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Preventing and combating gender discrimination in health

Report[1]
Committee on Equality and Non-Discrimination
Rapporteur: Ms Camilla Fabricius, Denmark, Socialists, Democrats and Greens Group

[1] Reference to Committee: Doc. 15806, reference 4765 of 9 October 2023.

A. Draft resolution[2]

1. Access to healthcare remains unequal and gender discrimination in health is prevalent across European countries. In a context of rising attacks against women's rights and LGBTI rights, ensuring universal access to healthcare and preventing and combating gender discrimination in health form important elements which should become political priorities.

2. The 2025 review of the Beijing Platform for Action represents an opportunity to remind United Nations member States of their commitment to uphold women's right to the highest attainable standards of physical and mental health and to increase efforts to fully achieve the United Nations Sustainable Development Goals, including Goal 3, target 7 on achieving universal access to sexual and reproductive health-care services, and target 8 on achieving universal health coverage.

3. Women's health has for a long time been considered a secondary issue. In medical research, the cisgender male body has been regarded as the norm. The Assembly considers that the lack of attention paid to the health of women, in all their diversity, is a reflection of the traditional patriarchal organisation of society and the profound gender inequalities this enforces. Gender discrimination in health, including gender bias in medical research and during clinical settings, leads to misdiagnosis and delays in treatment. Traditional views of women and their roles may lead to a societal expectation that women must simply tolerate pain and discomfort, particularly when linked to the reproductive cycle, while medical practitioners may discount or minimise such pain.

4. Referring to its Resolution 2048 (2015) "Discrimination against transgender people in Europe", its Resolution 2191 (2017) "Promoting the human rights of and eliminating discrimination against intersex people" and its Resolution 2576 (2024) "Preventing and combating violence and discrimination against lesbian, bisexual and queer women in Europe", the Assembly deplores the existence of specific discrimination against LGBTI persons in healthcare settings, which can also lead to the avoidance of medical consultations (the "minority stress" effect). Gender discrimination in health, amplified by intersecting forms of discrimination related to disability, age, origin, sexual orientation, sex characteristics, social status, or religion, has multiple long-term consequences on health status and beyond. It is time to transform the health sector culture and to ensure that treatment protocols take into account the needs and specificities of all genders, including regarding mental health. Medicine should contribute to the protection and enhancement of human rights and not to further discrimination.

5. Societal expectations and gender stereotypes affect access to healthcare, including sexual and reproductive care. Persons seeking such care may face questions, judgement and attempts to control their choices and intentions. There is evidence-based knowledge showing that cis male general practitioners may have a negative bias against women and LGBTI persons. This must be addressed both within the medical profession itself and by national governments. The Assembly emphasises that attempts to control the bodies of others, including in medical settings and reproductive care services, are not acceptable and can be discriminatory. It recalls its Resolution 2331 (2020) "Empowering women: promoting access to contraception in Europe", in which it stressed that access to modern contraception was crucial to women's empowerment.

6. Gender-based violence also occurs in the health sector. The Assembly recalls its Resolution 2306 (2019) "Obstetrical and gynecological violence", in which it called on member States to prevent and combat discrimination on any grounds in access to healthcare in general. It reiterates that there can be no room for impunity for perpetrators of violence.

7. Gender discrimination in health compounds existing inequalities and has an important economic cost. The Assembly stresses that gender needs to be considered when devising health policies and deciding on investments to be made in the health sector, including research. Inclusive policies facilitate better treatment and investing in women's health and combating gender discrimination in health has not only moral and social benefits but also economic ones.

8. The Assembly welcomes the fact that several member States have adopted feminist foreign policies which fund programmes supporting women's health, including sexual and reproductive health and rights, and combating gender discrimination in health.

9. In the light of these considerations, the Assembly calls on the Council of Europe member and observer States and on those enjoying observer or partner for democracy status with the Assembly:

9.1. with regard to preventing and combating gender discrimination in healthcare, to:

[2] Draft resolution adopted by the Committee on 11 September 2025.

9.1.1. mainstream gender in health policies, promote inclusive care models, draft and fund national action plans for women's health, including a focus on preventing gender discrimination in healthcare and national LGBTI health strategies;

9.1.2. ensure that equality and non-discrimination laws cover the area of healthcare services and all grounds of discrimination related to sexual orientation, gender identity and expression, and sex characteristics, and ensure their implementation;

9.1.3. include sessions on the prevention of gender bias and the promotion of respect of identities in the training of health professionals, both during their studies and throughout their career;

9.1.4. launch awareness-raising campaigns on preventing gender discrimination in health and gender bias, targeting different age groups;

9.1.5. ensure that women, in all their diversity, and LGBTI persons, are represented in decision-making bodies in healthcare settings and in research teams;

9.1.6. ensure through design, testing and monitoring that artificial intelligence systems used in healthcare systems do not reproduce gender bias;

9.1.7. ensure that women in addiction are afforded the same access to services as others;

9.2. with regard to preventing and combating gender discrimination in medical research and clinical trials, to:

9.2.1. invest in data collection and research on women's health and on the health of LGBTI persons, with the requirement that research proposals be gender inclusive and gender sensitive, and to work towards the establishment of an ethical European biobank with female body tissue;

9.2.2. promote an intersectional approach in medical data collection and research and look into intersecting forms of discrimination in health;

9.2.3. ensure that participants in clinical trials represent a diversity of genders;

9.2.4. invest in mental health research;

9.3. with regard to preventing and combating gender-based violence in the health sector, to:

9.3.1. (re)sign, ratify and fully implement the Council of Europe Convention on preventing and combating violence against women and domestic violence (CETS No. 210, "Istanbul Convention"), if it is not yet the case;

9.3.2. provide training to health professionals on preventing and combating gender-based violence;

9.3.3. ensure that the perpetrators of gender-based violence are prosecuted, including those in the health sector;

9.3.4. raise awareness on mechanisms of redress and on how to report gender-based violence experienced in contact with the health sector;

9.4. with regard to ensuring equality in access to healthcare, including sexual and reproductive health services, to:

9.4.1. ensure the accessibility, quality and adequate funding of sexual and reproductive health services;

9.4.2. provide comprehensive sexual health education adapted to various age groups in schools;

9.4.3. adopt inclusive policies on medically assisted reproduction;

9.4.4. remove any medical requirements, such as sterilisation or surgery, which hinder the access to legal recognition or reproductive services for transgender persons;

9.4.5. work towards ensuring that fertility issues are not consistently approached with a gender bias and recognising that any of the partners could face them;

9.4.6. provide free or subsidised access to menstrual products, appropriate sanitary facilities in schools, public places, and workplaces, with a view to combating period poverty.

10. The Assembly encourages health committees in national parliaments to hold regular and public debates on women's health and on the health of LGBTI persons and to monitor the situation and needs at national level, so as to encourage and support national policy development.

11. The Assembly calls on member States to support programmes on combating gender discrimination in health, both at international level via feminist diplomacy programmes, and at national level, including via funding to non-governmental organisations working in the fields of women's health, LGBTI health, inclusive healthcare and sexual and reproductive health services.

B. Explanatory memorandum

1. Introduction

1. Gender discrimination[3] in health is a global issue. Gender specificities are still not systematically taken into account and cisgender men are still too often considered the so-called norm. The fact that healthcare services are largely designed by and for men reflects deeply rooted and structural gender-based discrimination in our societies.

2. Profound gender-based discrimination in the health sector leads to inequalities in both treatment and access to care. Gender bias can be at the source of misdiagnosis, late diagnosis, absence of treatment and a lack of attention to gender diversity, which can obviously lead to harmful health consequences. There is a need for systematic knowledge and evidence on diseases affecting primarily women, as well as a focus on reducing gender disparities in healthcare. Gender discrimination in health, amplified by intersecting forms of discrimination related to disability, age, origin, sexual orientation, sex characteristics, social status, or religion, has multiple long-term consequences on health status and beyond.

3. Ignorance of, or lack of attention to pain has also been experienced by many women. Their pain is minimised, not heard or not believed and therefore not treated. Women's health issues are often regarded as "natural," and, therefore, disease and pain suffered by women are not seen as something to be investigated into or invested in preventing or treating. Symptoms are not recognised or detected, and treatment is delayed, sometimes for years. Cardiovascular diseases, for instance, are not characterised by the same symptoms in women as in men.[4] In addition, women also often prioritise the health of their family members over their own.

4. In her book "Invisible Women: Exposing Data Bias in a World Designed for Men",[5] Caroline Criado Perez demonstrates that healthcare is "systematically discriminating against women, leaving them chronically misunderstood, mistreated and misdiagnosed". Using a series of practical examples, she explains how gender bias has an important impact on women's health. In addition, women's health has been less prioritised for decades. As an example, while menopause concerns all women, there has been a lack of interest from researchers on this topic.

5. Sexism and gender-based violence have also been reported in the health sector regarding the relation between patients and health professionals, and amongst health professionals themselves. In a 2019 report on obstetrical and gynaecological violence[6] Ms Maryvonne Blondin (France, SOC) analysed the unequal relationships between patients and the medical profession, and institutional violence. She stressed that "women victims of gynaecological and obstetrical violence are victims of both patriarchal and institutional domination".

6. It is important to underline that LGBTI persons are victims of discrimination and experience challenges in access to healthcare. Victor Madrigal-Borloz, former UN Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity (SOGI)[7] stressed in his 2022 report that LGBTI persons experienced discrimination by health providers and systems, stigmatisation, denial of legal recognition of gender identity and of gender-affirming healthcare, as well as gender-based violence.[8]

7. Economic aspects should also be taken into consideration. According to a report prepared for the 2024 World Economic Forum,[9] the difference in care for women's health compared to men's costs 1000 billion dollars a year worldwide. This figure is based solely on the loss, without taking into account the potential returns from gender-specific medicine for women. Investing in global health, including women's health, has economic benefits. A global Alliance for women's health was set up at the Forum.[10]

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[3] The use of "gender discrimination" refers to discrimination based on gender, gender identity, and/or gender expression.
[4] Mobiliser les femmes sur leurs risques cardio-vasculaires, Ministère chargé de l'égalité entre les femmes et les hommes, 7 March 2025.
[5] Caroline Criado Perez (2019), *Invisible Women: Exposing Data Bias in a World Designed for Men*.
[6] Obstetrical and gynaecological violence, explanatory memorandum by Ms Maryvonne Blondin, 19 September 2019. In its Resolution 2306 (2019) on Obstetrical and gynaecological violence, the Assembly called on member States to prevent and combat discrimination on whatever grounds in access to healthcare in general.
[7] Office of the United Nations High Commissioner for Human Rights, "UN expert: Tackling discrimination against LGBTI persons is a right to health and sustainable development imperative", 17 June 2022.
[8] "The right to the enjoyment of the highest attainable standard of physical and mental health of persons, communities and populations affected by discrimination and violence based on sexual orientation and gender identity in relation to the Sustainable Development Goals", report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity, Victor Madrigal-Borloz*, A/HRC/50/27, Human Rights Council, Fiftieth session, 18-22 June 2022.
[9] "Santé: l'écart de prise en charge entre femmes et hommes coûte 1 000 milliards de dollars par an au niveau mondial", *Le Monde*, 17 January 2024 (only in French).
[10] Global Alliance for women's health.

8. In the political declaration on the occasion of the 30th anniversary of the Fourth World Conference on Women, adopted at the 69th edition of the Commission on the Status of Women, ministers and representatives of the governments of United Nations member States recommitted to "taking further concrete action to ensure the full, effective and accelerated implementation and resourcing of the Beijing Declaration and Platform for Action and the outcome documents of the twenty-third special session of the General Assembly, which can contribute to the achievement of the Sustainable Development Goals, including by (…) promoting, respecting and protecting the right to the enjoyment of the highest attainable standard of physical and mental health for all women and girls, throughout their life course and without distinction of any kind, towards the achievement of universal health coverage, including safe, available, affordable, accessible, quality and inclusive healthcare services, as well as maternal and neonatal health, menstrual health and hygiene management and all communicable and noncommunicable diseases".[11]

9. As stressed in the Council of Europe Gender Equality Strategy 2024-2029, "Acquired rights cannot be taken for granted. This is confirmed by backsliding on gender equality policies and the rise of anti-gender movements which weaken existing acquis and seek to limit – among other things – women's access to health services, including sexual and reproductive health and rights, and protections for lesbian, gay, bisexual, transgender and intersex (LGBTI) persons and women who use drugs".[12] Restrictions in access to sexual and reproductive healthcare are attempts to control a persons' body and are discriminatory. The lack of attention given to women's health, in all their diversity, reflects an overall patriarchal society and profound gender inequalities. It is time for the Assembly to raise awareness about gender discrimination in health and to call for action to prevent and combat it.

2. Aims and scope of the report

10. This report aims to shed light on gender-based discrimination in health and call for action to prevent it. More specifically, I have investigated gender-based discrimination in medical research and treatment, and in access to healthcare for women in all their diversity. I have also investigated gender-discrimination against LGBTI persons in health, sexism and gender-based violence in the health sector. I have also tried to analyse why women's health issues are still regarded as "natural".

11. I have had a specific interest in examining the reasons behind the lack of scientific research on endometriosis, menopause, and women's mental health. These specific topics have been under-researched for years, which has resulted in delays in the discovery of effective treatments. For example, it is estimated that 10% of women have endometriosis, yet nowadays it still takes almost a decade to receive a diagnosis.[13] Alzheimer's disease and depression have a significantly higher prevalence among women, and menopause has far greater implications than initially thought. At the same time, in countries with a high number of women in the workforce, women are observed to withdraw from the labour market 5 to 7 years earlier than men, possibly due to menopausal symptoms.[14] For many years in Denmark, depression was considered to be a "women's disease". Women's health seems to be surrounded by prejudice.

12. I intend to present good practices enabling to ensure that gender discrimination in health is prevented and combated and that the intersectional dimension is taken into consideration. The adoption of targeted health plans, investment in research, the training of health professionals and preventing and combating gender-based stereotypes through campaigns and education are some of the practices which deserve attention.

3. Working methods

13. The committee held a first hearing at its meeting on 12 September 2024, with the participation of Ms Melanie Hyde, Gender, Equity and Human Rights Technical Officer at the World Health Organisation (WHO) Regional Office for Europe and Ms Marina Kvaskoff, epidemiologist at the French National Institute for Health and Medical Research (INSERM). They identified different forms of gender discrimination in access to healthcare and described the lack of gender-based research in health. We discussed the reasons behind the comparatively small amount of funding allocated to treatment for women and to research on women's health.[15]

14. On 4 December 2024, I visited the Maison des Femmes in Saint Denis. On 5 December 2024, the committee held a hearing on addressing gender-based violence in the healthcare sector and providing support for survivors by medical staff, with the participation of Ms Violette Perrotte, Executive director of La Maison des Femmes, Dr Sophie Tellier, Head of the unit on sexual violence of La Maison des Femmes and Dr Gilles Lazimi, General practitioner.

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[11] Concluding Session, Commission on Status of Women Adopts Declaration Urging Full, Accelerated Implementation of Beijing Declaration, Platform for Action, United Nations, 21 March 2025. See document E/CN.6/2025/L.1.
[12] Council of Europe Gender Equality Strategy 2024-2029, adopted on 6 March 2024.
[13] Endometriosis, Key facts, World Health Organization, 24 March 2023.
[14] The Nordic Menopause White Paper, November 2023.
[15] Researchers optimistic about potential new treatment for endometriosis, The Guardian, 8 March 2023.

15. On 21 January 2025, I held an online bilateral meeting with Ms Andreea Petre-Goncalves, Director of Communications and Advocacy at Women in Global Health. On 30 January 2025, I held in-person meetings with Ms Charlotte Altenhoener Dion and Ms Katharina Kirchberger, advisers to the Council of Europe Commissioner on Human Rights, Dr Angelina Pace and Ms Manon Reinbolt, researcher, and Ms Caterina Bolognese, Head of the Gender Equality Division of the Council of Europe.

16. On 4 February 2025, I held an online bilateral meeting with Ms Tlaleng Mofokeng, United Nations Special Rapporteur on the right to physical and mental health and she took part in a hearing with the Committee on 12 May 2025.

17. I took part in the Commission on the Status of Women held in New York in March 2025, where I held bilateral meetings and attended side events on issues related to the topics covered by this report, including mental health, period poverty and investing in women's health.

18. On 18 March 2025, the committee held a hearing on addressing discrimination against LGBTI persons in the health sector during a joint meeting of the committee and the Parliamentary Platform for the rights of LGBTI persons in Europe, with the participation of Mr Graeme Reid, United Nations Independent Expert on sexual orientation and gender identity, Ms Evgenia Giakoumopoulou, Head of the SOGIESC Unit, Council of Europe, Dr Eszter Mihály, LGBTQI+ Rights Officer, Amnesty International Hungary and Dr Serge Covaci, Leader of the University Clinic, Faculty of Medicine of Strasbourg, general practitioner.

19. On 28 March 2025, I held an online meeting with the founding members of the Alliancen for Kvinders Sundhed" (Alliance for Women's Health), an organisation which was established in Denmark: Ms Susanne B. Christensen,[16] Ms Marianne Lynghoj Pedersen and Ms Anne Sophie Callesen.

20. On 10 April 2025, I held an online meeting with Ms Choolwe Jacobs and Ms Flata Mwale representing Women in Global Health Zambia.

21. I also carried out desk research and received valuable information from committee members during our hearings. I would like to thank them for the information shared and the questions raised, which helped me progress in the preparation of the report.

4. Lack of research on women's health

22. In its Recommendation CM/Rec (2008)1[17] on the inclusion of gender differences in health policy, the Committee of Ministers of the Council of Europe already acknowledges the gender gap in research. It also recognises that gender differences and inequalities affect treatment, and it presents concrete recommendations.

23. At our hearing on 12 September 2024, Ms Hyde underlined the lack of data and lack of research on women's health. According to her, systemic historical gender biases have perpetuated the underrepresentation of women in clinical trials and health research and underinvestment in research for conditions that exclusively, disproportionately or differently affect women. She emphasised that inadequate analysis of sex and gender in health research, male dominated leadership and control of research funding and publishing, and bias in public health education and medicine could also explain sex and gender blindness in medical research.[18] She stressed that the first 3D anatomical model of the female body was only developed in 2022. At the same hearing, Ms Kvaskoff stressed, among other points, that women's health was not only under-studied but also under-funded.

24. Women are still under-represented in clinical trials.[19] At first, they were excluded from trials as these could prove risky for a possible early-stage pregnancy, which would not be known yet by the woman participating in the trial. The reception conditions for patients participating in trials may also act as a deterrent for women. They are not systematically gender-sensitive, for instance in some cases requiring participants to sleep in dormitories for days or even weeks, irrespective of their gender, which could make women, in all their diversity, reluctant to participate.

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[16] She represents the Confederation of Danish Industry and provides secretarial support to the Alliance.

[17] Recommendation CM/Rec(2008)1 on the inclusion of gender differences in health policy, adopted by the Committee of Ministers on 30 January 2008 at the 1016th meeting of the Ministers' Deputies. The Committee of Ministers recommended that the governments of Council of Europe member States "in the context of protection of human rights, make gender one of the priority areas of action in health through policies and strategies which address the specific health needs of men and women and that incorporate gender mainstreaming; promote gender equality in each sector and function of the health system including actions related to healthcare, health promotion and disease prevention in an equitable manner".

[18] Amin, A., Vijayasingham, L., & Stevenson, J. (2022). Sex and gender blind spots and biases in health research. In: A. Broadbent & S. Venkatapuram (Eds.), The Routledge Handbook of Philosophy of Public Health, pp. 266–284. Abingdon: Routledge. Available at: https://doi.org/10.4324/9781315675411-21.

[19] 'Integrating a gender equality perspective', Council of Europe Committee on Bioethics (DH-BIO), 2020.

25. Gender bias leads to the "underrepresentation of women in research on cardiovascular disease, hepatitis, HIV, chronic kidney disease and digestive disease". The Council of Europe Steering Committee for Human Rights in the fields of Biomedicine and Health (CDBIO) reported on a data gap on women's health due to their underrepresentation in clinical trials and research.[20]

26. International guidelines on integrating gender in health research are still lacking. At the hearing, Ms Hyde underlined that only 4% of registered COVID-19 studies included gender or sex as an analytical variable, and over 75% of treatment trials excluded pregnant women despite the fact that they were at high risk of severe COVID-19 illness. Until now, research into women's health has focused largely on diseases with high mortality rates, such as cancer. According to analyses of global data, just 1% of overall healthcare research and innovation has been invested in female-specific conditions beyond oncology, such as endometriosis.[21] Research is mostly carried out on cisgender male bodies, using masculine standards, and as a consequence, the possible dangers or side effects of new treatments or vaccinations are better known for men than for women.

27. Investing in research on women's health can have an important impact but is unlikely to become a reality without clear support from public authorities. The University of Vienna has a sponsored professorship on gender medicine which is a good practice.

28. Investing in women's health is beneficial to society, and it is evident that better care can also have a positive impact at economic level. Investing in gender-responsive medicine, research and training will have long-term positive effects. Moving away from the assumption that the cisgender male body is the norm and thus requiring that research proposals include women in all their diversity across the life course, are first obvious steps to ensure that medical research is more inclusive. To achieve this aim, the inclusion of a gender dimension and inclusion of female cell lines as a funding condition could be an incentive. As stressed by Ms Dunja Mijatović, former Commissioner for Human Rights of the Council of Europe, "all health efforts must (…) be gender-responsive, taking gender norms and inequalities into account and acting to reduce their harmful effects."[22]

29. In Denmark, the Alliance for Women's Health is a multi-party organisation which was created with a view to triggering change and joining forces to make women's health a public policy priority. Their premise is that no one disagrees that women deserve to have better healthcare, more research and more innovation for treatment. The objective of the Alliance for 2025 is to secure the adoption of a budget for a national research centre on women's health under the Ministry of Health. In addition, public/private partnerships would be built. So far, 6,000 persons have joined the Alliance.

5. Pain bias

30. Pain experienced by women is often minimised or overlooked. A diagnosis for endometriosis takes about 7 to 10 years. At our hearing, Ms Kvaskoff underlined that women with endometriosis were often dissatisfied with their care and that their symptoms were dismissed. On average, they were obliged to consult 8 healthcare professionals before arriving at a diagnosis. Despite the prevalence of endometriosis, the intensity of its painful symptoms, the economic consequences and life impact, this condition is not yet well known and there is no treatment for it. The dismissal or minimisation of the pain felt by women is certainly linked to a gender stereotype: women's pain is simply considered as less important and less worrying by health professionals.

31. Period pain is considered "normal", although the levels of pain which are experienced by women with endometriosis can be unbearable. Some municipalities and businesses recognise the right of their workers to menstrual leave, but it is not yet generalised, and it is often criticised.

32. I would like to stress that period poverty and menstrual health are not just about access to products, they are structural issues requiring a multidisciplinary approach. Period poverty limits women and girls' participation in economic, political and social life.

33. According to Ms Hyde, the misalignment between between investment in women's health and the actual burden of disease is deeply rooted in gender bias, including the dismissal of women's pain by health providers. For instance, while research and development for Viagra progressed from lab to market in under six months, endometriosis and menopause have faced decades of underinvestment. This disparity reflects a societal tendency to normalise women's pain, while prioritising and valuing men's sexual performance—ultimately reinforcing persistent gender-based health inequities.

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[20] Integrating a gender equality perspective, Expert report for the DH-BIO (former name of CDBIO) by Prof. Dr Ina Wagner, 2020.
[21] Data presented by Ms Hyde at the hearing on 12 September 2024.
[22] Protecting the right to health through inclusive and resilient health care for all, Issue paper published by the Council of Europe Commissioner for Human Rights, 2021.

34. Ms Petra Bayr spoke to the committee about the Austrian film "Nicht die Regel" which focuses on the years of suffering for women with endometriosis. This kind of awareness-raising initiative should be further encouraged. As already stated, women's health is a global issue, with a global impact. Contribution to awareness-raising through documentaries, films and popular culture can be useful as it improves global public understanding of the challenges of gender inequalities in care. Awareness-raising among young teenagers, including boys, is of crucial importance.

35. The French Rights Defender reported on differences in healthcare, depending on the patient's sex, origin, nationality or economic vulnerability. According to her findings, emergency services underestimate the pain and gravity of symptoms felt by women, notably when they are young, of foreign origin or perceived as such.[23] With similar symptoms, white men would have more chances of being considered a vital emergency when consulting an emergency service for chest pain.

36. Risks also arise with the increasing use of artificial intelligence in healthcare settings. AI systems may simply reproduce human gender bias and minimise women's pain, basing diagnostic on perceived needs, rather than on needs expressed by women.[24] For example, many AI algorithms used in diagnostics and treatment are trained on datasets that primarily reflect male patients, which can lead to misdiagnoses for women, particularly regarding conditions such as cardiovascular disease, where symptoms often differ between women and men".[25] It is therefore crucial to monitor the gender impact of artificial intelligence systems and to test them regularly for gender bias.

6. Discrimination against LGBTI persons in the healthcare sector

37. In its Resolution 2048 (2015) "Discrimination against transgender people in Europe", the Assembly called on member States to provide protection from discrimination on the grounds of gender identity in access to healthcare. In its Resolution 2191 (2017) "Promoting the human rights of and eliminating discrimination against intersex people", the Assembly stressed the importance of ensuring that intersex persons have access to healthcare without obstacles. These calls are still valid today.

38. Ms Giakoumopoulou underlined at our hearing on 18 March 2025 that cultural norms, anti-LGBTI rhetoric, institutional barriers, and insufficient training for healthcare professionals, contribute to inadequate healthcare access and quality for LGBTI persons across Europe. The 2020 EU Agency for Fundamental Rights (FRA) survey found 16% of LGBTI people faced discrimination in healthcare, rising to 34% among transgender respondents. "Minority stress," which leads to persons avoiding medical consultations, has an impact on health status.

39. The Report on the Right to the Highest Attainable Standard of Health and Access to Healthcare for LGBTI People in Europe, published in 2024 by the Council of Europe, highlights that there are heightened rates of mental health issues within the community, exacerbated by intersectional factors such as ethnicity, disability and socio-economic status.[26] This report includes 38 key recommendations to address these issues, including adopting human rights-based health policies and improving data collection on LGBTI health needs. There is also a need for better training for healthcare professionals, stronger community participation and targeted support for trans-specific healthcare and older LGBTI persons. It is of crucial importance to ensure that women and LGBTI persons are reaching leadership positions in healthcare and politics so as to have an impact on health-related decision-making.

40. Mr Reid underlined that some progress had been made in countries like Portugal, Iceland, and Spain by taking steps towards integrating LGBTI health into national plans and providing training for healthcare professionals. Throughout career training on combating discrimination and respecting identities should be provided. Extending non-discrimination laws to cover healthcare services and all SOGIESC grounds is essential to tackle discrimination against LGBTI persons in health.

41. Pathologising legal gender recognition hinders access to healthcare. In Hungary, the project "Wishing well" showed that a considerable number of transgender persons experience humiliation and discrimination in healthcare. Bureaucratic hurdles also complicate access to healthcare for transgender persons.

42. The number of Danish centres offering care for transgender and non-binary persons has increased from one to three in the past five years. There are still long waiting times, which can significantly impact mental

[23] Défenseure des droits (French Rights Defender), Prévenir les discriminations dans les parcours de soins : un enjeu d'égalité, 2025.
[24] The Guardian, AI tools used by English councils downplay women's health issues, study finds, 11 August 2025, Libération, «Des différences basées sur le sexe» : selon une étude, l'IA de Google minimise les besoins médicaux des femmes, 11 August 2025 and Rickman S., Evaluating gender bias in Large Language Models in long-term care, 2025.
[25] European Institute for Gender Equality (EIGE), Beijing Platform for Action +30 Impact driver - Marking milestones and opportunities for gender equality in the EU, 27 May 2025.
[26] Right to the Highest Attainable Standard of Health and Access to Healthcare for LGBTI People in Europe, Council of Europe, 2024.

health and leads some persons to seek treatment abroad to avoid delays in the Danish healthcare system. Transgender persons continue to report discrimination in healthcare services. Trans specific healthcare for minors is being politicised throughout Europe.

7. Gender stereotypes and mental health

43. Socially constructed gender differences in roles, status, and power contribute significantly to mental health disparities. Gender norms and societal expectations shape behaviours and attitudes. This has an influence on how mental health concerns are expressed by patients, recognised, and treated by health professionals.[27] LGBTI persons are disproportionately affected by mental health issues due to stigma and exclusion.

44. Gender-based discrimination increases the risk of depression and lowers self-esteem. Adolescent girls, for example, often experience lower self-esteem and greater body-image anxiety than boys, increasing their risk of depression.

45. In addition, so-called traditional gender roles can limit women's autonomy in key life decisions, further contributing to mental health challenges.[28] Women are expected to prioritise the needs of others over their own emotions.

46. Self-silencing is characterised by suppressing self-expression. While both men and women may engage in self-silencing, women are more often socialised to adopt this behaviour, which can have an impact on mental well-being.[29] Women's mental health should be understood in terms of structural inequalities and power dynamics. Self-silencing serves as a critical mechanism through which gendered expectations shape women's well-being.

47. Gender-based violence has severe mental health implications, with women being disproportionately affected.[30] Survivors often experience anxiety, vulnerability, loss of confidence and depression. Other effects include sleep difficulties, panic attacks, and long-lasting psychological distress.[31] These compounded impacts highlight the need for a deeper understanding of how gendered experiences shape mental health.

48. At our hearing on 18 March 2025, Mr Reid noted that mental health issues were directly linked to the environment in which people found themselves, highlighting that factors such as social, economic, and physical surroundings played a crucial role in well-being. He emphasised that more training was needed for professionals to better understand and address these influences.

49. Societal gender stereotypes can also contribute to delayed diagnoses of mental health conditions; symptoms may not be recognised or adequately addressed by health professionals. Autism research has historically focused on boys, especially white boys, further perpetuating the belief that autism is predominantly a male condition. Consequently, traditional diagnostic tools were designed for boys, and, as a result, they often fail to capture the subtler manifestations of autism in girls. Furthermore, autistic girls tend to use more verbal communication, which can lead to misinterpretations and underdiagnosis, as the symptoms may not align with standard diagnostic criteria typically associated with males.[32]

50. This gender bias, combined with behavioural differences, has contributed to the misdiagnosis or omission of autistic girls in clinical assessments. Girls with autism, particularly those with higher verbal abilities and without severe psycho-social disabilities, often learn to camouflage or imitate social behaviours. Additionally, the higher prevalence of co-occurring mental health conditions, such as anxiety and depression, in females may further complicate the diagnosis.[33]

51. The historical view of autism as a primarily male condition perpetuates the underdiagnosis of women and girls, as teachers and healthcare professionals may not take the possibility of autism into consideration, leading to delayed or missed diagnoses for many girls. This underscores the need for a more inclusive, gender-sensitive approach to autism diagnosis, ensuring that the specific ways in which autism manifests in women are recognised and addressed.

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[27] World Health Organization, Gender and mental health, 2002.
[28] *Ibid*
[29] A. Ali, K. Oatley, B. B. Toner, Life stress, self-silencing, and domains of meaning in unipolar depression: an investigation of an outpatient sample of women, Journal of Social and Clinical Psychology, Vol. 21, No. 6, 2002, pp. 669-685.
[30] K. Bhui, Gender, power and mental illness, Cambridge University Press, 2018.
[31] FRA Fundamental Rights Survey, 2021.
[32] Autism Diagnoses in Adult Women Are on the Rise. We Asked Experts to Explain Why, in Self, 2025**.**
[33] *Ibid*

8. Ensuring access to sexual and reproductive health services

52. Access to sexual and reproductive health services can also be challenging. Barriers include any attempts to restrict access to abortion care services, access to contraception and access to information about sexual and reproductive health and rights (SRHR). It is vital to ensure that all generations have access to information about SRHR so as to be in a position to make informed choices: restricting information about these matters is in essence a way to undermine the empowerment and agency of those concerned.

53. There is also discrimination with regard to access to medically assisted reproduction (MAR). Some states like Spain, Denmark and Belgium have adopted inclusive medically assisted reproduction policies, France granted access to MAR to single and lesbian women in 2021. Bulgaria and Latvia allow MAR for single women, but not for lesbian couples.

54. Several Council of Europe member States, including Italy, Poland, Czech Republic, Serbia and Slovakia allow neither single women nor lesbian couples to access MAR.[34]

55. Even when access is legally provided for, same-sex couples can encounter prejudice and judgement when consulting a doctor about MAR, leading some couples to decide to conceal their relationship.

56. A transgender person may also face discrimination in accessing MAR. Spain appears as an exception. In 2021, the Spanish government adopted a ministerial order restoring free access to MAR for single women, lesbians, bisexuals, and transgender persons.

57. I believe that fertility preservation should be offered to any persons going through a transition process and any obligation to be sterilised during this process should be removed. It is the case that transgender persons often experience exclusion, misgendering, and microaggressions that compromise medical safety, and may for such reasons hide their reproductive goals to their health practitioners, fearing stigma and discrimination.

9. Preventing and combating gender-based violence in the health sector

58. During our meeting on 4 February 2025, the UN Special Rapporteur on the right to physical and mental health stressed that the health sector had to be considered as part of a broader social system. Power dynamics, gendered social norms and asymmetries also affect this sector, both from the standpoint of health workers and that of patients. Choolwe Jacobs stressed during our meeting that "when frontline healthcare workers do not feel safe, motivation, performance and quality of service delivery can go down."

59. Women working in the health sector often face gender pay gaps and poor working conditions. They are also the targets of sexist comments made by patients or colleagues. Women health workers, in all their diversity, may find themselves in vulnerable situations, at work and at home. Training for health professionals should include strategies to counter sexism and gender-based violence as well as education against sexist behaviour and violence.

60. A #metoohealth hashtag on social media has helped collect testimonies of violence and bring to public notice that gender-based violence and discrimination are widespread in the health sector.[35] Some health workers realise that they are survivors of gender-based violence when hearing testimonies of survivors and, in their turn, need support. The WHO Regional Office for Europe has prioritised strengthening the health response to violence against women and girls, including within the health workforce, as part of its next five-year programme of work.[36]

61. Some female doctors are completely in denial of the existence of gender bias. They have integrated sexism and stereotypes in their own approaches to female patients. In parallel, some male health workers have started raising their voice to denounce a climate of gender-based violence and sexism in the health sector.[37] More needs to be done at multiple levels to prevent this violence and combat it.

62. Health practitioners may also be perpetrators of gender-based violence against patients or coworkers, and cases of psychological violence, physical violence and sexual violence against patients have been reported.

63. The question of consent is also at the heart of the relationship between a health professional and a patient, as a vital element contributing to building trust. There should certainly be no imposed medical

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[34] Marie-Caroline Compans, Hannah Zagel; Medically assisted reproduction and non-normative family forms: legislation and public opinion in Europe, European Societies 2025; 27 (1): 171–203.
[35] #Healthtoo Her stories: ending sexual exploitation, abuse and harassment of women health workers, Women in Global Health, December 2022.
[36] World Health Organization, Special Initiative on Violence against Women and Girls.
[37] Tribune « Nous, médecins, souhaitons dénoncer publiquement le sexisme systémique dans le monde médical hospitalier et universitaire », Le Monde, 17 February 2025.

procedure on a patient without prior consent, except in emergency situations where expressed consent is not possible.

10. Leading role of health practitioners in preventing gender discrimination

64. At our hearing held on 5 December 2024, Ms Violette Perrotte told the committee that the Maison des Femmes had been created after realising that women were more likely to disclose violence to health professionals than to dedicated organisations. The structure provides a holistic, one-stop model offering care in family planning, support for women victims of violence, support to female genital mutilation (FGM) and sexual assault survivors and support for women leaving violent households. It brings together doctors, psychologists, social workers, lawyers, police officers, and other professionals in a multidisciplinary approach. 26 similar structures based on the Maison des Femmes model are now operating in France and Belgium. Ensuring medical confidentiality and vocational training is essential. La Maison des Femmes also plays a preventive role by training healthcare professionals, law enforcement and military personnel, and by working with perpetrators of domestic violence.

65. Health professionals have the responsibility to prevent gender-based violence. Dr Lazimi spoke about the importance of asking patients if they were survivors of gender-based violence. They tend to open up when asked direct questions in a safe and trusted environment. A general practitioner can play a crucial role in detecting violence and providing support to survivors.

66. All health professionals stressed the importance of training, and the persisting difficulties in training medical staff on gender-related topics. In the Mid-term Horizontal Review of baseline evaluation reports,[38] the Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO) underlined the importance of training health workers to interact with victims of sexual violence and domestic violence, including cooperating with the police to report cases, collecting data and ensuring women's access to justice.

67. "Medicine is a powerful tool to protect human rights" stressed Ms Tlaleng Mofokeng, United Nations Special Rapporteur on the right to physical and mental health. Unfortunately, in some cases, health practitioners are the ones who discriminate on the grounds of gender, social status or origin.

68. The training of health professionals concerning these questions should be improved and be more inclusive. It is striking that most leadership positions in the health sector are held by men, while women represent the majority of health workers. Investing in primary care research and providing training for young healthcare professionals, so as to drive forward changes in medical practices, which fully reflect the most progressive human rights principles, will help reduce, and finally prevent, gender discrimination in health.

69. Health professionals must also play a crucial role in providing support to LGBTI patients. A doctors' surgery, where the identity and dignity of each individual patient are fully respected and protected, can be a safe haven and must never be a place where one feels judged and discriminated against.

11. Raising awareness

70. One of the keys to removing gender discrimination in health is raising awareness of its existence and consequences, both among professionals and the public at large. For example, targeted awareness-raising campaigns on detecting heart diseases in women[39] have been launched in several Council of Europe member States and could inspire other campaigns.

71. Recent years have seen an upsurge in debates and discussions about menopause, endometriosis, and menstrual healthcare. These efforts should be intensified to ensure that these topics are no longer a taboo and that the pain related to them is no longer ignored.

72. Age-specific awareness-raising campaigns about women's health should also be explored. Investing in research on treatment and care for endometriosis and menopause is crucial. Ensuring access to information on pre-menopause and menopause, and their effects can help women going through these phases. Making endometriosis and menopause public health priorities is important so that the professionals and public are aware of and understand these important health matters affecting women.[40]

73. Data collection on women's health and gender discrimination in health and its effects needs to be further developed, as does data on the challenges faced by LGBTI persons in accessing healthcare services. Such data collection can inform awareness-raising campaigns and policy-making.

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[38] Mid-term Horizontal Review of GREVIO baseline evaluation reports, 2022.
[39] HER Disease, Heart Research UK.
[40] Un rapport parlementaire présente 25 préconisations pour faire de la ménopause une priorité de santé publique en France, Le Monde, 9 April 2025.

74. Non-governmental organisations working on women's health and on the health of LGBTI persons must be supported in their important work. In today's context of budget restrictions, allocation of grants for health-related projects remains critical and should not be reduced.

75. Several States, such as France[41] and Canada, have adopted feminist foreign policies and made women's health and rights a strategic priority in their external relations. They fund programmes supporting sexual and reproductive health and rights throughout the world.

76. The withdrawal of the United States Agency for International Development (USAID) from many countries will leave gaps in this field, especially with regard to sexual and reproductive health and rights programmes, which might not be filled by European donors. The rise of populist movements on our continent also brings threats to investment in women's health and women's rights, both at national level and as regards funding to external aid programmes.

12. Conclusions

77. As parliamentarians, we have the responsibility and the possibility to put women's health and the health of LGBTI persons on the parliamentary agenda and to support funding of related health services during parliamentary budget discussions. We can raise awareness of the gender dimension of healthcare and thus contribute to reducing gender bias in this area.

78. National action plans for women's health, with roadmaps for action, are essential and require dedicated budgets for research, treatment, awareness-raising and prevention campaigns. In addition, national LGBTI health strategies can contribute to a more inclusive approach and to addressing any gaps in provision for LGBTI persons.

79. Systemic change is required in the healthcare sector to tackle gender discrimination and gender-based violence, both of which affect access to healthcare. Mandatory training on preventing and combating gender discrimination should be organised throughout health workers' career.

80. We must be pro-active in countering the narrative and initiatives of anti-gender movements aiming at restraining women's bodily autonomy. At the United Nations Women's Commission on the Status of Women (CSW69) in March 2025, Dr Mofokeng underlined that "The moment we stop fighting for people who are invisible, who cannot fight for themselves for whatever reason, we lose even humanity for ourselves."

81. Preventing and combating gender discrimination in health is a way to fight for ourselves and for others and to invest in a future of equality. Health systems must be first and foremost person-centred and certainly not economy driven. Ensuring access to healthcare for all is a way of shaping more equal societies. We must show the political determination and courage to push forward with a human rights-based approach in health policy making.

[41] Ministry of Europe and Foreign Affairs, « Stratégie internationale de la France pour une diplomatie féministe 2025-2030 », February 2025.