment, in that it increases women's decision-making power and autonomy, individually and within the household, enables them to plan employment and professional development more efficiently and leads to an improved balance between private and work life.
2. Access to contraception is not guaranteed to all women equally. Geographic disparities are found across and within Council of Europe member States, with more difficulties in rural and remote areas.
3. Furthermore, financial and economic barriers hinder access to contraception. Economic and financial status are particularly important for young and lower-income people who experience difficulties in accessing contraception if reimbursement or subsidisation are not provided.
4. Cultural and social barriers, including cultural norms, gender stereotypes, prejudices and moral stigmas also negatively impact access to contraception and result in a lack of or insufficient knowledge of methods of contraception, their availability and correct use. They affect potential users, particularly women, young and non-married people, discouraging them from seeking contraceptive devices and advice. In addition, myths and misconceptions, misrepresenting contraception as unnecessary or potentially harmful, are widespread.
5. Vulnerable and marginalised groups, including people with a migrant background, persons with disabilities and ethnic and linguistic minorities, are particularly exposed to both financial and cultural barriers in access to contraception, which calls for specific attention and measures.
6. The Parliamentary Assembly believes that protecting women's sexual and reproductive health and rights should be given a high priority by public authorities at all levels, as an important part of gender equality policies, with a view to building fair and equal societies and promoting health and well-being.
7. The Assembly is convinced that comprehensive sexuality education in schools at all levels is an indispensable part of the upbringing of children and young people. It is an investment in a healthier society; it improves the understanding of individual freedoms and boundaries in the area of sexuality; it contributes to avoiding early and unintended pregnancies; increasing the use of modern contraception; preventing sexually transmitted diseases; improving the knowledge, attitudes and skills necessary for young people's wellbeing; promoting more equitable social and gender norms; preventing sexual, gender-based and intimate partner violence; promoting self-determination, empowerment, equality, non-discrimination and respect for diversity.
8. The Assembly considers that all types of modern contraception, including long acting reversible contraception (LARC) should be accessible and affordable for everyone, irrespective of their sex, social and national origin and any other status, and should be accompanied by reliable advice and information. Responsibilities should, insofar as possible, be shared by women and men.
9. In the light of the above considerations, the Assembly calls on Council of Europe member and observer States, as well as those enjoying observer or partner for democracy status with the Parliamentary Assembly, to:
 - 9.1 as regards sexuality education, information and awareness raising:
 - 9.1.1. introduce comprehensive sexuality education as part of all school curricula and ensure that age-appropriate sexuality education is mandatory for all pupils, and that children cannot be withdrawn from it. This education should be evidence-based and scientifically accurate, and address issues including the prevention of early pregnancies and sexually transmitted diseases; the promotion of gender equality, relationships, consent, prevention and protection from sexual, gender-based and intimate partner violence; gender norms, sexual orientation and gender identity and expression;
 - 9.1.2. review textbooks used in sexuality education curricula and ensure that their contents and illustrations are scientifically accurate;
 - 9.1.3. provide teachers, school doctors and school nurses with specific training and resources on comprehensive sexuality education;

² Draft resolution adopted unanimously by the Committee on 4 December 2019.

9.1.4. conduct information and awareness-raising campaigns on sexual and reproductive health and rights, including comprehensive information on all modern contraceptive methods, and all other issues covered by comprehensive sexuality education in schools, targeting young people in and out of school, parents and the general public, through internet and social media as well as traditional media, such as the press, radio and television, including public television;

9.1.5. set up and advertise information websites providing comprehensive, fact-based information on contraception, including all types of modern contraceptive methods, their cost and where they can be obtained. Information should also be accessible for people in rural and remote areas, those belonging to language minorities, persons with disabilities and migrants;

9.2. as regards access to contraception:

9.2.1. ensure that all modern methods of contraception, including emergency contraception without prescription, are made available to the public, including in rural and remote areas and to marginalised and vulnerable groups;

9.2.2. ensure the affordability of contraceptive methods by including them in national health insurance schemes with adequate reimbursement or subsidisation;

9.2.3. develop specific reimbursement or subsidisation schemes for young, low-income and vulnerable groups, with a view to countering economic barriers that determine unequal access to contraception and review such schemes regularly to ensure their effectiveness;

9.2.4. provide affordable, confidential and non-judgemental individual counselling to those seeking contraception with a view to providing users with all the necessary and personalised information, including the choice of the contraceptive methods best suited to their needs, and to reviewing that choice when needed;

9.2.5. provide mandatory training on contraception both at post-graduate level and as refresher courses for healthcare professionals, as well as regular information on relevant scientific evidence;

9.2.6. develop evidence-based guidelines for healthcare professionals on modern contraception, based on the standards set by the World Health Organisation (WHO);

9.3. as regards research and data collection:

9.3.1. improve existing or develop new data collection systems, ensuring a comprehensive collection of comparable data on contraception, disaggregated by sex, age, income, social status and level of education;

9.3.2. start or enhance research on the use of all methods of contraception, their prevalence, evolution, costs, and impact on users;

9.3.3. promote and support scientific research on male contraception methods, with a view to developing and making available innovative contraceptives and devices for use by men;

9.4. as regards cooperation with civil society, health professionals and service providers:

9.4.1. strengthen cooperation and support for civil society and health profession organisations active in promoting and providing contraception, collecting data and conducting research, designing and carrying out information and awareness raising campaigns, providing training of healthcare professionals and sexuality education; and provide an enabling environment and funding for civil society organisations active in this field.

B. Explanatory memorandum by Ms Petra Bayr, rapporteur

1. Introduction

1. Women's empowerment is a complex process encompassing various factors, ranging from access to education and increased political representation to participation in the economy, improved work-life balance and freedom from gender-based violence. Empowering women means removing all the obstacles preventing them from contributing to the development of society on an equal footing with men.
2. Protecting women's sexual and reproductive health and rights is part of this process, particularly so in the current context of global backlash against women's rights. Today, it is important not only to consolidate what has been achieved, but also to push forward for further progress. This also applies to contraception, an area which is crucial to women's empowerment and where further progress is necessary. Contraception increases women's decision-making power and autonomy, as individuals and within the household, and helps them to strike a better balance between private and work life.
3. The United Nations' Sustainable Development Goals highlight the correlation between gender equality and sexual and reproductive health and rights. In particular, Goal 5 ("Achieve gender equality and empower all women and girls") includes the specific target to "Ensure universal access to sexual and reproductive health and reproductive rights".³
4. Council of Europe member States are far from reaching goal 5: the Europe-wide "Contraception Atlas" published by the European Parliamentary Forum on Population & Development (EPF) and presenting the situation in 46 European countries regarding access to contraception, supplies and the availability of relevant information and counselling, concludes that "every country analysed needs to do more to improve access".
5. The *Barometer of Women's Access to Modern Contraceptive Choice in 16 EU Countries*, published by the International Planned Parenthood Federation – European Network (IPPF EN) in January 2015, highlights "the strong grip that patriarchal, traditional and religious influences still have over the everyday lives of women and girls in many European countries" and finds that access to contraception has "stagnated or even worsened" in recent years in the countries covered by the report. However, the report also indicates that progress is possible and highlights some of the positive examples, such as Cyprus and Denmark for their sexuality education policy and Poland and Sweden for their updated national medical guidelines on contraceptive service delivery.
6. It is significant to note that in most cases, countries with easier access to contraception also present higher fertility rates. France, for instance, ranks among the first European countries for both⁴. Contraception policies, in other words, do not decrease birth rates. The figures also indicate a decrease of voluntary terminations of pregnancy where access to modern contraceptives is made easier. While abortion is not part of the scope of this report in itself, this correlation, confirmed by several sources, cannot be ignored.
7. Access to contraception and protecting and promoting access to sexual and reproductive health and rights should be high in the list of political, equality and health priorities of European governments.
8. In addition, access to such rights should be guaranteed to all women equally. Governments need to tackle existing inequalities in access to contraception, which mirror socio-economic inequalities within the population. Women with higher incomes and better education for example, are much more successful avoiding unintended pregnancies, as they have easier access to contraception and information about it.
9. Barriers in the access to contraceptives exist especially for marginalised and vulnerable groups such as migrants, young people, persons with disabilities and minorities. People in these groups often lack the necessary knowledge on how to obtain and correctly use contraceptives, including emergency contraception.
10. When talking about contraception, we must not forget the responsibility of men in preventing unintended pregnancies and the transmission of infections. Men also need access to contraception and education on how to take responsibility in informed, self-determined family planning.

³ Point 5.6 of the Sustainable Development Goals.

⁴ France ranks first in IPPF EN's Contraception Atlas and its total fertility rate, according to Eurostat is 1.90, the second highest in Europe

11. Informing and raising awareness, not only in the specific groups mentioned but also among the population at large, are key. Sexuality education must be part of school curricula and awareness raising activities must target young and adult populations alike.

12. In the preparation of this report, I cooperated closely with civil society organisations, which I consider to be crucial partners in view of their commitment and their direct knowledge, not only of legislation and policies but also of the actual situation on the ground. In addition to inviting experts from civil society organisations to a hearing, I sent out a questionnaire and received information from non-governmental organisations active at national level, and on several occasions, I had informal meetings and exchanges.

13. On 16 and 17 October 2019, I conducted a fact-finding visit to Finland, a country with excellent public social services and health care (ranking among the top OECD member States in this area⁵) which has been very active in experimenting contraception policies and offers a repertory of good practices. Among the reasons that motivated the choice of Finland, I would mention an awareness of gender equality issues (the modern debate in this area dates back to the 1960s), a long-established sexuality education in schools, and the fact that regulations and policies on contraception vary across the country, allowing to identify more successful experiences.

14. Furthermore, the Issue paper on Women's sexual and reproductive health and rights in Europe, published by the Council of Europe Commissioner for Human Rights in December 2017, is a timely document that provides a wealth of valuable recommendations. While my report covers only part of the issues discussed in the paper, I have paid great attention to both the descriptive and the prescriptive parts of this document that specifically concern contraception.

2. Access to contraception in Europe: an overview

15. In April 2019, the Committee on Equality and Non-Discrimination held a hearing with the participation of representatives of two civil society organisation that are active in sexual and reproductive health and rights in Europe: Mr Neil Datta, Executive Director of the European Parliamentary Forum on Population & Development (EPF), and Ms Camille Butin, Advocacy Advisor at the International Planned Parenthood Federation European Network (IPPF EN). The hearing was an excellent opportunity to learn more about the overall situation regarding access to contraception in Europe, and the findings of EPF's *Contraception Atlas* and IPPF's *Barometer of Women's Access to Modern Contraceptive Choice in 16 EU Countries*.

16. The discussions and exchanges on the occasion of the hearing highlighted the shortcomings that exist in many Council of Europe member States and allowed the best performing systems to be identified with a view to disseminating them as "good practices" which may inspire others to take action to fill existing gaps and improve access to contraception.

17. The two studies that were presented to the Committee during the hearing complement each other. The Atlas describes the situation of as many as 46 countries, based on only two main criteria. The Barometer covers a wider range of policies, but its geographic scope is limited to sixteen countries, all of them members of the European Union.

18. The Barometer uses eight policy benchmarks, corresponding to eight policy areas, to evaluate and rate the countries' situation with regard to access to modern contraception, which includes contraceptive pills, condoms (male and female), intrauterine device (IUD), sterilization (male and female), injectables, hormone implants, patches, diaphragms, spermicidal agents (foam/jelly), and emergency contraception. The eight areas are as follows:

- policy making and strategy;
- general awareness of sexual and reproductive health and rights (SRHR) and modern contraceptive choice;
- sexuality education in schools;
- education and training of healthcare professionals and service providers;
- provision of individualised counselling and high-quality services;
- existence of reimbursement schemes;
- prevention of discrimination;
- empowering women through access to the modern contraceptives of their choice.

19. The study concludes that, due to shifting political priorities, the monitoring and evaluation of policies on sexual and reproductive health and rights are both weak and inadequate. Religious influence continues to

⁵ Health at a glance, OECD, 2018.

negatively impact access to contraception. Public awareness of contraceptive options appears to be low in most European countries. Only two countries have launched information campaigns on contraception. In most cases, not all the stakeholders are involved in information activities. Including civil society organisations working at grassroot level, health professionals and service providers would bring real added value and increase the impact of information campaigns. The study also found that sexuality education curricula vary considerably across countries, and often rely on the personal knowledge and views of individual teachers, which is detrimental to the consistency and possibly the accuracy of teaching. Conservative and religious groups tend to oppose sexuality and relationship education. The training of healthcare professionals on contraception is rare and often of poor quality, which is reflected in the low quality and quantity of individualised counselling available in most countries. Only half of the countries studied offer reimbursement, and policies in this area are unsatisfactory from a non-discrimination perspective: economic and social barriers are not always taken into account and the focus on vulnerable groups is insufficient.

20. The last area analysed by the study, namely women's empowerment, is particularly relevant to the political perspective of my report. The IPPF EN notes that in the vast majority of the countries studied, access to contraception is not viewed by regulators as part of gender equality policies and a factor of empowerment. This is, in my opinion, a serious shortcoming that should be addressed and corrected. Being able to plan if and when a pregnancy should occur is crucial to women's individual autonomy and to their ability to manage the balance between work and private life and is therefore an empowering factor.

21. It's also worth noting that the Barometer for the policy areas in each country indicates a predominately static situation: in most cases, policies remain 80 to 90% unchanged. In one case (area 5, "Provision of individualised counselling and quality services"), none of the countries studied have evolved in any way. Considering the clearly unsatisfactory situation that currently exists in most countries, the absence of progress is a reason for concern.

22. It is worth highlighting the fact that the Barometer indicates that the urgently needed political will, ambition and support to improve sexual and reproductive health and rights, including access to contraception, are lacking.

23. EPF's Contraception Atlas ranks countries according to two main criteria (which in turn are based on several indicators):

- availability of online information about modern contraception;
- access to contraceptive supplies and counselling.

24. Countries score from "exceptionally good" to "exceptionally poor". The seven "champion States" at the top of the list are characterised by having a general reimbursement scheme for contraceptives and special reimbursement facilities for young people and low-income women. They offer free counselling for family planning. "Very good" countries have a general reimbursement scheme only and provide satisfactory counselling. "Medium" to "very poor" countries provide little to no reimbursement, and less comprehensive or less accessible counselling. The "exceptionally poor" category includes only Poland and was created because of the worsening situation in this country, which sets it apart from the rest of those observed. It is only in Poland that access to contraception requires the consent of a third party, and emergency contraception is provided only with medical prescription.

25. As regards the other key criterion, the best performing countries feature websites which are supported by their governments, provide up-to-date information on all modern types of contraception, and also indicate how to obtain it. In other countries, websites may not be supported by the government, or may not provide sufficient information.

26. The Atlas was first published in 2017 and then updated in 2018 and 2019. It is interesting to see how the situation has evolved in the countries studied, based on comparable data and criteria. The 2019 Atlas shows that 15 European countries have seen their score unchanged, 17 have improved and 14 have declined. Variations in the score, however, tend to be minor. The highly satisfactory situation of the top three countries in the ranking (France, Belgium and the United Kingdom) remains unchanged. The most serious decline occurred in Poland, in the context of a backlash against women's sexual and reproductive health and rights in general, and not only limited to contraception. The situation in this country is a reason for concern. Overall, EPF's Contraception Atlas confirms to a large extent the "static" situation described in the IPPF EN Barometer.

27. The contribution of experts and exchanges with fellow Committee members highlighted the fact that contraception is a less consensual matter than one may expect. Data shows that countries which grant easier access to modern contraception are also those with the highest fertility rates. In other words, planned parenthood does not decrease childbirth rates. And yet, conservative and religious groups continue to use this

argument and are firmly opposed to making modern contraception more accessible. Inequalities in access to modern contraception particularly concerned Committee members, and rightly so. The hearing also stressed the difficult access to contraception for marginalised and vulnerable groups, such as Roma or refugee women and called for action to address the situation. A number of measures have proved to be useful, including information campaigns; online information; specific guidelines for professionals; mobile clinics; the involvement of cultural mediators and, in the case of Roma women, of community leaders.

28. I would like to reiterate once again that the key element missing is political will. Inciting decision makers to act is therefore the main aim of this report and of the relevant resolution to be adopted by the Assembly.

3. Access to contraception in Europe: a comparison of selected countries

29. In June 2019, I sent out a questionnaire to civil society organisations that are active in the field of sexual and reproductive health and rights at national level, with the aim of updating the information I had collected by other means. The questionnaire helped me to gather information on the contraceptive methods available in Council of Europe member States and whether they are subsidised or reimbursed; the kind of training that health professionals are offered in this area and their attitudes towards contraception; barriers to contraception and opposition to contraception policies; the role of civil society organisations, and sexuality education in schools.

30. Organisations based in Albania, Austria, Georgia, Germany, Lithuania, the Netherlands, North Macedonia and Serbia provided replies. Although limited in number, the diversity of the regions covered by the respondents (Southeast Europe/Western Balkans, Western Europe and the Caucasus), allows for a robust analysis and some interesting parallels.

31. In addition to the information collected through the survey, I will also present the main findings of the visit that I conducted to Finland.

4. Types of contraception and reimbursement

32. The widest difference across the countries surveyed is whether contraceptives are covered under public health insurance, subsidisation or reimbursement schemes (or provided free of charge). In **Georgia**, no reimbursement is provided by public health schemes. While contraceptive methods are widely available (including emergency contraception, with no need for prescription), their cost is entirely born by users. State budget funds are not allocated for family planning consultations or services, and these services are not included in the State programmes, or in private insurance companies' packages. In the past, international entities such as the United Nations Population Fund (UNFPA) and the United States Agency for International Development (USAID) were active in this area and funded programmes that provided modern contraceptives throughout the country. However, this is no longer the case. No reimbursement is provided for contraception in **Austria, Lithuania, North Macedonia and Serbia**.

33. In **Albania**, according to the information provided non-profit organisation Albanian Centre for Population and Development, the Ministry of Health is leading efforts to strengthen access to contraception, aiming to provide it to all those who need it. The Ministry covers the costs of contraceptive procurement for the entire public sector and Albania is self-sufficient and independent of outside donor support in this respect. Contraceptives, including pills, condoms, and injectables are made available without prescription and free of charge in over 425 public health facilities such as hospitals, polyclinics, and health centres. Sterilisation and intrauterine device (IUD) insertion are available in facilities with trained obstetricians/gynaecologists.

34. In **Germany**, all contraceptive methods prescribed by doctors, including emergency contraception, are reimbursed to women until the age of 22. Over this age, some methods are reimbursed (for example to women who receive social security payments), and only in some cities. In the **Netherlands**, contraception is reimbursed by the basic health insurance for adolescents and young adults up to 21 years of age. Over the age of 21, medical expenses relating to contraception are only partially covered by the public insurance. This may mean that people with lower income have limited access to certain contraceptive methods that are more costly, such as long-acting reversible contraception (LARC), and thus they may not be able to freely choose a method according to their own preferences and needs. The affordability and availability of modern contraception methods for low income and vulnerable groups from 21 years, is now part of a political debate in the Netherlands.

35. As regards the access to contraception through Internet, wide differences exist across the countries examined. In **Austria**, non-hormonal methods, including emergency contraception, are available legally via the Net. Hormonal contraception, however, is available only on prescription. In **Georgia**, no contraceptive is available online. In **Germany**, online pharmacies sell all types of contraceptives by screening the requests

through an “internet doctor”. In **Lithuania**, emergency contraception is available through online pharmacies, but other contraceptives are not. In **Serbia**, none of them can legally be sold online.

36. In **Finland**, contraception falls within the remit of Finnish municipalities, which means that 311 different systems coexist each corresponding to the number of municipalities. A reform aiming to make healthcare part of the mandate of regional governments, has been part of the political debate for several years. Once approved, the reform should simplify the situation and reduce disparities across cities. 50 out of 311 municipalities have introduced various forms of reimbursement of contraceptives, varying slightly in terms of methods of contraception covered and age limits (reimbursement is given to young people, the maximum age being between 20 and 25 depending on the scheme) which allows to observe the impact of different policies.

37. Promoting contraception, particularly long-acting reversible contraceptives (LARC) has proved to be effective in reducing the number of induced abortions. The experience of Vantaa, the fourth-largest city in Finland and part of Greater Helsinki, is particularly meaningful in this respect. I had the pleasure to meet with Frida Gyllenberg, a researcher of Helsinki University who studied the case of Vantaa closely. This municipality has provided public family planning free of charge to all residents since 1975. It then launched a free of charge LARC programme in 2013⁶. A time-series analysis shows that, thanks to this programme, the use of LARCs increased 2.2 times (from 1.9 to 4.2 per thousand women) and the abortion rate declined considerably: by 16% in the total sample and by 36% among those aged 15 to 19 years. These conclusions confirm the findings of previous research conducted in the United States and elsewhere⁷. They provide invaluable indication that no legislator or policy maker should ignore.

38. The current government programme stipulates that “there will be a national experiment on free contraceptives to everyone under the age of 25. Making the experiment a permanent practice will be decided at the end of the electoral term, taking into account the outcomes of the experiment.” Furthermore, the practice will cover all modern contraception methods, short- and long-term, with a view to preventing unintended pregnancies and sexually transmitted infections and diseases. Ten million Euros were allocated to the programme for the years 2021-2022.

5. Sexuality education, professional training and misconceptions

39. Other factors largely contribute to determining the access to and actual use of contraception. These factors include the availability of sexuality education in school curricula; the training of health professionals (whether or not it is provided and compulsory); the existence of myths and misconceptions regarding the need and the effects of contraception and organised opposition to the use of contraception by certain political segments, conservative and religious groups.

Healthcare professionals: training and attitudes

40. The training of doctors and other healthcare professionals on contraception is generally not compulsory, but rather voluntary, and it is provided by various actors. In **Albania**, for instance, the main provider is the NGO ACPD, supported by UNFPA and the International Planned Parenthood Federation (IPPF). The average length of training is 18 hours. In **North Macedonia**, training on contraception is part of the specialisation curriculum for obstetrician-gynaecologists, while most family doctors (as from 2015) receive a two-day training course (12 hours) on modern contraception counselling. Training is funded by the Ministry of Health preventive programme for mother and child. The **Austrian** organisation ÖGF International reports that training for healthcare professionals is not obligatory and considers it to be insufficient. In the Netherlands training is also done on a voluntary basis. In **Georgia**, there is no post-graduate course available for healthcare professionals in this area. However, the Association HERA-XXI has developed an online learning platform for health service providers, available at www.ehera.ge, which offers health professionals various types of courses on family planning, modern methods of contraception and counselling techniques. It is important to note that courses are free of charge. In **Serbia**, while contraception is not part of university curricula, healthcare professionals may attend seminars on contraception as part of their continuous medical education. In addition, they are provided with national clinical guidelines on contraception.

41. As regards a possible preference in the choice of contraceptive methods, it appears difficult to identify a trend. The **Dutch** organisation Rutgers does not rule out the possibility of doctors promoting certain types of contraception over others but is not able to provide more details. It reports that young people generally receive information on at least two methods. In **Albania**, professionals tend to recommend LARC methods only to

⁶ Frida Gyllenberg et al., *Long-acting reversible contraception free of charge, method initiation, and abortion rates in Finland*, American Journal of Public Health, April 2018.

⁷ Rachel Benson Gold, Adam Sonfield, *Publicly funded contraceptive care: a proven investment*, Contraception, November 2011.

adults, and to promote condoms and pills to young people. This also applies to **North Macedonia**. In **Georgia**, doctors seem to recommend intrauterine devices more than other methods. In **Germany**, doctors show a preference for methods that reduce the risk of human error, particularly IUDs and three-months injections. In Serbia, healthcare professionals seem to prescribe all different types of contraception unbiasedly, depending on each individual's situation and needs.

Sexuality education

42. Comprehensive sexuality education is key in determining the awareness of access to and use of contraception among the general public, particularly young people. It should be made available and compulsory for pupils and students. While in some systems the parents are allowed to withdraw children from this part of education, age-appropriate sexuality education should be taught to pupils and students without exception. It is worth noting that the case-law of the European Court of Human Rights recognises the importance of sex education regarding the prevention of sexual violence and exploitation of children and the development of their cultural, social and life skills. In this regard, the Court confirms that sexuality education may be compulsory for all students and member States are not under the obligation to grant exemption from such curricula⁸. In **Austria** and in **Germany**, sexuality education is part of school curricula and parents are not allowed to withdraw their children from these classes (in Germany, however, cases are reported of parents keeping children at home and pretending they are ill). In the **Netherlands**, parents can opt to withdraw children from sexuality education classes, but only few of them do so.

43. In **North Macedonia**, contraception is part of the curricula of Biology and Life skills education. However, the NGO HERA reports that contraception is barely taught during these classes. According to a HERA study carried out in 2014, only 2% of young people received some type of information on contraception in schools. Moreover, this included some false information (for example, that oral contraception was not recommended for young people and that it could cause infertility or breast cancer).

44. In **Albania**, considerable progress has been achieved in the last few years, mainly due to the efforts of the Ministry of Education and the Institute of Educational Development, with financial and technical support from UNFPA and IPPF. Civil society, including the Albanian Centre for Population and Development and other NGOs, have played an important role in advocating sexuality education. A curriculum on 'Life Skills and Sexuality Education' was developed on the basis of international standards and officially introduced at school level (ages 9 to 15) in 2012. About 3000 teachers have received specific training in this area.

45. In **Lithuania**, sexuality education is part of school curricula but is met with hostility by religious and conservative organisations, which have an influence on public education. Parents have the right to opt-out and textbooks are not always adequate, according to Family Planning and Sexual Health Association.

46. Opposition to sexuality education in school curricula is reported in several of the countries considered and is usually said to come from churches and religious organisations, sometimes connected to political parties. In some cases, Christian denominations offer alternative sexuality education curricula, for instance dealing with sexuality only within marriage. Misconceptions, stemming from intentional disinformation spread by these groups about sexuality education may be a challenge – the Macedonian organisation, for instance, reports that sexuality education curricula were presented as a way of “promoting homosexuality” by one of the ruling parties, which opposed it. Sexuality education is not part of school curricula in **Georgia**. In **Austria**, the political debate on sexuality education dealt among other things with claims of a risk of “early sexualisation” of children. The Austrian parliament passed a resolution to ban external educators from schools, as they “would endanger the quality and impartiality of sexuality education”.

47. **Finland** has been an example of advanced comprehensive sexuality education for decades: curricula were first introduced in 1970. Today, sexuality education begins early, with some elements being provided in kindergarten and then in school between ages seven and twelve. As knowledge on sexuality increased among young people in 1970s and 80s, a decrease in the rate of teenage pregnancies was observed. Sexuality education programmes were reduced in the 1990s, but the trend was reversed in the following decade. The impact of sexuality education has been measured by two national surveys, in 1996 and 2006, and by evaluating young people's knowledge in 2000 and 2006. Assessments showed considerable improvement of young people's knowledge on sexuality between the first and the second evaluation. In parallel, there was once again a decrease of teenage pregnancies. A correlation between the two trends was suggested by various observers⁹. In Helsinki I visited a *Tyttöjen talo* or “House of girls” established in 2000 as part of a network of seven structures of this kind across the country (two “Houses of boys” were also set up). Sexuality education

⁸ A.R. and L.R. v. Switzerland (application no. 22338/15).

⁹ Osmo Kontula, *The evolution of sex education and students' sexual knowledge in Finland in the 2000s*, Sex Education, November 2010.

and awareness raising on gender-based violence are central among the activities of this centre, which cooperates regularly with health care structures and schools, where they conduct workshops. The director, Ms Herttua, explained that while sexuality education in school is generally adequate, additional activities were helpful. Several organisations, for instance, held internet chat sessions to give advice individually and anonymously. Young people still sought information about sexuality in pornography which is both unreliable and conveys a distorted, often dangerous image of sex and interpersonal relations. However, the overall situation was improving, with better awareness of one's feelings, needs and rights. The House of girls provides a "safe place" for girls where group activities and courses are organised and individual counselling is provided. Tests for sexually transmitted diseases and pregnancy are also available, as well as condoms and emergency contraceptives. The work of this structure shows that sexuality education may be taught in schools but also in other contexts. Cooperation between various actors, including schools, other public entities and non-governmental organisations, ensures that correct, unbiased and scientific-based information is conveyed to young people and the community at large, with a positive impact on their health, awareness and self-determination.

48. Väestöliitto, or the Family Federation, a non-governmental organisation that has been active in advocacy, counselling and education on sexuality for decades, finds that while sexuality education is generally available in schools, there is room for improvement. Training of doctors and other healthcare professionals on sexuality, for instance, is not compulsory, and is rather expensive. NGOs are therefore advocating for training on sexuality education to be promoted and made more easily accessible by professionals. Väestöliitto, like other organisations, is also directly involved in sexuality education and awareness raising actions in schools and the provision of individual counseling, including through internet chat.

Myths and misconceptions about contraception

49. Several respondent organisations mention that myths and misconceptions about contraception are widespread among the general public, including in the form of misinformation circulated on social media, and are often difficult to counter. Examples of misconceptions include the idea that hormonal contraception would be a potential cause of infertility, weight gain, hair growth and various diseases. Doctors and other health professionals do not necessarily have the tools to debunk these myths, which end up adding to the barriers which prevent or limit women's access to modern contraception. At the same time, information provided by the survey showed that information and awareness raising activities are conducted regularly. In **Albania** for example, a variety of actions were carried out including media and social media campaigns (promoted by the UNFPA and ACPD), parliamentary activities (such as the presentation of the Contraception Atlas to the All-Party Parliamentary Group for Population and Developments), as well as other activities carried out by public health institutions and human rights activists. The Dutch organisation reports that campaigns were carried out in the **Netherlands** on the use of condoms to prevent AIDS and other sexually transmitted diseases, but not on contraceptives in general. The information from **Austria** also concerns an activity on condoms and STDs carried out at local level in Vienna in 2013. From the information collected so far it appears that information and awareness raising campaigns are sporadic and inadequate. Public authorities should step up efforts to provide unbiased, evidence-based information and to counter misconceptions and misinformation regarding contraception.

Other barriers to contraception and possible countermeasures

50. Among the barrier to contraception, its costs are mentioned most often by respondent organisations. When no reimbursement is provided, access to contraception is difficult, particularly for lower income groups and the more expensive methods. A low level of commitment of the authorities in promoting access to contraception is also mentioned by some organisations, and so are social and cultural barriers, in particular harmful social norms and traditional gender stereotypes, including the stigma attached to the use of contraceptives; logistic difficulties, in particular for people residing in remote areas who have to travel to cities to obtain contraception, also have an impact. Lack of information and data is mentioned repeatedly. For refugees, language barriers also contribute to making access to contraception more difficult.

51. The exchanges I had with Finnish politicians, namely fellow MPs Taria Filatov, Hanna Sarkinen, Mirka Soinikoski and Minna Reijonen, as well as Maria Makynen, member of the City Council of Lathi, reinforced my belief that politics in Finland is largely supportive of contraception. Opposition comes from certain religious communities, which are stronger in the "Bible Belt" in the centre of the country, and from those who believe that Finland "needs more Finnish babies". While this attitude is typical of conservatives, no official position regarding contraception policies was adopted by the right-wing True Finns party at national level. The debate on this issue, as on healthcare in general, seems to be a pragmatic one, focusing mainly on designing cost-effective policies and promoting the well-being of Finland residents. Some of my interlocutors pointed out that support for radical, religion-inspired stances against contraception may originate from abroad.

52. Responding organisations indicated a wide range of measures to overcome such barriers: strategies to make available all types of contraception to vulnerable groups such as Roma, LGBTI people and sex workers; specific training of health professionals to reduce social stigma and tackle prejudice and misconceptions; effective collection of disaggregated data to guide policies and legislation, communication strategies and social marketing programmes; ensuring access to comprehensive sexuality education which includes working with parents and teachers to create a supportive school environment; sexual empowerment programmes for vulnerable groups; and access to a broad range of contraceptives without financial barriers.

A good practice from Finland: the Neuvola.

53. I had the opportunity to visit a health center in Vuosaari, a more ethnically diverse neighbourhood of Helsinki. I was impressed both with the enthusiasm and commitment of the staff members that I met (two doctors and one nurse) and with the wide range of services provided. The Health Centre hosts a Neuvola, a Finnish structure that can be described as a “one stop-shop” providing all necessary maternity and child care to children and their families. Neuvola services are available in all municipalities and are free of charge. In Vuosaari, a family planning clinic is also available and is open daily from 7am to 7pm, which makes it accessible to anyone. As the staff members explained, availability of all types of care services under one roof makes it easier for users to access the services but also for professionals, ranging from psychologists to social workers and from diet specialists to gynaecologists, to cooperate. In the centre, specific attention is paid to the needs of persons with a migration background. Information material, for instance, is made available in English in addition to Finnish and Swedish. Overall, Neuvola is a successful example of a holistic approach to childcare and parenting, which should be an inspiration for legislators and policy makers elsewhere in Europe and beyond.

6. The role of civil society organisations

54. Civil society organisations play a crucial role in raising awareness and promoting access to contraception. Most of the organisations participating in the survey reported good cooperation with public authorities, other non-governmental organisations or international donors. Their work consists mainly of education, information and awareness-raising activities. In some cases, they oversee the actual provision of contraceptives, particularly to specific vulnerable groups. While women’s rights organisations are in many cases active in the area of sexual and reproductive health and rights and may offer advice on contraception, they generally cannot prescribe contraceptives. In **Albania**, a programme carried out by ACPD provided sexuality education and better knowledge of contraception to young people belonging to vulnerable groups. Young people taking part in the programme were made aware of the availability of contraception and its benefits, as well as the barriers preventing access to contraception because of the social stigma attached to it. In **Austria**, ÖGF provides contraception (copper coil) at low or no cost to vulnerable groups including refugees. The service (not the devices) is financially covered by the state. SRH **Serbia** distributes male condoms and, in some of its projects, IUDs, together with information leaflets, and provides free counselling services in their Drop-In Centre, aiming to both increase demand and tackle the lack of information on contraceptives. In **Georgia**, HERA offers youth-friendly sexual and reproductive health counselling free of charge. They indicate that online counselling is very popular among young people. In the **Netherlands**, Rutgers cooperates with governmental and non-governmental actors to run Sense.info, an exemplary website providing comprehensive information to young people on all aspects of sexuality. An online chat and phone counselling services are also made available by this project to young people, free of charge.

55. The elements provided by respondent organisations highlight the need to systematically collect data and information on access to and use of contraception. Comprehensive data, disaggregated by sex, age, income, social status and education level, are necessary for the authorities to design and implement effective policies.

56. It also confirmed that social and cultural barriers, misconceptions and myths hinder access to effective contraception. They may originate from lack of sexuality education in schools; lack or insufficient training of healthcare professionals; traditional patriarchal social norms and gender stereotypes; and social stigma affecting, among others, young and unmarried people seeking reliable contraception.

57. Civil society organisations are active on the ground and have a direct knowledge of the needs of the public and the challenges they face. They are best placed to support public authorities in the implementation of relevant policies, and in most cases also have valuable information and recommendations to share, of which the authorities should make good use.

7. Conclusions

58. The preparation of this report was based on information originating from a variety of sources. It draws on the work carried out by civil society organisations at local and national level, the research and advocacy of international networks, the experience and the achievements of some Council of Europe member States, and particularly Finland, which I had the opportunity to observe more closely. Academic work was also largely taken into account to better understand the current situation. I would like to highlight briefly the main elements emerging from this review, which I believe were confirmed consistently by the various sources that I have mentioned.

59. Firstly, detailed information on contraception is lacking or insufficient across Europe. There is a need to systematically collect data and information on access to and use of contraception, disaggregated by sex, age, income, social status and education level. Comprehensive, reliable, comparable data are necessary for public authorities to be able to design and implement appropriate policies.

60. Secondly, social and cultural barriers, misconceptions and myths severely hinder access to modern contraception. They may originate from a lack of sexuality education in schools and among the larger public; lack of awareness about contraception and its availability; lack or insufficient training of healthcare professionals; biased and judgemental behaviour of healthcare professionals and lack of confidentiality; traditional patriarchal social norms and gender stereotypes; and social stigma affecting, among others, women, young and unmarried people seeking reliable contraception. All these factors need to be addressed urgently.

61. Thirdly, civil society organisations play an important role in the area of sexual and reproductive health and rights. Public authorities should strive to create an enabling environment for civil society and provide sufficient public funding to support the work and activities of these organisations. At the same time, they should take advantage of their competence and commitment, and cooperate closely with them in the design and implementation of contraception policies. A more detailed presentation of the main challenges that Europe is facing in the area of contraception, of the main lines that should inspire our action, and of concrete measures that should be taken, is to be found in the preliminary draft resolution attached to this report.

62. I would like to thank wholeheartedly the organisations that have participated in the survey, namely ACPD (Albania), ÖGF International (Austria), HERA XXI (Georgia), Pro Familia (Germany), the Family Planning and Sexual Health Association (Lithuania), Rutgers (the Netherlands), HERA (North Macedonia) and SRS (Serbia). I am grateful to the Centre for Reproductive Rights, the European Parliamentary Forum for Sexual & Reproductive Rights (EPF) and the International Planned Parenthood Federation – European Network (IPPF-EN) for their invaluable contributions throughout the preparation of the report. My gratitude goes to the Finnish parliament, both fellow parliamentarians and the secretariat of the delegation to the Parliamentary Assembly, for their warm hospitality and the efforts they made to give me the opportunity to meet with the most relevant interlocutors. The visit to Finland was an excellent way both to collect new information and to discuss the findings of previous research with experienced actors. Finally, I would like to acknowledge the interest of fellow members of the Committee on Equality and Non-Discrimination for my work. Their support and their views on this matter were an important source of inspiration.