IFMSA Policy Proposal
Sexuality, Sexual Health and Rights

Proposed by Team of Officials
Presented to the IFMSA Hybrid General Assembly March Meeting 2022

Policy Commission

- **Jule Stobrawe - bvmd Germany - jule.stobrawe@arcor.de**
- **Mauli Mehta - MSAI India - mehtamauli98@gmail.com**
- **Klaudia Szymuś – IFMSA Liaison Officer for Sexual and Reproductive Health and Rights Issues, incl. HIV&AIDS - lra@ifmsa.org**

Policy SWG

- **Christos Papaioannou - HelMSIC-Greece**
- **Amira Amroune - Le Souk Algeria**
- **Juliette Claudine Mattijsen - IFMSA-NL**
- **Arpit Mago - MSAI India**
- **Cecilie Helling - bvmd Germany**
- **Myesha Maliha Binte Mamum - BMSS-Bangladesh**
- **Lea Habib - LeMSIC Lebanon**
- **Fatima Rehman - IFMSA-Pakistan**

Policy Statement

Introduction

Sexuality has been identified as an intrinsic characteristic of human beings and thus human health and well-being. The World Health Organization defines sexual health as a “state of physical, emotional, mental, and social well-being in relation to sexuality.” The establishment of sexual rights led to significant progress in discussing the contribution of sexuality to every person’s life. Still, enormous challenges persist due to obscure legislation, stigma, and discrimination, which put many individuals’ safety and sexual, mental, and physical well-being at risk. Understanding and strengthening society's concept of sexuality will eventually help us in progressing towards a sex-positive society that will further play as the anti to stigma and discrimination hovering over the same.

IFMSA Position

The International Federation of Medical Students’ Associations (IFMSA) is a firm advocate for the recognition, protection, and promotion of the sexual rights of all people in all places and at all times. It is a key priority to empower individuals, especially left-behind populations, to realize their full potential in attending and maintaining their sexual health to the highest level. The IFMSA recognizes the role of consent, a non-judgemental approach, and supportive social attitudes in realizing sexual rights and outlines the importance of sensitization of healthcare workers on these topics. The IFMSA emphasizes the need for sex-positive policies, which protect those more often left to the sidelines because of characteristics related to their sexuality, sexual orientation, and gender identity.

Call to Action

Therefore, IFMSA calls for:

Governments and policy-makers to:

a. Recognize the WHO concept of sexual health and rights in all their national functions;
b. Foster meaningful participation of youth and marginalized communities, such as LGBTQIA+ people, people with disabilities, or sex workers, in decision making that concerns SRHR; and take their perspective and needs into account;
c. Implement policies and strategies to provide sexual health and rights for all, especially people with disabilities, older adults, adolescents, LGBTQIA+ people, sex workers, and others;
d. Promote and invest in research and segregated data-collection regarding sexual health and rights issues, not only for the general population but also focusing on groups with specific needs;
e. Invest in the update and promotion of universally available, acceptable, and quality sexual health services provided to all in the minimum amount of spending;
f. Ensure access to sexual health services and sexual health education for everyone through targeted and ambitious legislative reformations;
g. Update safety, reporting, and judicial mechanisms and regulations that protect and prevent residents against violations of their sexual rights;
h. Protect and improve the health and rights of sex workers by creating and enforcing evidence-based policies;
i. Implement measures of internet safety to minimize the occurrence of sextortion and grooming as well as improve law enforcement towards perpetrators.

WHO, UN Agencies & Intergovernmental Institutions to:

a. Include explicit mentions of sexuality and sexual rights in future resolutions pertaining to SRHR issues in high-level meetings;
b. Support, fund, and promote actions towards awareness within the society and facilitate collaboration and research between countries in terms of sexuality, sexual health, and rights;

c. Initiate solidarity movements towards supporting and empowering all left-behind populations regarding their sexual rights as well as promoting evidence-based discussions about the topic;
d. Provide technical guidance to countries to ease them reformations implementation on topics of sexual health and rights;
e. Include young advocates in the field of sexual health and rights, especially those involved in the provision of such services and sex work, in policy processes and high-level meetings;
f. Secure the safety regarding sexuality and sexual rights of their personnel, recipients of their activities, and delegates in high-level meetings.

The Healthcare Sector to:

a. Follow a gender and sexuality-sensitive and sex-positive approach to the patient-provider relationship and recognize sexual health as a health component;
b. Implement policies and strategies to create an inclusive and empowering environment for all people regardless of their sexuality or sexual orientation;
c. Build the capacity of healthcare professionals across all sectors on issues of sexuality, sexual health, and rights, ensuring that the professionals feel confident to implement this knowledge in their clinical practice;
d. Promote and advocate for the recognition of sexology as a specialty of medicine;
e. Take actions against healthcare personnel found guilty of discrimination, violence, or other illegal action against people's diverse sexual practices, sex workers, and sexual and gender identities;
f. Establish mechanisms of reporting any form of sexual harassment and take actions against healthcare personnel found guilty of it.

Medical schools and other teaching institutions to:

a. Incorporate comprehensive education on sexual health and rights, with a sex-positive, pleasure-based approach to health promotion, into the medical curriculum;
b. Promote research into areas pertaining to sexual health, emphasizing on left-behind populations ;
c. Increase students' skills in non-judgemental communication and taking a sexual history and promote open-mindedness and de-stigmatization pertaining to sexuality and sexual health;
d. Support student-led activities focusing on issues of sexuality, sexual health, and rights.
e. Establish reporting mechanisms for students to inform about discrimination committed against or by patients, students, or other healthcare personnel based on sexuality.

The General Public and Civil Society Organisations to:

a. Actively work towards and contribute to a society that secures sexual health and rights and fights against discrimination and stigma, hence promoting a sex-positive society around;
b. Advocate for the elimination of any insensitive material in media, in cultural and religious processes surrounding sexuality
c. Hold government officials and healthcare professionals accountable for their actions or omissions concerning sexual health and rights.

IFMSA National Member Organizations and medical students to:

a. Organize activities to raise awareness and build the capacity of their members and target populations on issues of sexuality, sexual health, and rights;
b. Take advantage of existing mechanisms inside IFMSA (e.g., Realizing SRHR program) to expand their activities and advocacy efforts;
c. Implement internal policies to ensure the protection of the sexual rights of their members inside their organizations.

Position Paper

Background Information

The World Health Organization defines sexual health as “a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity” (1). Inept to the concept of sexual health is a sex-positive approach that pays respect to the human and sexual rights of individuals and requires that all people are empowered to create and sustain safer sexual experiences and relationships, free of coercion, discrimination, and violence (2).

Sexuality has been recognized as a significant aspect of human health and well-being for decades now. A turning point for the discussion on sexual health and rights was the International Conference on Population and Development in 1994 in Cairo. It resulted in the Programme of Action, which was further renewed in 2019 in Nairobi. The purpose of this program is:

“The enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.” (3)

The Beijing Platform for Action was quite progressive in its time of inception, 1995, for the explicit mention of sexual rights, stating:

“The human rights of women include their right to decide freely and responsibly on all matters related to their sexuality, free of coercion, discrimination and violence.” (4)

Another milestone was the development of the Yogyakarta Principles by human rights organizations in 2006, a document that instated international principles to issues of sexuality and sexual orientation. These were further enhanced in 2017 (5). Sexual health and rights are also central to several targets of the Sustainable Development Goals, especially SDG3 (Good Health and Well Being) and SDG5 (Gender Equality) (6). Yet, many countries and officials still resist and oppose the recognition of sexuality and sexual rights (7).

Some additional definitions relevant to this policy document are presented below.

Sexuality is *“…a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors .”*

Sexual Rights are *“The application of existing human rights to sexuality and sexual health constitute sexual rights. Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination.” (8)*

“Sexual pleasure is the physical and/or psychological satisfaction and enjoyment derived from solitary or shared erotic experiences, including thoughts, dreams and autoeroticism. Self-determination, consent, safety, privacy, confidence and the ability to communicate and negotiate sexual relations are key enabling factors for pleasure to

contribute to sexual health and wellbeing. Sexual pleasure should be exercised within the context of sexual rights, particularly the rights to equality and non-discrimination, autonomy and bodily integrity, the right to the highest attainable standard of health and freedom of expression. The experiences of human sexual pleasure are diverse and sexual rights ensure that pleasure is a positive experience for all concerned and not obtained by violating other people's human rights and wellbeing ." (9)

Discussion

Sexual Rights

Sexual rights are a segment of fundamental liberties. They are a developing arrangement of qualifications identified with sexuality that add to all individuals' opportunity, fairness, and respect, and they can't be disregarded. In the present context, gender discrimination, taboo, dread, and brutality present genuine dangers to numerous individuals. These dangers and activities trigger numerous individuals from achieving sexual rights and well-being. Particularly vulnerable populations like youth, sex workers, LGBTQIA+ individuals, victims of child marriage, and pregnant adolescents are frequently deprived of sexual rights (10).

According to the WHO, there is a link between sexual rights and basic human rights, and this includes:

- The rights to equality and non-discrimination
- The right to be free from torture, inhumane and degrading punishment
- The right to privacy
- The rights to the highest standard of health, including the sexual health
- The right to freedom of opinion and expression

Many Civil Society Organizations (CSO) working for the rights of women and LGBTQIA+ have fought hard for sexual rights. Thus many countries are now adopting laws and policies to protect sexual rights at a country level. In 2010 Argentina, and in 2021, Northern Ireland legalized same-sex marriage among a total of 31 countries by now (2021) (11). Many initiatives are being taken at the regional level as well. However, implementing these laws and procedures remains a long process after their enaction.

The Montevideo Consensus on Population and Development was adopted in August 2013. The document commits to promoting policies that will enable people to exercise their sexual rights, including the "right to a safe and full sex life" and the right to take voluntary responsible decisions on sexuality, sexual orientation, and gender identity without any force or violence.
Although many initiatives are being taken to ensure global sexual rights, there are also regressions, such as the Same Sex Marriage (Prohibition) Act 2013 in Nigeria (12). Hence more awareness needs to be created on sexual rights, and more organizations need to come upfront with a solid voice to talk about the discrimination against sexual rights (13).

Healthcare implications and access to services

In every part of the world, people who have a sexual orientation and gender identity different from heterosexual and cisgender experience forms of discrimination. They can reach the extent of physical torture, rape, and murder. Cases from around the world depict that sexual and gender minority patients experience discrimination or even denial of care (14).

Until 1973 homosexuality was considered to be psychological maladjustment and recorded in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), and could be relieved

through psychotherapy or electro-stun repugnance therapy. Discrimination still exists despite fundamentally changing laws and perspectives towards individuals who identify as LGBTQIA+. Researchers have noticed that queer individuals are less satisfied with healthcare services in comparison to other patients. People of minority sexual orientations and gender identities often face biased treatment, encounter discriminatory, harsh, or cis-heteronormative language from care providers. This discrimination often forces people to hide their identity and orientation from the care provider or, in some cases, prevents them from seeking assistance (15).

Medical practitioners often have insufficient knowledge regarding the (health) issues that affect the LGBTQIA+ community. Without proper information, they are unable to provide specialized care. LGBTQIA+ people often experience mental health problems, resulting in higher suicide rates. These issues have become more prevalent due to discrimination, exclusion from society, and inability to access healthcare services (16).

Young people face various hindrances in accessing the services related to sexual and reproductive health care. These barriers are mostly related to accessibility, availability, and quality of services delivered. Many countries have policies and laws which prevent young people from accessing services related to sexual health and may often address the needs of married women only. For example, Plan International is working with civil society organizations and governments to increase sexual and reproductive health services, which will be tailored to the needs of young clients. They use innovative ideas such as mobile apps to create awareness and answer questions related to sexual health (17). Apart from clinics and counseling centers, comprehensive sexuality education is also needed to provide the youth and children from an early age with the appropriate knowledge and skills to stay healthy and to promote healthy sexual development. Trained professionals generally provide comprehensive sexual health education and cater to the needs of all students irrespective of their sexual orientation and gender identity (18).

Meaningful Youth Participation in SRHR

According to the Convention on the Rights of the Child, all young people have the right to meaningful youth participation (19). Meaningful youth participation means that young people are part of the development, implementation, and evaluation of decision-making and participate on equal terms with adults (20). It is generally assumed that more meaningful participation will result in better-developed interventions to promote adolescent sexual and reproductive health and rights (21). Youth activities include peer education, (social) media-based approaches, youth-led research, and youth governance. However, the measurement of youth engagement is limited due to the methodological shortcomings of many initiatives. In an extensive literature review, it was revealed that even when youth is included in the development and delivery of sexual health and rights-related projects, their participation is subjected to rigid practices that are not effective and inclusive for young people, thus, limiting their meaningful engagement in transformative activities (22).

Sexual history and non-judgemental communication

Sexuality is a core component that helps assess the overall well-being of an individual. With increased sexual awareness, considering a patient's sexual well-being, background, and functioning has become a crucial part of health assessment. This evaluation takes into account different medical, psychological, interpersonal, intrapsychic, social, ethnic, and cultural variables despite barriers impeding communication about sexual topics during sexual history taking. It is important to explore, assess, integrate and summarize existing knowledge on these obstacles, especially in research areas such as sexual health education, sexual pleasure, STIs, sexual dysfunction, LGBTQIA+ health, and sexual violence. Deficiencies in the process of sexual history collection, education and training, resistance to taking sexual history by a healthcare professional, and social stigma and negative attitudes towards sex are some of the biggest barriers in sexual history taking and assessment. Sexual

history collections hold the key to promoting sexual health and could serve as the basis for the treatment, prevention, promotion, and education of sexual health (23).

Service providers, including sexual health and family planning, determine that the personnel is trained to ask the community about their past sexual history in an inclusive, non-judgmental, and supportive manner. This process can be ensured in the form of a self-completion checklist and can facilitate the healthcare staff (24).

Gender sensitization in healthcare

As mentioned earlier in the text, the right to equality and non-discrimination is one of the components of sexual rights as human rights (13). This includes gender equality and the elimination of gender-based discrimination in health care. Sex and gender are important determinants of health. Indeed, gender roles and inequalities in gender relations and social and economic factors result in unequal exposures to health risks and, hence, unequal access to healthcare services, leading to different health outcomes between people of different genders (25). This is why the WHO has been vocal about the need for a gender-based approach to healthcare and has been encouraging countries to integrate gender in their public health policies and drafting strategies that will tackle the issue of gender-based inequalities in healthcare systems (26).

A systematic review by Lindsay et al. has shown that gender plays a critical role in prevention, diagnosis, treatment, and prognosis. Indeed, some of the studies mentioned show that women are offered different treatments than men or are less likely to receive advanced medical interventions even if their symptoms are as severe as men. Moreover, one of the most significant factors explaining inequalities in accessing healthcare for LGBTQIA+ patients is the lack of gender sensitization among healthcare workers, highlighting the necessity for hospitals to develop educational programs tackling the specific needs of LGBTQIA+ patients (25).

Gender sensitivity is an essential part of patient-centered care. It entails that healthcare providers have significant knowledge in existing sex and gender inequities and have the competence to include these in their practice. The review mentioned earlier also sheds light on the need for increased gender-sensitivity training among health care providers after evidence has shown their limited exposure to concepts of sex and gender in their medical training (27).

When it comes to implementing gender sensitivity, a study by Celik et al. demonstrated that this includes adjusting opportunities and obstacles at the professional, organizational, and political levels. Therefore, the gendered transformation of healthcare systems requires a multiple-track approach to implement gender sensitivity (25).

Sexual dysfunctions

According to the International Statistical Classification of Diseases and Related Health Problems (ICD-11), sexual dysfunctions are defined as “syndromes that comprise the various ways in which adult people may have difficulty experiencing personally satisfying, non-coercive sexual activities.” For diagnosis, the dysfunction must “1) occur frequently, although it may be absent on some occasions; 2) have been present for at least several months; 3) be associated with clinically significant distress”. Sexual dysfunctions can be divided into five categories: Hypoactive sexual desire; Sexual arousal dysfunctions; Orgasmic dysfunction; Ejaculatory dysfunction; Sexual pain disorder (28).

Sexual dysfunctions are also classified in the DSM-5. Diagnostic criteria are the following, a patient must 1) be experiencing the disorder 75%-100% of the time to make any diagnosis of sexual disorder, with the notable

exception of substance or medication-induced disorders, 2) the required minimum duration is approximately six months 3) in order to make a diagnosis, the disorder must be deemed to have caused significant distress 4) the disorder should not be better explained by a “nonsexual mental disorder, a consequence of severe relationship distress (e.g., partner violence) or other significant stressors” (29).

Sexual dysfunctions have a high prevalence amongst the population, with approximately 22.8% of women and 38.2% of men reporting at least one sexual problem. However, the number dropped to 3.6% and 4.2%, respectively, when DSM-5 criteria were used. Erectile dysfunctions and premature ejaculation are estimated to be the most prevalent among men, while among women - orgasm difficulties, hypoactive sexual desire, and pain during sexual activity (30).

Although these numbers showcase the high prevalence of sexual dysfunctions, many are still hesitant to consult their primary care physician concerning sexual health. Though many adults with sexual problems would like to seek help, only a small fraction does so. In a study by Moreira et al., 2008 it was evaluated that 26% of men and 17% of women discuss their sexual health with a healthcare provider. The reasons for these discrepancies and possible barriers to care remain for further investigation (31,32).

Sexual orientation & Practices

Sexual orientations can be categorized into several types: heterosexual (people who are physically attracted to the other gender), bisexual (people who are attracted to more than one gender), homosexual (people who are attracted to the same gender), and asexual (people who experience low to no sexual attraction to any gender) (33), among others.

Perspectives toward sexual minorities got perhaps the most dynamic spaces of general assessment research in the years, paving the way to the legitimization of same-sex marriage in the United States (34).
Despite the advances to date, 69 countries criminalize homosexuality. A significant hindrance to tending to this disgrace and SOGI-based prohibition is the absence of information on the existence of LGBTQIA+ individuals. Robust, quantitative data on differential improvement encounters and results of LGBTQIA+ individuals, particularly those in countries from the Global South, is significantly less (35).

Another aspect central to sexuality and sexual health is that of practices. Sexual practices might not reflect someone’s self-labeling of sexual orientation. According to the WHO definition of sexual health, sexual practices include intercourse and emotional intimacy, close companionship, flirting, affection, petting, hugging, kissing, desire, and self-pleasure. Many of these activities may not even have sexual intention, as stated in a manuscript by Freak-Poli, but still contribute to individuals’ overall sexual and emotional well-being (36).

Sexual pleasure and sex-positivity

The promotion of sexual health is often rooted in societal stigma around sex and conducted in a risk-based way emphasizing on prevention of sexually transmitted infections (STIs), unintended pregnancy, and sexual violence. Although these are valid health concerns, this narrative doesn’t encompass sexual pleasure as a part of human sexuality (37).
A sex-positive, pleasure-based approach to sexual health promotion is crucial (1). Sexuality and experiences of sexual satisfaction and pleasure can improve the overall health and well-being, mental and physical health outcomes (38).

Risk-based approaches, and at times even scare tactics, seem to have limited effects. In contrast, promoting pleasure in preventive measures like condoms can lead to increased adherence and effectiveness in STIs risk reduction and prevention of unintended pregnancies (39). Sexual pleasure is also a major influence on personal decision-making around contraceptive usage (40).

Despite the advances to establish a sex-positive, pleasure-based approach as part of comprehensive health care and public health promotion, many aspects remain to be researched, and more evidence needs to be introduced (41).

Sexuality of specific population groups

Youth and Adolescents

Different age groups have different ways of understanding and going through the process of discovering one's sexual identity. Dating in adolescence has a shaping role in defining one's social and sexual identities, particularly for the youth belonging to sexual minorities or those whose identity-forming is hampered by their marginalized status. A research paper suggests that same-sex relationships among youth from sexual minorities positively influence self-esteem in males and negatively correlate with changes in internalized homophobia in females, resulting in an overall betterment in the youths' psychological well-being (42).

People with Disabilities

Young people with disabilities are entitled to equal rights regarding their sexuality, sexual expression, and relationships in order to achieve complete physical, mental, and social well-being. Unfortunately, societal misconceptions that classify bodies with disabilities as non-normative and view people with disabilities as asexual have created significant obstacles to sexual citizenship among young people with disabilities. This has led to unequal access to comprehensive sexuality education and sexual knowledge among this population compared to people without disabilities. This puts them at risk for exploitative and disempowering sexual relationships and compromises their sexual safety (43).

Indeed, according to research conducted by Women with Disabilities Australia, 90% of women with an intellectual disability have suffered from sexual abuse, and 20% of rapes against women reported in Victoria were against women living with disabilities (44).

Upon these facts, comprehensive sexual education should be accessible to people with disabilities. Unfortunately, parents and healthcare providers are often uncomfortable or feel ill-prepared to discuss the topic of sexuality among young people with disabilities. A Dutch study revealed that up to 90% of youth living with cerebral palsy did not receive any information around sexuality from their healthcare providers. (40) It is thus of paramount importance for parents, educationalists, healthcare providers, and social care professionals to be trained and gain knowledge on these issues to educate young people with disabilities about sexuality (43).

Older Adults

WHO estimates that by 2050 the number of older adults (people older than 60 years) will increase by approximately 1.1 billion (45). It is a common misconception that older adults do not engage in sexual activity, leading to the common assumption that older people are practically asexual. However, studies reveal that sexual desires and activity remain present at an older age, though they are affected by several physiological, mental, and societal factors (37,46).

Some of the changes that naturally come with aging include, but are not limited to, lower testosterone levels, which may make erection and achieving orgasm more difficult, thinning, and lesser natural lubrication of the vaginal wall, which may lead to dyspareunia, and erectile dysfunction. Other factors that may negatively affect the ability or the interest in sexual activities include chronic pain, cardiovascular diseases, incontinence, neoplasias, arthritis, other musculoskeletal conditions, mental health conditions, surgeries, and medications, for example (47).

Contrary to popular belief, age has not been found to be the main factor behind lower sexual activity in older adults. Partner availability, gender norms, and health conditions seem to play a much bigger role. (30) Many people reinforce the stereotype that sexual behavior in older people is immoral, unnatural, and disturbing, while the media portray distorted images of sexuality in older ages (46). However, a study conducted in Brazil found concepts such as love, companionship, affection, and respect to be crucial for older people, besides actual intercourse(46,48).

Ignoring the sexual health needs of older adults can result in dire consequences. According to a US study, 38% of older men and 22% of older women discuss issues about their sexual health with health practitioners. STIs diagnosis is lower due to inadequate testing, and additionally, omitting discussions on sexuality can obscure symptoms relevant to other health conditions. What is more, ignorance amongst health professionals on the sexual health of older adults often leads to the prescription of medication that further disadvantages the sexual activity of patients and exacerbates feelings of loneliness, lack of intimacy, and mental health disorders. These cases make evident the need for a broader discussion on this issue (36).

Sex work

Sex work in broad terms refers to the exchange of sexual services for money or nonmonetary items. Sex workers face a number of health challenges (49). People under 18 are excluded from this, as engaging in such behaviors would be classified as exploitation.

Sex workers, their clients, and partners are at a higher risk of obtaining an STI, HIV, and blood-borne infections. Female sex workers are 30 times more likely to be diagnosed with HIV than other females of reproductive age (50). Further, sex workers are at higher risk of becoming subjected to violence, threatening their health, and increasing their risk of contracting HIV (51).

The WHO recommends several preventive measures like condom usage, regular STI and HIV screenings, cancer screenings, and counseling. Studies also indicate that the decriminalization of sex work could effectively reduce HIV infections by 46% (50).

Sex workers face numerous barriers to care. They are often hesitant to share their involvement in sex work and possible drug use out of fear of judgment. On a structural level, many health workers lack the training on communication and special health requirements of sex workers (56).

The WHO calls for structural interventions such as supportive legislation, policy, and funding, addressing stigma and discrimination; community empowerment; and addressing violence to improve the health and overall situation of sex workers (50).

Implementing the “Nordic model,” which perceives purchasing sexual services as illegal and providing services as legal, was proved to be inefficient (53). Further evidence supports and showcases the negative impact of

criminalization on the health of sex workers and has been linked to elevated risks for violence and reduced ability to negotiate safer sex transactions (54).

There is a great need for policy and societal shifts towards decriminalization and improved access to adequate, non-judgemental health care services to improve the health of sex workers. Evidence strongly points to decriminalization being a necessary step to strengthen the rights of sex workers and improve their health (55).

Conversion therapies

Conversion therapies (CTP) or reparative therapies refer to various pseudoscientific practices that have the intention to convert the sexual orientation of non-heterosexual individuals into heterosexual and the gender identity/expression of trans, non-binary and gender non-conforming people to cis and gender conforming (56,57). It might include harmful and often non-consensual procedures such as: electroshock, “corrective rapes”, chemical aversion, hypnosis, exorcisms, food deprivation, verbal abuse, among others. Many procedures are considered as tortures or humiliations, making conversion therapies a violation of human rights (58).

Attempts to change a person's sexual orientation or identity or sexual behavior, such as in conversation therapy, result in significant social and psychological harm, in addition to the potential physical consequences from treatment. Few but numerically increasing data on the consequences of CTP have been collected or made available, often primarily statistics were gathered without addressing the personal impact. Therefore, there are only a few results, which, however, already indicate significant harms of CTP on the mental health and social life of the affected persons. A Canadian survey of sexual minority men indicated that experiencing sexual orientation change efforts correlates with loneliness, illicit drug abuse, and suicidal thoughts and attempts (59). In addition, one study examined further aspects of psychological and social health and found that 77% of participants suffered from severe consequences of conversion therapy, including depression, anxiety, and sexual dysfunction (60). Regarding Identity Orientation Change Efforts, a study was conducted in 2015 with over 20000 participating transgender adults in the United States to investigate the influence of past experienced change efforts on mental health. The results showed a significantly higher number of lifetime suicidal thoughts and attempts among those who recalled a change effort throughout their lives (61).

According to a rapid survey of a global representative sample of LGBTQIA+ individuals from a collaborative effort between the LGBT Foundation and Hornet Gay Social Network with 8092 individuals participating from over 100 countries between the age group of 18 to 85+, 22.8% of the population was aware of the practice of conversion therapy in their own country while 21.08% and 21.70% responded unsure and maybe to the same respectively. More than a quarter of the individuals had responded expressing that the decision to sought conversion therapy was largely outside of their control or made on their behalf while nearly a quarter responded soughting conversion therapy on their own (62).

Based on the awareness and practice of Conversion Therapy in different parts of the world, the percentage estimates of the LGBTQ adult population living in the 50 states and the District of Columbia reflected that 48 % of LGBTQ population lives in states that ban conversion therapy for minors, 9 % of LGBTQ population lives in states that partially bans conversion therapy for minors, 11 % of LGBTQ population lives in states in federal judicial circuit with a preliminary injunction currently preventing enforcement of conversion therapy bans, 32% of LGBTQ population lives in states with no laws or policies banning conversion therapy for minors (63).

Cultural and religious bias

In many societies, religion and culture are important factors in the depiction of sexual norms and values and can present obstacles to the attainment of sexual rights for all. The “traditional” religiously-based body of thought primarily promotes cis-heteronormative beliefs. The sexualities of women, non-heterosexual people, or unmarried people are often normatively or even legally restricted.

Many countries from all continents and different religions have been found to oppose SRHR based on religious views. Multiple countries in the Middle East, such as Egypt, Iran, and Saudi Arabia, use Islamic arguments. It also applies to Christian countries in Europe, such as Malta, which opposes access to safe and legal abortion.

Moreover, comprehensive sexuality education for unmarried young people can be seen as dangerous or harmful in conservative societies, which leads to the promotion of abstinence, thus denying the lived realities of many young people and causing feelings of shame and guilt. However, strong allies can be found within said conservative societies, highlighting the importance of wider community building to improve attitudes towards sexual education and sexual rights.

Rutgers, the Dutch expert center on sexuality, highlights the need for a culturally sensitive approach and the broader inclusion of people’s opinions and feelings considering moral values and how they relate to the language used in advocacy messages. It is essential to understand the negative and positive connotations that language can have and how it can improve the conveyed message. It means there is a need to collaborate with other audiences and target groups to treat SRHR as a matter of health, gender, social power relations, and sustainability (64).

Indeed, many gender issues are considered controversial because of the different interpretations present, including sacrosanct, which cannot be changed. According to UNFPA, the best method to approach such culturally sensitive issues is by addressing them in the context of health through a scientific perspective to be more easily discussed and accepted. Ultimately, cultural norms can continuously be contested and changed in the context of changing political and economic systems as well as scientific and technological advancements. It is noteworthy to mention that many cultural beliefs and practices can be harmful to the sexual health of all genders, and these include but are not limited to: son preference, upbringing in the spirit of toxic masculinity, gender-based violence, female genital mutilation, dry sex (65).

Sometimes, health care providers’ own cultural and religious beliefs can constitute barriers to ensuring reproductive health services. For example, in Myanmar, many healthcare professionals felt the need to reprimand their clients needing care for post-abortion complications to prevent them from requesting abortions later on in their lives. This meant many people able to get pregnant from rural communities feared seeking medical help for complications, hence delaying access to essential healthcare services (66).

In order to address this issue, it is crucial to train healthcare providers to explore their values and attitudes to improve their competence in the delivery of needed services.
It is also essential to recognize that religious frameworks can constitute an important entry point for reproductive health programming. By collaborating with religious leaders and providing them with evidence-based information, they can adapt their teachings then and interpret them progressively. This is especially possible when all parties are working towards the same goal or when the health intervention is not contradictory to any religious teaching or practice (65).

Political leaders are other key actors that can play a role in facilitating or hampering discussions on culturally sensitive topics. Collaborating with political leaders and getting their support can provide credibility to these sensitive topics. For example, in the Philippines, where parliamentary advocacy and the activism of different NGOs allowed the passing of laws addressing violence against women, such as the anti-rape law, and in Indonesia, where the Zero Tolerance Policy against Violence against Women was passed (65).

Sexuality & media

Media has a considerable role in shaping young people's sexual development, thoughts, and behaviors. This makes it crucial for health providers to be conscious of the content related to sexual health delivered to young audiences, its influences, and gaps. While media content is often representative of the current attitudes of teenagers, it can also suggest new behaviors, teach skills and challenge prevalent social and cultural norms. Health professionals can engage in shaping media content by utilizing its various outlets to deliver information about sexual health and cover relevant topics and diverse populations. Such engagement requires proper training, assessment of current young people's attitudes, and close collaboration with editors, media experts, and officers. There are diverse media outlets that feature in various methods the topic of sexual health and sexuality and that are sought after by audiences for different goals.

Studies noted a focus on risks and dangerous behavior during the portrayal of sexual relationships of teenagers in movies and TV shows, especially in the ones aimed at adults and parents. Additionally, common depictions of characters' behaviors and thoughts in relation to sex were variable according to their gender. Female characters were more likely to discuss their decisions related to sex with their friends, be interested in emotional aspects of relationships, express hesitancy, and be actively pursued. In contrast, male characters were depicted as more interested in pursuing sex and being initiators. Conversations between characters included consent and readiness but often excluded choice of contraceptives and STIs prevention and status.

Magazines with young audiences focused more on non-sexual relationships and subtle sexual references compared to the ones with adult audiences with a high prevalence of gender norms. Magazines aimed at young men often pressured them to engage in sexual acts regardless of their own comfort and readiness. Articles aimed at cis-women focused on women's rights and entitlement to decide their own sexuality; however, they were often held responsible for contraception. Furthermore, there isn't diversity in teenage representation. People with disabilities, LGBTQAI+ youth, and people of color are often excluded from articles or their stories associated with abuse, shame, or anxiety (67).

Pornography is defined by Kohut 2014 as: "website content that has descriptions, pictures, movies, or audio of people having sex or engaging in other sexual behaviors." It may serve several functions, including sexual arousal, mood management, entertainment, curiosity, sexual exploration, and self-education. Young people state its ability to facilitate sexual experimentation, providing practical and visual knowledge about sexual acts, including oral and anal sex, genital aesthetic, identity, and queer sexuality. While the content includes various aspects of sexuality, reports highlight the portrayal of a narrow standard body and genital aesthetic, low depictions of female orgasms, unequal sexual roles, high prevalence of non-verbal communication of consent, as well as ethnic and racial differences in the portrayal of violence and aggression. Certain aspects of female objectification were less common in queer and feminist pornography (68).

Social media apps are often used as tools in people's sexuality and romantic life. They are used to meet new partners, display relationships, communicate with others, learn and express identity. Despite the fact that such platforms make certain sexual subcultures accessible, offer safety for being intimate and queer visibility, some

barriers to sexual health promotion were noted, including the commercial interest of app owners and the reluctance of users to engage with health workers in such spaces.
Mobile technology also exposes young people to a wide range of risks beyond STIs. Young people are concerned about outings in unsafe settings and deception by other users. As a result, they developed management strategies to navigate similar situations such as passwords, app locks, background checking new acquaintances on other apps or video calls, etc. Some social media apps display a relationship status and disclose commitment or limit the visibility of an ending social bond. It has also been stated that the relationship status features available often follow a narrow narrative that follows a heteronormative progression through dating, engagement, and marriage, which excludes users that experience different types of partnerships (69).

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