POSITION PAPER ON

Sexual and Reproductive Health and Rights

Belgrade, 2026

Summary of Main Positions

This scientific Society affirms the following core positions on Sexual and Reproductive Health and Rights (SRHR):

1. SRHR are fundamental human rights. All individuals are entitled to the highest attainable standards of sexual and reproductive health, free from discrimination, coercion, and violence.
2. Evidence-based medicine and human rights principles must guide SRHR policy and clinical practice at every level.
3. Contraception is an essential, life-saving intervention. Universal, equitable, and free access to a full range of modern contraceptive methods must be guaranteed globally.
4. Safe abortion must be accessible, legal and provided with dignity to those who seek it. Conscientious objection must never impede timely access to care.
5. Comprehensive, age-appropriate sexuality education is a right, not a privilege. It must be delivered to all young people, free from ideological interference.
6. Sexually transmitted infections (STIs), including HIV, demand robust prevention, screening, and treatment strategies — especially for vulnerable populations.
7. Reproductive tract cancers are largely preventable. Vaccination, screening, and treatment must be universally available.
8. Gender-based violence (GBV), including female genital mutilation (FGM), is a public health crisis and a human rights violation requiring immediate action.
9. Marginalized populations, including adolescents, LGBTQIA+ individuals, migrants, refugees, people with disabilities, older adults and sex workers, require dedicated, inclusive SRHR services.
10. Misinformation, censorship and politically or ideologically motivated restrictions on SRHR must be actively countered through research, advocacy, and solidarity.

Preamble

Sexual and Reproductive Health and Rights (SRHR) are inseparable from human dignity, equity, and sustainable development. Access to comprehensive SRHR services — including contraception, safe abortion, maternity care, STI prevention, sexuality education, and infertility treatment — is not a privilege, but a fundamental entitlement of every person, regardless of sex, age, gender identity, sexual orientation, socioeconomic status, nationality, disability, or legal status.

This position paper is issued by the European Society of Contraception and Reproductive Health, a global scientific and professional organization dedicated to advancing knowledge and practice in the field of sexual and reproductive health. It draws on landmark international frameworks — including the Guttmacher-Lancet Commission report (2018), the WHO Action Plan for Sexual and Reproductive Health (2016), the FIGO Cartagena Declaration (2022), the ESC Madrid Declaration (2019), the Porto Proclamation on Sexual Health, Rights and Justice (2025), and the UN World Family Planning 2022 report — to articulate a comprehensive, evidence-based, and rights-centered position on SRHR.

We are issuing this paper at a moment of global urgency. Political regression, with rising authoritarianism, misinformation campaigns, humanitarian crises, funding cuts and systemic inequalities is eroding hard-won SRHR gains. At the same time, 164 million women worldwide still have unmet contraceptive needs; unsafe abortions cause tens of thousands of preventable deaths annually; HIV incidence is rising in several regions; and millions of young people lack access to adequate and comprehensive sexuality education. These are not abstractions but measurable failures of global justice.

This Society takes a clear, unambiguous stand: regression in SRHR anywhere is a threat to human rights everywhere. We call on governments, health systems, policymakers, professional bodies, civil society organizations, and international institutions to urgently accelerate progress toward universal SRHR.

1. Definition and Scope of Sexual and Reproductive Health and Rights

Sexual and reproductive health (SRH) is a state of complete physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction — not merely the absence of disease or dysfunction. This definition, established at the 1994 International Conference on Population and Development (ICPD) in Cairo and reaffirmed in the 2030 Agenda for Sustainable Development, underpins all our positions.

Sexual and reproductive rights are human rights. They include the rights of all individuals to:

- decide freely whether, when, and with whom to have children;
- access safe, effective, affordable and acceptable methods of contraception;
- receive safe and respectful care during pregnancy, childbirth, and the postpartum period;
- access safe abortion services where legally permitted, and be protected from unsafe abortion everywhere;
- receive accurate, age-appropriate information and education about sexuality and reproduction;
- have their bodily integrity, privacy, and personal autonomy respected;
- live free from sexual violence, coercion, exploitation, and other harmful practices;
- access services for infertility prevention, diagnosis, and treatment;
- be protected from reproductive tract cancers through prevention, screening, and treatment;

Fulfilling these rights requires that SRHR services meet the WHO standards of AAAQ framework (Availability, Accessibility, Acceptability and Quality), and that these services are integrated within national health strategies as a part of essential, not supplementary, care.

2. Contraception

Contraception saves lives, improves health outcomes, reduces poverty, and constitutes one of the most cost-effective public health investments available. The evidence is unambiguous: every dollar invested in contraception generates significant savings in maternal and neonatal health costs, and reduces risks of unintended pregnancy and unsafe abortion.

Globally, the number of modern contraceptive users has nearly doubled since 1990, reaching 874 million in 2021; however, despite the noticeable progress — profound inequities persist. An estimated 164 million women of reproductive age have an unmet need for contraception. These gaps are most pronounced among adolescents, unmarried women, migrants, women living in rural areas, and those in lower-income settings. In sub-Saharan Africa, only 56% of women with a family planning need use a modern method of contraception / a modern contraceptive method.

Within Europe, the 2026 Contraception Policy Atlas produced by the European Parliamentary Forum (EPF) for Sexual and Reproductive Rights and covering 47 countries, reveals a deeply unequal landscape: France (97.9%), the United Kingdom (95.8%), Portugal (93.8%), Luxembourg (93.3%), and Belgium (92.3%) lead in contraceptive policy coverage, while Hungary (36.9%), Slovakia (32.2%), Russia (37.8%), and Turkey (37.5%) fall at the bottom of the ranking.

- Only 21 out of 47 European countries cover contraceptives within their national health system and include at least one long-acting reversible contraceptive (LARC).
- Only 12 countries provide special coverage for young people up to the age of 25.

- Only 8 countries provide emergency contraception (EC) available free of charge at pharmacies or in public health facilities, and 2 countries (Hungary and Poland) still require a prescription for EC.
- 8 countries still require parental or legal guardian consent for a minor to access contraception — a barrier that undermines adolescents' right to confidential healthcare.
- Postpartum contraception national guidelines are available in only 19 countries and postpartum contraception is provided at hospital discharge in only 14 countries — a critical missed opportunity for care.
- Only 11 countries allow hormonal contraceptives to be obtained at the pharmacy without a prescription, which is a significant and common access barrier in the majority of the European states.

These figures, based on the most current available evidence, confirm that access to contraception remains profoundly inequitable across Europe, with significant consequences for individual autonomy, public health, and gender equality.

Our Positions:

- A full range of modern contraceptive methods, including long-acting reversible methods (IUDs, implants), short-acting hormonal methods, barrier methods, and emergency contraception, must be freely accessible to those who wish to use them.
- Contraceptives must be included in essential medicines lists and covered under public health insurance schemes, without co-payment barriers.
- Emergency contraception must be available over the counter, without prescription requirements, in all countries.
- Male contraceptive methods must receive renewed research investment and male engagement in family planning must be actively promoted.
- Sterilization must be freely available as an irreversible contraceptive option, with valid, freely given, and uncoerced informed consent. Coercive or forced sterilization — particularly women from travelling communities, women with disabilities, and transgender individuals — is a grave human rights violation that must be prosecuted.

3. Abortion

Restricting access to abortion does not reduce its incidence — it only makes it unsafe. Globally, abortion rates are similar in countries where it is broadly legal to those where it is severely restricted; what changes is the safety of the procedure. Unsafe abortions cause approximately 39,000 preventable deaths annually, and result in millions more cases of serious morbidity. The Parliamentary Assembly of the Council of Europe has affirmed that the denial of abortion care may constitute torture or cruel, inhuman, or degrading treatment.

Denial of abortion has profound negative psychosocial, physical, financial, and social consequences. It is impossible to achieve low maternal mortality without access to safe abortion. Legal restrictions on abortion are a form of gender-based discrimination and a violation of bodily autonomy.

The European Abortion Policies Atlas 2025 — ranking 49 European countries in relation to abortion policies, access, clinical care, and information — reveals an alarming disparity across the region. Sweden ranks at the top of the index, with a score of 94.6%, followed by France (85.2%), Finland and Denmark (78.0%), Norway (76.8%), and Iceland (76.2%). At the opposite end of the spectrum there is Andorra (0%) and Malta (3.7%) with no legal abortion whatsoever. Poland (18.6%), Liechtenstein (13.4%), Hungary (30.5%), and Monaco (23.8%) remain highly restrictive environments where access is, in practice, severely constrained. Several countries — including Poland, Andorra, and Malta — actively prosecute abortions performed outside their extremely narrow legal frameworks.

The Atlas identifies a wide range of specific structural barriers persisting across the European countries. These include:

- Mandatory waiting periods remain in place in countries including Germany, Belgium, Finland, and Italy, despite recommendations from the World Health Organization advising against such requirements.
- Healthcare professionals' right to conscientious objection is unregulated or poorly regulated in several countries; for example, in many regions of Italy, rates of conscientious objection among gynaecologists exceed 60–70%, effectively denying legal abortion to women who cannot travel.
- Third-party authorization, including judicial or parental consent for minors, remains a requirement in numerous countries, including Georgia, Greece (indirect consent), and Lithuania.
- Medical abortion via telemedicine, a modality endorsed by the WHO for the first trimester, is fully available in only a small number of countries, including France, Ireland, and the United Kingdom.
- Mifepristone is not licensed or not available in 10 European countries, imposing women's reliance on outdated methods of abortion.

Our Positions:

- Abortion must be accessible, safe, and provided without stigma, unnecessary barriers, or delay for all those who seek it.
- Criminal laws governing abortion should be repealed. Abortion should be treated as a health matter, not a criminal matter.
- Conscientious objection by healthcare professionals must be strictly regulated: objectors must refer patients to available providers; they must never refuse care in emergencies, and institutional conscientious objection is never permissible.
- Mifepristone and misoprostol, the recommended drugs for medical abortion listed on the WHO Essential Medicines List, must be licensed, available, and accessible in all countries.
- Post-abortion care, including contraception counselling, must be available to all, regardless of the legal status of abortion.
- Self-managed medical abortion aided by telemedicine and digital platforms, where safe and appropriate, should be supported as part of an expanding continuum of care.

4. Sexually Transmitted Infections and HIV

STIs, including HIV, remain a major global public health challenge. New HIV infections in Europe have nearly doubled over recent decades and approximately 25% of people living with HIV in Europe are unaware of their health condition. Antiretroviral therapy (ART) coverage remains critically low in central and eastern Europe. Gonorrhoea, chlamydia, and syphilis continue to rise in many regions, with multidrug-resistant gonorrhoea emerging as a serious threat.

STIs disproportionately affect young people, in particular men who have sex with men, transgender individuals, sex workers, migrants, and people who use drugs — populations that also face the greatest barriers to healthcare access. Gender-based violence is directly linked to increased STIs and HIV transmission. Reproductive coercion, including stealthing (non-consensual condom removal), further increases the risk.

Our Positions:

- Universal, affordable STI and HIV testing, treatment, and follow-up must be embedded in primary healthcare systems.
- HIV pre-exposure prophylaxis (PrEP) must be accessible, affordable, and actively promoted to all at-risk populations.
- Condom promotion must be integrated into all sexual health programs, with their free distribution in key settings.
- Criminal laws governing HIV non-disclosure, exposure, and transmission — which drive people away from testing and healthcare — should be reformed or repealed.
- STI surveillance must be strengthened and standardized across all countries to enable effective public health response.
- Young people must be provided with youth-friendly, confidential, non-stigmatizing sexual health services.

5. Comprehensive Sexuality and Reproductive Health Education

Comprehensive Sexuality and Reproductive Health Education (CSRHE) is a lifelong, age-appropriate process that equips children, adolescents, and adults with the knowledge, skills, attitudes and values necessary to safeguard their sexual and reproductive health, dignity, and rights. Evidence clearly demonstrates that CSRHE does not encourage earlier sexual debut — on the contrary, it is associated with delayed first sex, reduced unintended pregnancy, lower STI rates, and greater equality in sexual relationships.

Despite this evidence, ideological opposition to CSRHE remains deeply entrenched. Religious and politically conservative groups spread disinformation about its effects, with harmful consequences for young people who are deprived of essential life skills and accurate

information. Lack of CSRHE reinforces ignorance, perpetuates stigma, and fuels gender-based violence (GBV) and sexual exploitation.

Comprehensive sexual education and information is not limited to adolescence but should be guaranteed to women and men throughout their life course, both in individual medical consultations and in the form of accessible public information, to help people to maintain their sexual health or to find assistance when facing sexual health-related problems.

Our Positions:

- Comprehensive, age-appropriate, evidence-based, and rights-centered sexuality and reproductive health education must be mandatory in all schools and accessible in community settings.
- CSRHE must be inclusive — addressing gender identity, sexual orientation, disability, diversity of bodies and relationships — and must respect the principle of non-discrimination.
- Digital literacy about sexual health, including the risks of sexting and online exploitation, must be integrated into CSRHE curricula.
- Professional training in CSRHE delivery must be a core component of teacher education and healthcare professional training.
- Parents and communities are important partners in CSRHE, but parental objection should not override a child's right to access life-saving health information.
- Sexual health should be an integral part of reproductive health care throughout life.

6. Reproductive Tract Cancers

Cervical cancer is the third most common cancer among European women aged 15–44, with over 58,000 new cases and 24,000 deaths annually. Incidence is highest in central and eastern Europe, reflecting deep inequities in screening access and HPV vaccination coverage. In countries with robust screening and vaccination programs, cervical cancer is now rare, e.g. Scotland has achieved an 89% reduction in preinvasive cervical disease following HPV vaccination. In 2023, an average of 64% of girls in the European Union received all recommended doses of the HPV vaccine by age 15, with substantial variation across Member States, ranging from 91% in Portugal to 7% in Bulgaria. Yet in 20 of 53 WHO European Region countries, HPV vaccination is not routinely available.

Beyond cervical cancer, hormonal contraceptives are associated with a significantly reduced risk of endometrial and ovarian cancers, representing a major, albeit underutilized, public health benefit.

Our Positions:

- HPV vaccination must be universally available to all children — girls and boys — as part of national immunization programs.
- HPV-related reproductive tract cancers are largely preventable by vaccination, and their early diagnosis through screening must be universally available.

- The cancer-protective beneficial effects of hormonal contraception must be more widely communicated to both clinicians and the public.

7. Gender-Based Violence and Female Genital Mutilation

Gender-based violence (GBV) affects one in three women globally and one in four women in the WHO European Region over their lifetime. GBV, encompassing intimate partner violence, rape, sexual harassment, reproductive coercion, honor-based violence, trafficking, and child marriage, is both a cause and a consequence of gender inequality. It has devastating sexual and reproductive health repercussions, including unintended pregnancy, STIs, unsafe abortion, obstetric injury, and chronic physical and psychological harm.

Female genital mutilation (FGM) is an abhorrent practice that constitutes a severe violation of the bodily integrity and human rights of girls and women. An estimated 180,000 girls and women in Europe are at risk of FGM annually. Despite being a crime in all EU Member States, effective prosecution remains insufficient.

Our Positions:

- GBV — in all its forms — must be recognized as a public health emergency and a human rights violation. Health systems must be equipped to identify, respond to, and refer survivors of GBV with compassionate, trauma-informed care.
- All countries must ratify and implement the Istanbul Convention and the EU Victims' Rights Directive.
- Marital rape must be explicitly criminalized in every jurisdiction.
- Reproductive coercion, including contraceptive sabotage and 'stealthing', must be recognized legally and addressed clinically.
- FGM must be actively prosecuted. Preventive education, community engagement, and survivor support services must be funded.
- GBV identification, first-response, and referral pathways must be integrated into all SRHR clinical training and services.

8. Marginalized Populations

SRHR inequities are most acutely experienced by those who are most marginalized. Standard service models frequently fail the following groups, whose needs must be explicitly addressed:

Adolescents

Young people have a right to age-appropriate, confidential, and youth-friendly SRHR services. Gender inequality disproportionately restricts adolescent girls' autonomy over their sexual and

reproductive lives. Teen pregnancy rates vary widely across regions and are driven by social determinants — especially poverty and lack of education — not by innate behavior.

LGBTQIA+ Individuals

Lesbian, gay, bisexual, transgender, queer, intersex, and asexual people face discrimination, stigma, and inadequate clinical care across the SRHR spectrum. Healthcare providers must be competent in LGBTQIA+ affirmative care, including the specific SRHR needs of transgender individuals (fertility preservation, gender-affirming care, contraception and inclusive sexual health services).

Migrants and Refugees

Humanitarian crises disproportionately affect women's SRHR. Refugee and migrant women face heightened risk of GBV, STIs, unintended pregnancy, and maternal morbidity. SRHR services — including emergency contraception, safe abortion, and HIV prophylaxis — must be integrated into humanitarian response from the outset. Barriers to care related to language, legal status, documentation requirements, and limited cultural competence must be actively addressed and dismantled.

People with Disabilities

People with disabilities are frequently denied their sexual and reproductive rights — including by third parties making decisions on their behalf. Forced contraception, sterilization, and abortion imposed on people with disabilities are ongoing human rights violations. Services must be accessible and supported decision-making frameworks (not substituted decision-making) must be the legal norm.

Sex Workers

Criminalization drives sex workers away from health services. SRHR programs must engage sex workers as partners and ensure non-stigmatizing, readily accessible services. Legal frameworks that protect rather than penalize sex workers must be advocated for.

Older Adults

Sexual health remains important throughout the life course. Age-related assumptions about asexuality must be challenged. SRHR services must address the specific needs of older adults, including management of sexual dysfunction, STI risk and the ongoing importance of contraception and respectful reproductive care.

9. Evidence, Misinformation and Advocacy

The global SRHR agenda faces unprecedented threats from organized anti-gender, anti-rights movements, including the networks of religious fundamentalists who oppose not only abortion but all forms of contraception, sexuality education, and gender equality. These movements disseminate misinformation, exploit political systems, and have succeeded in rolling back human rights in multiple countries. At the same time, digital misinformation about contraception, abortion, and sexual health reaches billions of people, undermining informed decision-making.

Our Positions:

- SRHR policies must be grounded in evidence — not religious ideology, political opportunism, or moral concerns.
- This Society commits to countering misinformation actively through publications, public communication, professional education, and solidarity with civil society.
- Research funding for SRHR must be protected and expanded, with particular investment in under-researched areas including male contraception, the SRHR of LGBTQIA+ individuals, and the intersection of SRHR with climate change and displacement.
- Digital strategies that amplify accurate SRHR information, including telemedicine, mobile platforms, and social media, must be developed, supported, and regulated for safety.
- International solidarity among professional organizations, civil society groups, and advocacy networks is essential to defend and advance SRHR in the face of political regression.

10. Professional Education and Training

Healthcare professionals at all levels, including physicians, nurses, midwives, pharmacists, psychologists, and social workers, must be equipped to deliver evidence-based, rights-centered SRHR care. Currently, SRHR is inadequately covered in many undergraduate and postgraduate medical curricula, and healthcare professionals frequently lack training in sexual counselling, GBV response, conscientious objection regulations, and care for LGBTQIA+ patients.

Our Positions:

- SRHR, including human rights principles, sexual counselling, GBV response, and inclusive care, must be mandated as core content in all health professional training programs.
- Continuing professional development in SRHR must be required and resourced for practicing clinicians.

- Medical training in abortion care, including medical abortion using mifepristone and misoprostol, must be a standard component of medical education rather than an optional one.
- Professionals must be educated about their legal obligations regarding conscientious objection and patient referral.

Conclusions and Call to Action

Sexual and reproductive health and rights are not peripheral concerns; they are central to human dignity, gender equality, public health, and sustainable development. The evidence is overwhelming. The rights are established. What is required now is the political will, the institutional commitment, and the professional solidarity to act.

This scientific Society calls upon:

Governments and policymakers to:

- enact, protect, and enforce legislation that upholds SRHR as fundamental rights;
- consider and fund comprehensive SRHR services as an essential healthcare component, rather than an optional, residual, or ideologically contested one;
- develop and implement SRHR action plans aligned with the Sustainable Development Goals targets 3.7 and 5.6;
- collect and publish disaggregated data on SRHR indicators to identify and address inequities;

Health systems and professional bodies to:

- integrate SRHR into universal health coverage frameworks without exception;
- ensure workforce training, clinical guidelines, and service standards reflect current evidence and human rights norms;

The scientific and research community to:

- prioritize SRHR research, particularly for under-served populations and under-investigated topics;
- publish, disseminate, and advocate for evidence-based SRHR policy;
- counter misinformation with rigor, transparency, and public engagement;

Civil society, advocates, and communities to:

- hold governments and institutions accountable for SRHR commitments;
- center the voices of the most marginalized in SRHR advocacy and service design;
- build solidarity across sectors, such as health, education, justice, digital, and humanitarian, to advance SRHR comprehensively;

We, the members of the European Society of Contraception and Reproductive Health, commit to disseminating this position paper, to advocating for its recommendations, and to working in partnership with other Societies who share the conviction that every person, everywhere, deserves the right to safe, dignified, and fulfilling sexual and reproductive life and qualified healthcare.

Collaboration: Teresa Bombas, Manuela Farris, Sharon Cameron, Cristian Farau, Maja Banovic, José Quilez, Ana Mitrovic Jovanovic, Kristina Gemzell-Danielson, Berna Dilbaz, Giovanni Grandi, Amália Pacheco, Ali Kubba, Johannes Bitzer on behalf of the *European Society of Contraception and Reproductive Health (*ESCRH)

Key Source Documents

This position paper draws on the following foundational documents:

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The following organizations provided their endorsement of the ESCRH *Position Paper on Sexual and Reproductive Health and Rights*: