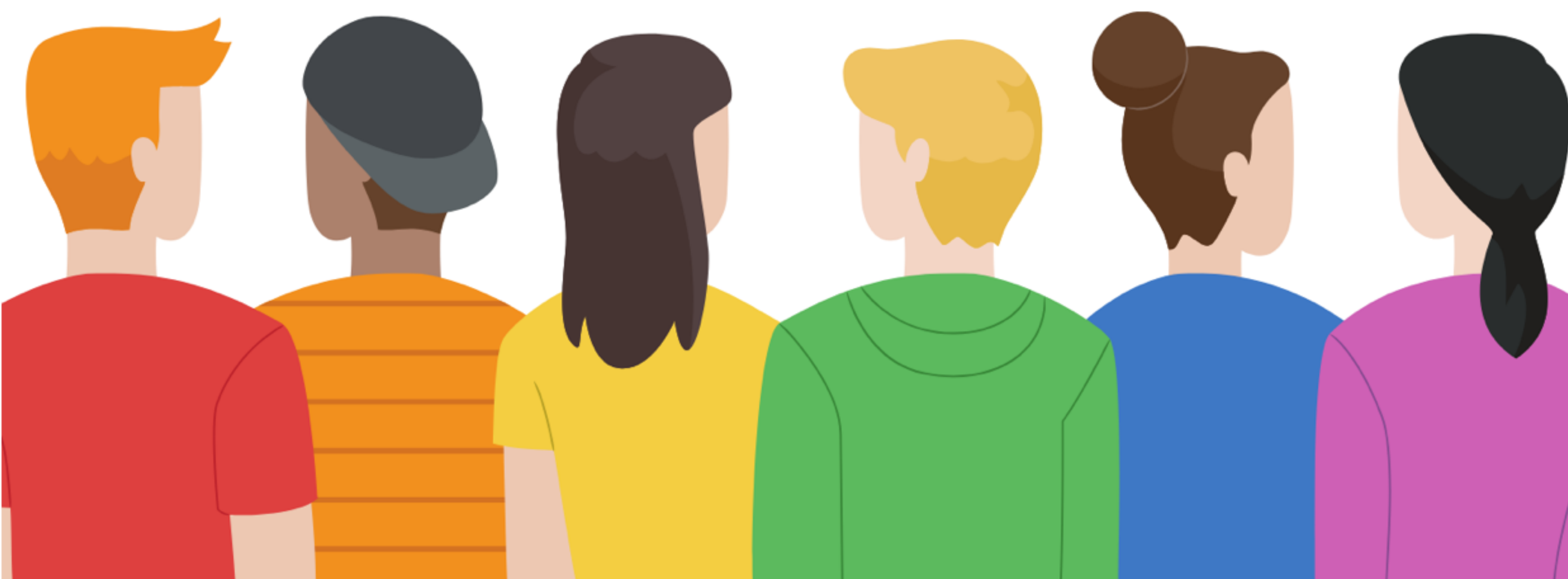
Queering SRHR

Report on the state of Sexual and Reproductive Health and Rights of LGBTIQ people in Europe



Inspire | European Partnership for Sexual and Reproductive Health and Rights

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Table of Contents

Introduction	4
LGBTIQ Families	5
• Why 15 MAY?	5
• The Yogyakarta Principles	5
• LGBTIQ Family Rights in Europe	6
• It's not all about setbacks, here is some recent Progress	9
Homo-Bi-Trans-Phobia No More	11
• Why 17 MAY?	11
• Homo-Bi-Trans-phobia	12
• Where does the stigma come from?	12
• LGBTIQ criminalisation around the world	14
• The Yogyakarta Principles	15
Lesbian women, Bisexual women and SRHR: the conversation we need to have	17
• Myths & Realities of Lesbian and Bisexual women's sexual and reproductive health	18
• Lesbian & Bisexual women's experience of parenthood	20
• Sexual Abuse, Same-Sex Domestic Violence and Mental Health	21
• Bi-Erasure	23
• The Right to Health and the Right to Education as cornerstones	24
Breaking Down Gay and Bisexual Men's Healthcare Barriers	26
• STIs and Cancer	27
• Other Health Considerations: Mental Health, Suicide and Sexual Violence	32
• Bi erasure	34
• The Right to Health and the Right to Education as cornerstones	35
De-pathologising Trans-people: WHO removes transgender as mental disorder from the International Classification of Diseases.	37
• The ICD-11: The World Health Organisation (WHO) finally de-pathologises trans identities	37
• The Yogyakarta Principles	39
• The current situation of SRHR related Trans-Rights in Eurasia.	39
The need for a trans-specific focus within SRHR	43
• The need for a trans-specific focus within SRHR	44
• The Need for increased research & Information Sharing	46

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The right to be Intersex 47
- Who is an intersex individual? 48
- Coercive Medical Interventions 48
- Access to Sexual and Reproductive Healthcare Services 51
- Structural Societal discrimination of intersex people 51
- Recommendations 52
- The Importance of Education 53
- Legal steps towards the fulfilment of Intersex rights 54
- Protection, Truth, and the right of Bodily Integrity as cornerstones of Intersex Sexual and Reproductive Rights 55

Conclusion 58
Sources 59

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Introduction

In May 2019, Inspire launched the "Queering SRHR" editorial series in the hope of raising awareness on current sexual and reproductive health and rights' struggles, goals and achievements related to intersex, queer, gay, lesbian, bi and trans people. With this series, the goal was also to challenge the binary and heteronormative narratives around sexual and reproductive health and rights, and to encourage colleagues, partners and other stakeholders to make SRHR discussions all-inclusive.

In this report, readers will find the complete compilation of the "Queering SRHR" articles published. The report starts by examining the rights of LGBTIQ families within Europe and by mapping the current state of LGBTIQ-centred discrimination across the world. It then proceeds to analyse in depth the sexual and reproductive healthcare barriers and inequalities that affect the daily lives of LGBTIQ individuals.

Inspire hopes this report will contribute to pushing the SRHR community to join forces with the LGBTIQ community and support their work by increasing information exchange and build SRHR projects that are LGBTIQ inclusive.

Together let's start working on Queering SRHR!

Acknowledgements:

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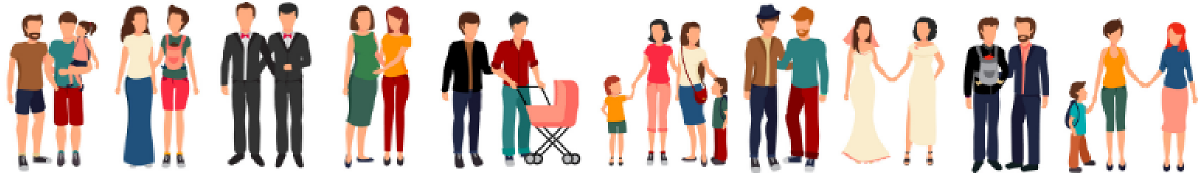
LGBTIQ Families



Every day in Europe, external social, cultural and political factors deeply impact the ways in which LGBTIQ Families experience life events such as marriage, reproduction, parenting etc. because of their gender, identity and sexuality. Analysing the current legal state of LGBTIQ families, one can understand that there are a range of SRHR topics such as adoption, fertility treatment or parental recognition that need to be singularly addressed within the SRHR community because of the different ways in which they are handled in politics, courts and in civil society. The longer we continue not addressing these specific needs, the more these families continue to be challenged, ignored and discriminated against. It is now time to act together to fight against LGBTIQ inequality.

Why May 15?

As it was proclaimed by the UN General Assembly in 1994, the world celebrates the International Day of Families' 25th Anniversary today. On this special day, it is of particular importance to highlight the current state of legal recognition of LGBTIQ families within the European context.

The Yogyakarta Principles

According to **Yogyakarta Principle 24,** which sets forth the **Right to Found a Family**: "*Families exist in diverse forms. Everyone has the right to found a family, regardless of sexual orientation or gender identity and no family should be subjected to discrimination because of it.*"

But why is this principle important?

In November 2006, 29 distinguished human rights experts met in Yogyakarta, Indonesia, to draft, develop, and redefine what are now called the Yogyakarta Principles on the Application of International Human Rights Law in relation to sexual orientation and sexual identity.

The YPs were issued to reflect existing international human rights laws in relation to issues of sexual orientation and gender identity considering the principles of universality and non-discrimination. In the upcoming "Queering SRHR" articles, we will be referring and coming back to these principles to highlight SRHR issues as they relate to LGBTIQ people.

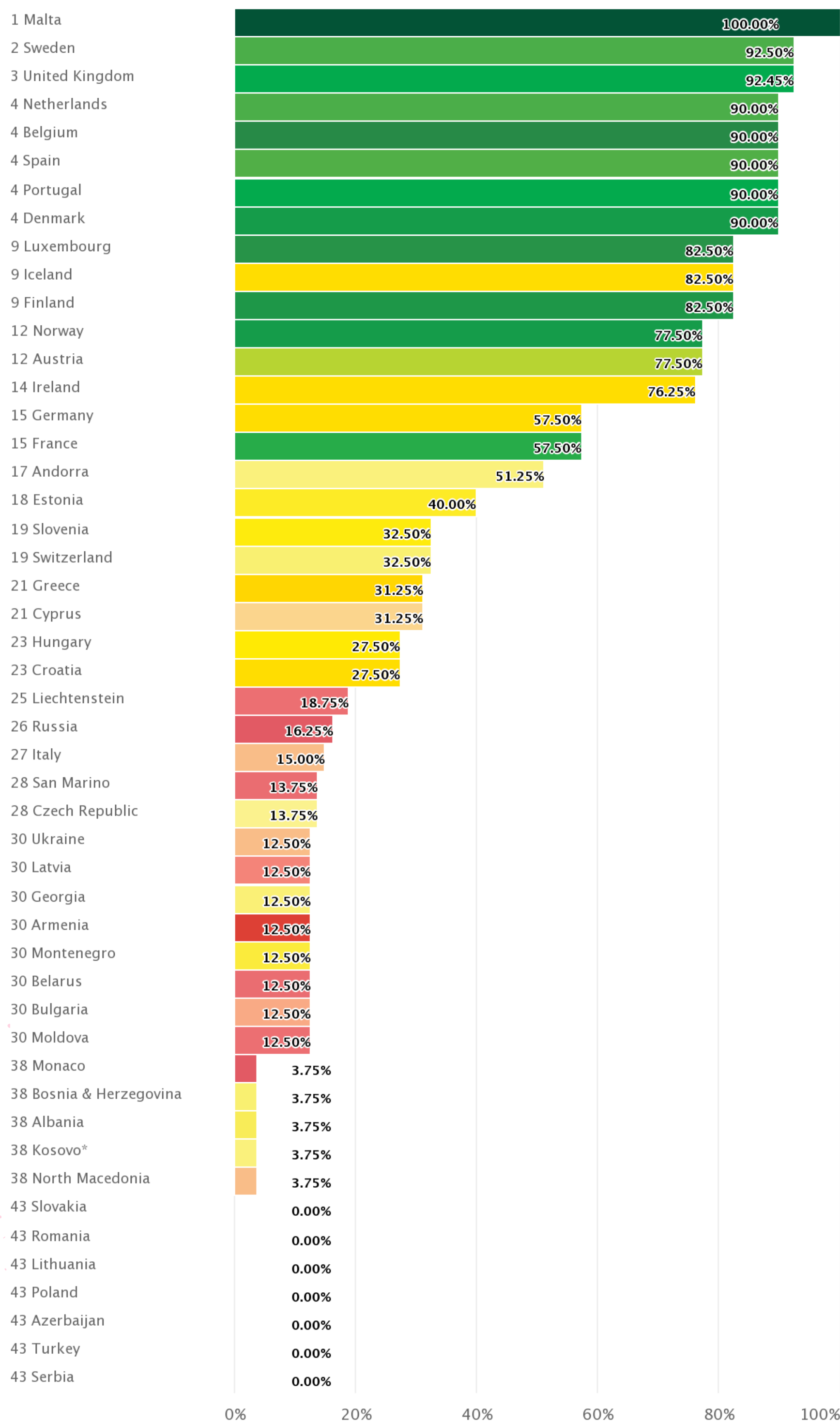
Principle 24 urges States to take specific actions in relation to the right for everyone to found a family. To name a few, States shall: *"ensure access to adoptions, assisted procreation, legal surrogacy and fertility treatments". States shall also ensure that "laws and policies recognise the diversity of families, that birth certificates reflect the self-defined gender identity of the parents and that where same-sex marriages or registered partnerships are recognised, the same measures are applied to both different-sex and same-sex couples."*

LGBTIQ Family Rights in Europe

LGBTIQ family rights have for long been topics of great debate amongst those who believe that the right of the family should be exclusive to cisgender, heterosexual couples. Resisting against extending legal family rights to LGBTIQ families has always been a strong priority in the agendas of right-wing conservatives still present today and seen through the wave anti gender discourse.

In 2019, ILGA Europe's Annual Review revealed not only a standstill in a significant number of European countries, but also a visible backslide on laws and policies.

Amongst the 49 States analysed, Serbia, Turkey, Slovakia, Romania, Poland, Lithuania and Azerbaijan jointly made up the bottom of the rankings with a 0 percent score. Scoring poorly in this case means that the State is failing to uphold the human rights of LGBTIQ persons and to protect them from discrimination, all with respect to the right to found a family.



Graph 1. LGBTQI Family Rankings

Source: Country Rankings, Rainbow Europe.

https://www.rainbow-europe.org/country-ranking **Retrieved 18.11.2019**

Countries like Albania, Armenia, Belarus, Bosnia Herzegovina, Bulgaria, Georgia, Kosovo, Latvia, Montenegro, Moldova, North Macedonia and Ukraine obtained an overall low score because they legally applied only one of the LGBTI Family criteria, either no constitutional limitation on marriage or medically assisted insemination for singles. Applying only one of these criteria

cannot define said country as an equal one because excluding other criteria automatically limits the benefits of the one legal criterion. A clear example of this can be seen in the case of Italy. Although the country has recently legalised registered partnerships, its highest court has just ruled that couples who seek surrogacy abroad will not be able to register themselves as co-parents. Regarding adoption and parenting legislations, ILGA Europe also reported that 17 European countries currently allow second parent adoption and only 10 recognise automatic co-parenting. Trans rights are the most ignored when it comes to parenting legislation as only 2 countries, Malta and Sweden currently recognise trans parenthood.

	Marriage equality	Registered partnership (similar rights to marriage)	Registered partnership (limited rights)	Cohabitation	No constitutional limitation on marriage	Joint adoption	Second-parent adoption	Automatic co-parent recognition	Medically assisted insemination (couples)	Medically assisted insemination (singles)	Recognition of trans parenthood
Albania					●						
Andorra		●	●		●	●	●				
Armenia										●	
Austria	●	●		●	●	●	●	●	●		
Azerbaijan											
Belarus										●	
Belgium	●		●	●	●	●	●	●	●	●	
Bosnia & Herzegovina					●						
Bulgaria										●	
Croatia		●		●						●	
Cyprus		●			●					●	
Czech Republic			●	●	●						
Denmark	●			●	●	●	●	●	●	●	
Estonia			●		●		●			●	
Finland	●	●		●	●	●	●		●	●	
France	●		●	●	●	●	●				
Georgia										●	
Germany	●	●		●	●	●	●				
Greece		●		●	●					●	
Hungary		●		●						●	
Iceland	●				●	●	●		●	●	
Ireland	●	●		●	●	●		●	●	●	
Italy		●									
Kosovo*					●						
Latvia										●	
Liechtenstein		●			●						
Lithuania											
Luxembourg	●	●			●	●	●		●	●	
Malta	●	●	●	●	●	●	●	●	●	●	●
Montenegro										●	
Moldova										●	
Monaco					●						
Netherlands	●	●		●	●	●	●	●	●	●	
North Macedonia					●						
Norway	●			●	●	●	●	●	●		
Poland											
Portugal	●	●		●	●	●	●	●	●	●	
Romania											
Russia					●					●	
San Marino			●	●	●						
Serbia											
Slovakia											
Slovenia		●	●	●	●		●				
Spain	●	⊙	⊙	⊙	●	●	●	●	●	●	

	Marriage equality	Registered partnership (similar rights to marriage)	Registered partnership (limited rights)	Cohabitation	No constitutional limitation on marriage	Joint adoption	Second-parent adoption	Automatic co-parent recognition	Medically assisted insemination (couples)	Medically assisted insemination (singles)	Recognition of trans parenthood
Sweden	●			●	●	●	●		●	●	●
Switzerland		●		●	●		●				
Turkey											
United Kingdom	⊙	●		●	●	●	●	●	●	●	
Ukraine										●	

Symbols: ● national / federal application ⊙ applicable in some regions only

*under UNSCR 1244/99

Graph 2. Family Criteria per Country in Europe

Source: Rainbow Map, Rainbow Europe,
https://www.rainbow-europe.org/#0/8682/0, **Retrieved 18.11.2019**

It's not all about setbacks, here is some recent Progress:

In contrast with these worrisome statistics, we did witness some victories on an international scale within the European Union, the UN and the Council of Europe.

On 5th June 2018, the Court of European Justice (CJEU) confirmed that: "the term 'spouse' needs to be interpreted as being inclusive of same-sex spouses of EU citizens in the framework of the freedom of movement directive and that all EU Member States must treat same-sex couples in the same way as different-sex couples when they exercise freedom of movement rights." Thanks to this judgement, same-sex spouses of EU nationals must now be recognised and granted residence rights on an equal basis.

In addition to this, UN Women launched a paper around "Exploring a contemporary view of the concept of family in international human rights law and the implications for the Agenda 2030, ensuring that all members of various forms of families in all contexts are protected equally."

Lastly, on 24th October 2018 the Council of Europe's Parliamentary Assembly passed a resolution: "Private and family life: achieving equality regardless of sexual orientation." Adopted by an overwhelming majority, "The resolution is the most advanced statement by any international representative body in support of the rights of rainbow families. It declared as crucial and urgent that European States overcome the discrimination experienced by both adults and children in these families and called for the elimination of all unjustified differences in treatment in the field of private and family life based on grounds of sexual orientation.

The resolution also includes important recommendations regarding trans parents, for instance calling on States to recognise the gender identity of trans

parents, also in the birth certificate of their children, and to ensure that non-binary parents can have their partnerships and their relationships with their children recognised without discrimination."

Preliminary Conclusions

Recently, we have seen progress for LGBTIQ families thanks to Court decisions and other entities. At the same time, LGBTIQ families remain existing in spaces and environments where their decisions, structures and wishes continue to be challenged, contested, and rejected, which can lead to serious consequences. Such families continue to disturb heteropatriarchal ideals. In fact, through the course of these rejections and challenges, people get hurt, children live in limbo situations, others must undergo sterilisation, etc.

Homo-Bi-Trans-Phobia No More.

Homophobia, Biphobia and Transphobia, whether internalised, social or institutionalised, persist in the majority of today's societies. As of 2019, homosexuality is criminalised in 72 countries. 11 of those carry the death penalty for 'homosexual activity'. In 26 other countries, an individual can be charged with 10 years to life-imprisonment. Even in countries where homosexuality is legal, there are either legal barriers to freedom of expression or discrimination against LGBTIQ persons goes unpunished on a daily basis. In today's world, the majority of people who do not conform with heteronormative binaries are denied full access to their human rights to love, to speak, to work, to give birth, to adopt, to access healthcare and, sometimes, to live. Everyday criminalisation and/or discrimination limits LGBTIQ persons' access to human rights, it furthermore excludes them from society and perpetuates stigma. This causes inevitable physical, mental and emotional pain and suffering. On 17 May 2019 we decided to fight back against discrimination and injustices to rebuild a future where sexual health, reproductive health, sexual rights and reproductive rights are truly accessible to all.

Why 17 May?

17 May is a historic date for the members of the LGBTIQ community. 29 years ago, on 17th of May 1990, the General Assembly of the World Health Organisation finally decided to remove homosexuality from their list of mental disorders. This action served to end more than a century of pathologisation of LGBTIQ persons.

In 2004, LGBTIQ grass root movements, committed to forever commemorating this day, appointed the 17 May as the International Day against Homophobia, Biphobia and Transphobia. The 17 May is a moment to draw the attention to the violence and discrimination experienced by the LGBTIQ people and it is celebrated in more than 130 countries around the world.

Homo-Bi-Trans-phobia

Homo-Bi-Trans-phobia is a very difficult issue to tackle because it manifests itself in different forms that are more or less visible. Phobias come in many different forms: internalised, social, emotional, rationalised, institutionalised etc. Internalised homo-bi-trans-phobia for example, refers to negative stereotypes, beliefs and stigmas that apply to conscious or unconscious behaviour in which a person feels a need to promote or conform to cultural expectations of heteronormativity or heterosexism. Institutionalised homo-bi-phobia is rather State sponsored or led by religious beliefs.

To understand why the stigma against LGBTIQ persons has been so prevalent, we wanted to research theories and projects underpinning it.

Although homo-bi-trans phobia manifests itself subtly at times, it can also be explicit as seen with the vast scope of countries that still criminalise same-sex activity.

Where does the stigma come from?

According to Queer theorists, how society members come to think about sex, gender and identity is contextual to specific times and cultures and varies greatly over space and time.

Early 19th and 20th Century sexologists paved the way for discrimination, criminalisation and pathologization (seeing people as wrong, bad or sick) on the basis of their sexuality. Put briefly, we are still dealing with the impact of heavy emphasis put on hierarchies around sexuality, sex and gender.

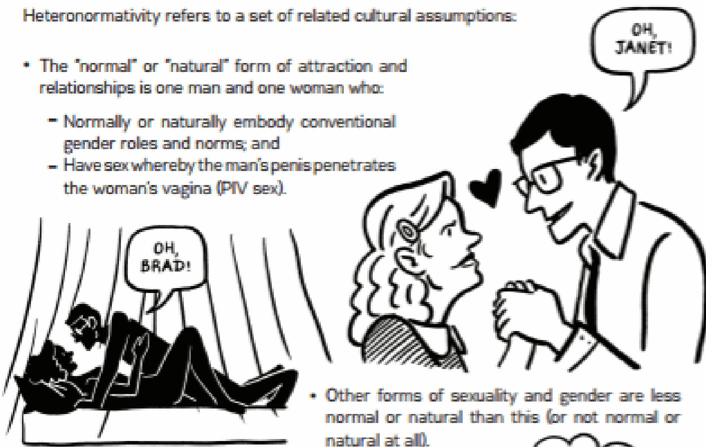
One of the most influential individuals in the classification of homosexuality as an illness was Austrian forensic psychiatrist, Richard von Krafft-Ebing. According to Krafft-Ebing, functional deviations of the sexual instinct (to be attracted to the opposite sex) caused sexual deviances (including, but not limited to, homosexuality).

Sigmund Freud, founder of psychoanalysis also played a huge influence on sexology. Many of his ideas have actually found their way into everyday understanding of sex, and sex education. Freud perpetuated the idea that penis-in-vagina (PIV) intercourse should be viewed as the ‘golden standard’ of mature sexuality.

HETERONORMATIVITY

An extremely helpful concept in queer theory, which encapsulates a lot of what we've just covered is *heteronormativity*. Queer theorist Michael Warner popularized this term in 1991, drawing on Rubin's sex hierarchy and Rich's compulsory heterosexuality.

Heteronormativity refers to a set of related cultural assumptions:



- The "normal" or "natural" form of attraction and relationships is one man and one woman who:
  - Normally or naturally embody conventional gender roles and norms; and
  - Have sex whereby the man's penis penetrates the woman's vagina (PIV sex).
- Other forms of sexuality and gender are less normal or natural than this (or not normal or natural at all).

- Thus, people are assumed heterosexual unless proven otherwise.

84

Excerpt from "Queer: A Graphic History"
by Meg-John Barker and Jules Scheele

Many other early sexologists contributed to creating a set of common dogmas around sex and sexuality that became embedded in Western cultures. In turn, via colonialism and other forms of oppression, values were brought and imposed abroad.

These theories have spread three key assumptions:

- *Identities are fixed and essential*
- *Sexuality and gender are binary*
- *Sex is either normal or abnormal*

These socially and culturally embedded assumptions around sexuality and gender have had a great impact in the context of healthcare and, in particular, in psychiatry.

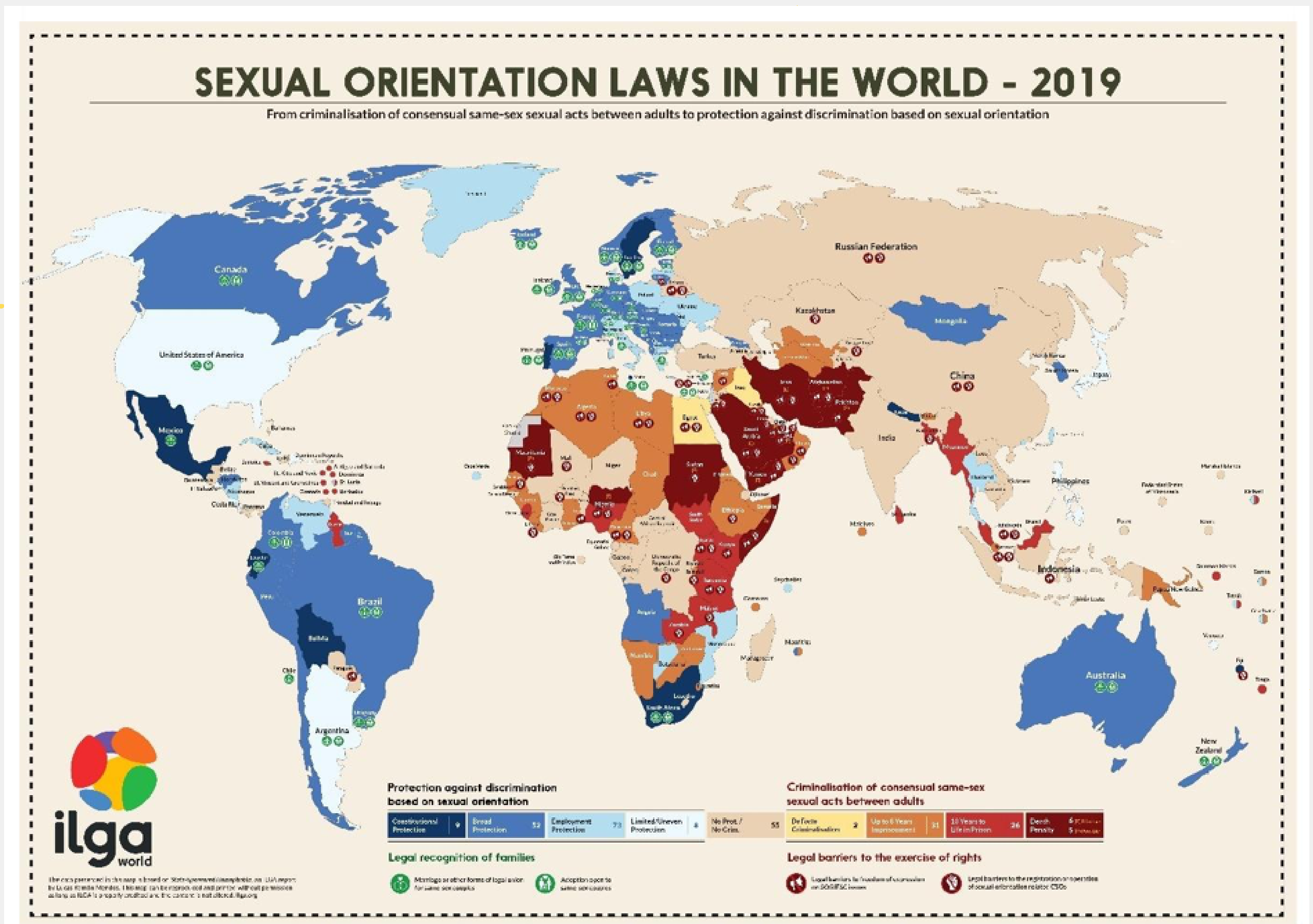
In 1952, The American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) defined homosexuality as asexual deviance. Sexual deviance was introduced as the new term for cases formerly classified as "psychopathic personality with pathologic sexuality." Homosexuality was thus classified as a pathological behaviour. Homosexuality's inclusion in this classification stopped only in 1973 when a revised version of the DSM that did not contain homosexuality was published.

Defining Homosexuality as a pathology played a great role in shaping how homosexuality was viewed in society. It also led to a great amount of physical, psychological and emotional suffering for all of those who had to endure conversion therapy and other aggressive medical procedures many times against their will.

For this reason, WHO's removal of homosexuality as an illness on May 1990 was a historic decision that played a great impact on LGBTIQ's people lives.

LGBTIQ criminalisation around the world

In parallel to pathologisation, discrimination founded on so called scientific principles, the law has also and still plays a key role in the marginalisation of LGBTIQ persons. According to ILGA's 2019 State-sponsored Homophobia Map, homosexuality is currently illegal in 70 countries.



Source : Sexual Orientation Laws in the world – 2019,
***ILGA,** https://ilga.org/maps-sexual-orientation-laws*, **Retrieved 18.11.2019**

Iran, parts of Nigeria, Saudi Arabia, Somalia, Sudan and Yemen currently have in-place the death penalty for homosexual activity. Mauritania, Qatar, Afghanistan and Pakistan all have in place laws where it is possible that same-sex activity could be punished by death.

In April 2019, Brunei announced that it would impose draconian new punishments, including death by stoning, on those convicted of homosexual activity. However, following a global backlash, the country's ruler, Sultan Hassanal Bolkiah later claimed that he would not impose the death penalty.

The possibility of life-imprisonment is also a reality in 26 countries whilst a sentence of up to 8 years imprisonment is in effect in 31 States. Luckily, LGBTIQ rights have not only come across setbacks in the recent years. In September 2018, India's Supreme court ruled that same sex activity is no longer a criminal offence, effectively decriminalising homosexuality for 1.34 Billion people.

The Yogyakarta Principles

Decriminalising homo-bi and transsexuality around the world is essential to ensure that each and every individual is safeguarded and enjoys universal human rights.

On this May 17, 2019, we wanted to highlight **Yogyakarta Principles 1** and **2**, which set forth the **Right to Universal Enjoyment of Human Rights** and the **Right to Equality and Non-discrimination** *"All human beings are born free and equal in dignity and rights. Human beings of all sexual orientations and gender identities are entitled to the full enjoyment of all human rights without discrimination. Everyone is entitled to equality before the law and the equal protection of the law without any such discrimination whether or not the enjoyment of another human right is also affected".*

Preliminary Conclusion

As we celebrate May 17 2019, we wanted to show the origins of stigma, pathologisation and criminalisation. Early theories led to scientific and legal marginalisation, which in turn led to stigmatisation and criminalisation. We still too often perceive sex, sexuality and gender as fixed and binary.

We invite all those working on sexual and reproductive health and rights to address the impacts of lingering stigmatisation, pathologisation and criminalisation of LGBTIQ person to ensure justice and protection for all.

YOGYAKARTA
PRINCIPLES 1 & 2

“ALL HUMAN BEINGS ARE BORN FREE AND EQUAL IN DIGNITY AND RIGHTS. HUMAN BEINGS OF ALL SEXUAL ORIENTATIONS AND GENDER IDENTITIES ARE ENTITLED TO THE FULL ENJOYMENT OF ALL HUMAN RIGHTS WITHOUT DISCRIMINATION."

The Right to the Universal Enjoyment of Human Rights & The Right to Equality and Non-discrimination

Lesbian women, Bisexual women and SRHR: the conversation we need to have

The right to sexual and reproductive health is a fundamental part of human rights and essential to living a dignified life. However, persistent myths and stereotypes might have adverse consequences when it comes to the sexual and reproductive health of lesbian and bisexual women. In this article, our goal is to debunk some of these perceptions, or at least to highlight them.

One striking fact when researching data for this article is the gap in available information on lesbian and bisexual women's access to / experiences regarding sexual and reproductive health. Research gaps on women' SRH are further emphasised in the case of lesbians and bisexual women, because of a generally heteronormative health care environment. Currently, LGBTIQ comprehensive sex education programmes on LBQ women are hardly available. Whether it concerns school curricula, NGO programmes or public healthcare, there is a general lack of information and education on LBQ women's sexual and reproductive health.

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Myths & Realities of Lesbian and Bisexual women's sexual and reproductive health

One of the primary concerns related to the sexual health of lesbian and bisexual women is caused by few and irregular gynaecological visits. Because mainstream reproductive rights discourse and policies are usually framed as heteronormative, many lesbians and bisexual women avoid gynaecological check-ups. Additionally, several studies have suggested that lesbians and bisexual women seem to avoid going to the gynaecologist due to fear of lesbophobic reactions and insensitivity or because of negative past experiences (Alencar Albuquerque et al, 2016; Blosnich et al, 2014, LGB&T Partnership, 2016; Quinn et al, 2015; Zeeman et al, 2017a; 2017b; 2017c).

Those who did visit health care providers have at times met providers who either assumed they were heterosexual, were uncomfortable with their sexual orientation or provided them with incomplete and incorrect information (LGB&T Partnership, 2016, Quinn et al, 2015, Zeeman et al., 2017a, 2017b, 2017c). The general lack of information on where to find LGBTIQ friendly health-care providers further limits LB women's access to gynaecological care (this is especially the case for those living in rural settings). In addition, LGBTIQ friendly gynaecologists that are available, are usually based at private clinics. This is problematic for LB women who, both as women and "sexual minorities" may face increased economic exclusion or poverty (Jann, Edmiston & Ehrenfeld, 2015; Khalili, Leung & Diamant, 2015).

Myth 1: Lesbian and Bisexual Women do not need cervical screening

In 2008 Ruth Hunt and Julie Fish conducted a survey on LB&Q women in Great Britain, where 6178 LB&Q women from an age range between 14-84 years responded to questions on their sexual health experiences. The survey revealed that half of those women had never been tested for an STI and three fourths of them believed they were not at risk. More than half of those who were tested throughout the study were then diagnosed with an STI.

In some contexts, the misbelief that bisexual and especially lesbians do not need regular visits with a gynaecologist is prevalent within the medical field itself: lesbians are screened less often. Hunt and Fish's survey revealed that health providers had been telling lesbians and bisexual women that they do not need cervical screening because they have sex with women. This was later re-confirmed by an LGB&T partnership research in 2016, conducted in England. What is important to know is that attending regular gynaecological check-ups is essential for all women as these can help detect and treat breast cancer, cervical cancer and sexually transmitted infections

This is especially important for lesbians and bisexual women who do not have children. Scientific studies have indeed demonstrated that both breast and uterine cancer are associated with not having children. Moreover, lesbians and bisexual women who have never used an oral contraceptive pill face a 50 percent greater risk of contracting ovarian cancer (American Cancer Society, 2019). However, in order to understand the correlation between the risks, more medical research is needed.

Cervical cancer is one of the most frequent types of cancer affecting women. Between 85 and 90 % of cervical cancers develop following a chronic infection by HPV (Human Papillomavirus), which is one of the most prevalent STIs on the planet. HPV is very contagious and can be transmitted through sexual contact with or without penetration. Any woman having had same-sex or heterosexual relations can be a carrier of HPV and prevention, screening and vaccination are essential.

Myth 2: Lesbian and Bisexual women cannot contract HIV

Because STIs can pass through sexual fluids or through blood, the risk of transmission can be caused by the lack of protection used by women during sex. Women are at heightened risks of contamination by STIs and HIV when: they practice cunnilingus & analingus during menstrual periods, rub vagina against vagina, or when exchanging sex toys and using them for vaginal or anal penetration.

The STIs that lesbians and bisexual women are particularly subjected to are yeast infection, genital herpes, genital and anogenital warts, trichomoniasis, syphilis, chlamydia and gonorrhoea, bacterial vaginosis and hepatitis B and C. In order to avoid being infected, women need to use protections such as dental dams, condoms and precautions such as hygiene (washing hands before and after sex) and avoiding unprotected oral sex if they have any cuts or sores on their mouth or lips.

Myth 3: Lesbian and Bisexual Women do not need protection

Another prevalent myth about lesbians and bisexual women's sexual health is that they do not risk being infected with the human immunodeficiency virus (HIV). Both HIV and STIs can be transmitted through blood, including menstrual blood, vaginal discharge, sperm, wounds on skin or drugs sharing through syringes. Several cases of HIV between women have been identified. Although the risk seems to be weak, there is a general lack of knowledge regarding HIV transmission between women caused by the limited and rare research that exists on the subject.

Lesbian & Bisexual women's experience of parenthood

Currently, there are many sociolegal challenges that stand in the way of lesbian and bisexual women seeking access to Assisted Reproductive Technology (ART). The reason why ART is difficult to access in the majority of countries is because ART is considered as a means to deal with infertility, thus the laws related to ART were established to help heterosexual couples with difficulties in conceiving. That's in part because health authorities such as the Centers for Disease Control and Prevention, the World Health Organization, and the American Society for Reproductive Medicine define infertility as the inability to get pregnant after one year of unprotected sex. This interpretation, of course, does not apply to women in a same-sex relationships — or, for that matter, to any woman who is interested in fertility benefits but not in unprotected penile-vaginal sex. Therefore, lesbian and bisexual women's inability to prove their infertility hinders their access to ART.

Lesbian and bisexual women's difficulties in accessing ART can be seen both in the case of intrauterine insemination (IUI), where lesbian and bisexual women use donor sperm from an anonymous or known donor and in the case of in Vitro Fertilisation (IVF), which involves the fertilisation of the egg by the sperm donor in an incubator outside the body.

At the moment, only fourteen countries in Europe (Austria, Belgium, Denmark, Finland, Iceland, Ireland, Luxembourg Malta, Netherlands, Portugal, Norway, Spain, Sweden and the UK) allow medically assisted insemination for same-sex couples (Rainbow Europe, 2019). In both Switzerland and Germany only heterosexual couples can use donated sperm cells. The current restrictions on reproductive rights in the countries has forced same-sex couples to travel abroad in countries such as Spain, Denmark or Austria in order to seek fertility treatments.

At the same time, after years of legal battles, on the 15th October 2019, France's lower house of Parliament approved a bill that will allow single women and lesbian couples access to medically assisted procreation. The bill is currently under discussion in the Senate and will go to a vote in January 2020. Although some steps seem to be taken to eliminate restrictions on access to IVF, even in countries where IVF is legalised, there are still major social obstacles that LB women have to face. In 2017, for example, a UK lesbian couple Laura Hineson and Rachel Morgan reported being denied access to funded IVF treatment by their local NHS Clinical Commissioning Group because of their sexual orientation (The Telegraph, 2017).

A third major obstacle for lesbian and bisexual women's experience of motherhood has to do with the social and legal recognition of the second non-biological parent. Currently in Europe, automatic co-parents are recognised only in Austria, Belgium, Denmark, Ireland, Malta, Netherlands, Norway, Portugal, Spain and the United Kingdom.

When living in countries that prohibit same-sex adoption, parents have to face the difficult choice of deciding who will be the legal parent and adopt as a single parent (Appel, 2003; Messina and D'Amore, 2018). This procedure can cause distress for the non-legal parent because of their invisibility, isolation, and lack of legal tie with their child (Goldberg, 2012). Social parents experience a sense of loneliness throughout the adoption process. The idea of not having a legal bond with the adopted child provokes insecurity together with a feeling of being a "second-class parent" (Messina and D'Amore, 2018). Moreover, there are almost no programs present to help non-biological mothers to deal with their new status.

Sexual Abuse, Same-Sex Domestic Violence and Mental Health

According to a 2012 survey conducted by the European Union Agency for Fundamental Rights (FRA), within the EU, 23% of lesbians were physically/sexually attacked or threatened with violence. Of those women, 54% said it happened because they were perceived to be part of the LGBTIQ community. Out of the women attacked, only 21% ever reported their most serious incident to the police.

Lesbians and bisexual women are subjected to discrimination and violence on a dual basis: their sex and their sexual orientation. For black women or women of colour, the experience might be additionally influenced by varying levels of racism or xenophobia.

GAMS Belgium has asserted that throughout research conducted with FGM survivors based in Belgium, they have encountered some who identified as either lesbian or bisexual. However, data on lesbian and bisexual women subjected to FGM is hardly available and this is perhaps one of the biggest gaps in lesbian/bisexual SRHR-related research. This is a good moment to recall the Yogyakarta Principle 17 which asserts that States shall: "take all necessary measures to eliminate all forms of sexual and reproductive violence on the basis of sexual orientation, gender identity, gender expression and sex characteristics, including forced marriage, rape and forced pregnancy."

"Corrective rape"

kuh-rek-tiv | reyp

noun

1. A violation of human rights perpetrated against lesbian, bisexual and trans women, and gender diverse people, under the false premise of "curing" them

2. LGBTI people who have experienced the coercive, inhumane and degrading practice of punitive rape often face challenges accessing psycho-social support, health care, and access to justice

Source: UN Women, 16 Days of Activism Series. https://trello.com/b/PpTdZvU4/16-days-of-activism
Retrieved 28.11.2019

"Corrective Rape"

In some specific contexts lesbians and bisexual women have also been targeted with 'corrective rape' or otherwise called 'homophobic rape' (Human Rights Watch, 2003). Accoridng to the United Nations Office of the High Commissioner for Human Rights (OHCHR), 'homophobic rape' is a hate crime that was first introduced via the term, 'corrective rape' by South African feminist activist Bernadette Muthien in 2001, during an interview conducted by Human Rights Watch:

"Lesbians are particularly targeted for gang rape. African lesbians are more likely to be raped as lesbians in the townships. To what extent are coloured lesbians also targeted for rape because of their sexual orientation? There are no statistics for this, and I don't know what percent of coloured lesbians are targeted for corrective rape action. Growing up, I never heard that lesbians were targeted in this way and so I want to know when that started happening. Gangsterism has always existed in the townships, so you can't attribute it to that. I don't know why black lesbians are targeted more, either. I'd like to know how many women are being raped by brothers, fathers, etc., in coloured townships. Why is no one studying this? Has it just been under-reported, not studied, or what?"

Homophobic/corrective rape often goes un-recognised by authorities, especially in countries without laws prohibiting LGBTIQ discrimination and violence or where same-sex relations are criminalised. Lesbians and bisexual women who endure these traumatic experiences may be faced with unwanted pregnancies or are infected with HIV or STIs. These horrible acts occur especially where the LGBTIQ community is severely marginalised and criminalised. Moreover, because these hate crimes are often carried out by family members or acquaintances, they very often go unreported.

Domestic violence in same-sex relations

In other instances, lesbian and bisexual women in same-sex relationships are also victims of physical, psychological, emotional, sexual and/or financial domestic abuse by their partners. Yet, the mainstream perception is that domestic violence only occurs within heterosexual relationships and that women are only ever abused by men and also rarely perceived as abusers. This assumption and lack of awareness generates a lot of denial and guilt within lesbian and bisexual women victims of domestic violence who feel excluded from domestic abuse support and avoid reporting the abuse.

Source: UN Women, 16 Days of Activism Series. *https://trello.com/b/PpTdZvU4/16-days-of-activism*
Retrieved 28.11.2019

In addition to this, there is generally no training done for police officers and social workers who encounter lesbian or bisexual women who have suffered from domestic violence from their partners. And domestic violence legislation usually excludes same-sex partners from its scope. Thus, in order to avoid additional marginalisation from their community, LB women fail to report their abuse.

The violence, exclusion and double discrimination that lesbians and bisexual women endure throughout their lives has a negative impact on their mental health. Lesbians and bisexual women are in fact at a heightened risk of depression, self-harming behaviour and suicidal thoughts.

Bi-Erasure

Bisexual women are also confronted with an extra layer of discrimination due to a recurrent hyper-sexualisation of their sexual orientation. Their bisexuality often leads them to be excluded or erased from narratives both within same-sex and opposite-sex relationships.

In addition to this, a common dualistic belief that one can either be homosexual or heterosexual puts double pressure on bisexual women who are often asked to pick a side. The lack of understanding and acceptance of their sexuality negatively impacts their mental health. Because of it, there is an essential need to create a safe and welcoming environment for bisexual women within the SRHR field.

In order to reduce and hopefully eliminate any forms of discrimination and stigma associated with lesbians and bisexual women, it is essential for the next generations to be taught about different sexualities and genders in an open and transparent way. Education is essential for the wellbeing of communities both on a mental health and SRHR level.

The Right to Health and the Right to Education as cornerstones

According to **Yogyakarta Principle 17**, the **Right to the Highest Attainable Standard of Health** "*Everyone has the right to the highest attainable standard of physical and mental health, without discrimination on the basis of sexual orientation or gender identity.*" YP 17 also stresses that: "S*exual and reproductive health is a fundamental aspect of this right.*"

Because lesbian and bisexual women face the risks of contracting STIs or getting cancer just like heterosexual women, as YP 17 stresses, States need to *"ensure that all persons are informed and empowered to make their own decisions regarding medical treatment and care"* and to "*ensure access to a range of safe, affordable and effective contraceptives, including emergency contraception, and to information and education on family planning and sexual and reproductive health."*

To take proper care of their sexual and reproductive health and for healthcare providers to offer a safe and welcoming space for lesbians and bisexual women there is a need for radical change within the field of sexual education. **Yogyakarta Principle 16** on **The Right to Education** sets forth that states need to: "*ensure inclusion of comprehensive affirmative and accurate material on sexual, biological, physical and psychological diversity and the human rights of people of diverse sexual orientations, gender identities, gender expression and sex characteristics in curricula taking into consideration the evolving capacity of a child."*

To be properly aware of their sexual and reproductive health, just like gay and bisexual men and heterosexual men and women, lesbian and bisexual young women and girls need to be properly taught about same sex sexuality.

Conclusion

Properly diagnosing cancers and STIs, and addressing the issue of sexual and domestic violence are only a few of the SRHR issues that concern the wellbeing of lesbian and bisexual women. The goal of this article was to shed light on some of the experiences lesbians and bisexual women face that are not properly addressed on a mainstream level. The lack of funding for both lesbian/bisexual women SRHR-related research and organising leads to a general lack of knowledge and data on SRHR health issues and injustices. Over the past few years, organisations such as the EL*C, the EuroCentralAsian Lesbian* Community, Crips Ile-De-France in France or Rainbow House in Belgium (and many more) have been working on raising awareness and trying to reduce the gaps in knowledge on LB women's SRHR. For instance, the EL*C has produced a Brief Report on discrimination and health on Lesbian* Lives in (parts of) Europe, Crips has produced a wide range of informative media resources on LB women's SRH and Rainbow house has been hosting a "Let's Talk about sex" project, a meeting place for respectful debates on SRH. We hope this article will serve as an inspiration for many SRHR and LGBTIQ organisations to focus further research on lesbian and bisexual women.

It is high time to recognise that restrictive sexual and reproductive rights policies are just as harmful in practice to lesbians and bisexual women, if not even more so, since their access to these rights are a challenge to start with. Moreover, omitting lesbians and bisexual women from the SRHR discourse erases the enormous contributions they have made as advocates fighting simultaneously against all forms (or many at least) of heteropatriarchal oppression. For example, 'Many campaign leaders, activists and organisers in Ireland's abortion rights movement were queer women or queer people capable of getting pregnant.'

Inspire

Breaking Down Gay and Bisexual Men's Healthcare Barriers

A vast majority of sexual and reproductive health programs and policies have been hetero-normative and women centric. Partially due to an initial lack of focus on men's SRH, rigid gender norms and a variety of social factors that over time have defined SRH as a "woman issue", have excluded men and adolescent boys from the SRH conversation. In particular, gay and bisexual men's health and wellbeing have been significantly impacted by this exclusion, being both men and members of the LGBTIQ community (IPPF, 2012). As readers will be able to extrapolate from this article, most of the research and data readily available on gay and bisexual men sexual and reproductive health and rights mostly focuses on curbing the HIV epidemic. When the SRHR community addresses gay, bisexual men and SRHR, it mostly does so in relation to HIV treatment and prevention at times overlooking other sexual and reproductive health needs of gay and bisexual men that start with the lack of access to and availability of SRHR services specialised in men's physical and mental healthcare.

Just like women, men and boys have specific and substantial sexual and reproductive health needs, which include the need for contraception, prevention and treatment of sexually transmitted infections, sexual dysfunction, infertility and male cancers. However, their needs are often unfulfilled due to a lack of service availability, SRH health facilities not

considered ‘male-friendly’, and a lack of healthcare seeking by men (IPPF and UNFPA, 2017).

Most of the existing statistics display a worrisome trend of gay and bisexual (GB) men’s lack of attendance of SRH specific services (IPPF, 2012). This is generally caused by both a lack of GB men’s specific health care services and general SRH clinics and hospital been viewed as female spaces (IPPF, 2012). The wide majority of SRH services focus on female-oriented facilities such as ante, post-natal and maternal care (IPPF, 2012). In a variety of environments service providers miss the opportunities to create “male-friendly” SRH services and especially non-hetero male-friendly SRH services (IPPF, 2012).

Those who have tried to seek help have often endured negative experiences in the health system, by encountering unskilled staff or by learning about the unavailability of men-specific treatment, which has consequently reinforced their lack of willingness to seek help again. The overall lack of training and ill treatment of GB men in health care settings has led to inadequate diagnosis and treatment of men’s SRH illnesses. Since GB men also avoid attending health-care services due to fear and discrimination, it is important to create confidential, friendly and welcoming spaces for them, especially because, as data shows, significant health disparities between GB men and heterosexual men are consistently observed (The Global Forum on MSM & HIV & OutRight Action International 2017).

The goal of this article is to put under the spotlight the many barriers that stand between GB men and adequate access to healthcare, and the extensive negative impact they have on GB men’s sexual, mental and social health. By diving in depth on issues such as STIs, Cancer, Violence, Mental Health and discrimination, it will become clear that there is an urgent need to address and invest on the accurate healthcare measures to ensure GB men’s overall wellbeing.

STIs and Cancer

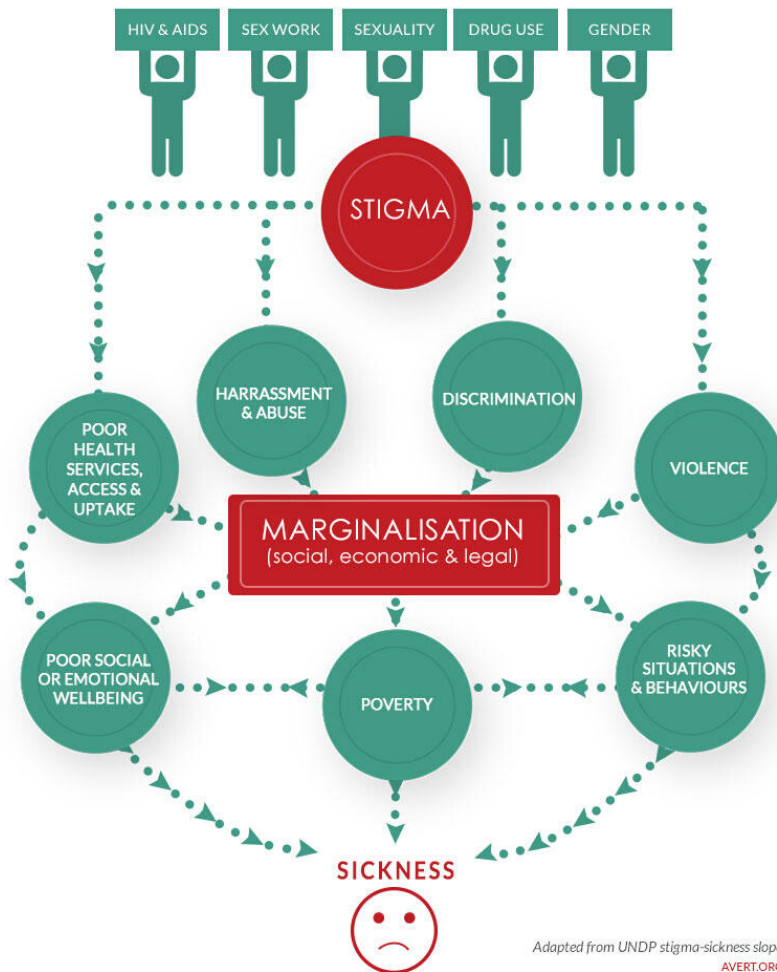
The most common sexually transmitted infections that concern gay and bisexual men are HIV, Syphilis, Gonorrhoea, Hepatitis A and B and Human papillomavirus (HPV). Because of poor healthcare measures, many among the MSM population, suffer disproportionately from health problems especially in the areas of mental and social health.

HIV discrimination and Blood Deferral Policies

The human immunodeficiency virus (HIV) that causes HIV infection and, over time, acquired immunodeficiency syndrome (AIDS), like other chronic diseases has been disproportionately affecting gay, bisexual men and other men who have sex with men (MSM) in all parts of the world (Advancing SRHR for MSM with HIV, 2010).

Historically, the global HIV epidemic has always been closely linked with MSM (Avert, 2019). Although the disease originated decades earlier, the outbreak of HIV and AIDS in the 1980s and early 1990s led to a general panic, which, combined with inaccurate medical diagnosis and irresponsible media sensationalism built up an homophobic narrative that singled out GB men as responsible for the transmission of HIV (Avert, 2019). A 1982 study from the US Center of Diseases and Control, suggested that the cause of the immune deficiency was sexual, and the syndrome was initially called gay-related immune deficiency (CDC, 1982). The general lack of information on HIV, fuelled by homophobia led to decades of stigma and discrimination towards GB men and HIV, a stigma that still permeates today. The great amount of focus and attention towards HIV and MSM, led the discourse around GB men's sexual healthcare to have become HIV-centric, a phenomenon that has negative repercussions towards GB men's health and rights.

Decades of stigma against GB men, led to a sexuality-based blood donation discrimination, where MSM have been classified as high-risk donors. Since the early 1980s, donor deferrals targeting men who have sex with men were implemented as a response to the outbreak of HIV/AIDS in countries like the USA, Germany, Switzerland, the Netherlands, Norway, Hong Kong, Denmark, Finland, France, Mexico, Slovenia, and Iceland. As of 2018, there are still deferral policies in place for blood donation based on a period of abstinence from men who have sex with men (MSM), often of 12 months duration, in jurisdictions like Australia, New Zealand, Brazil, Canada, the United States and many Western European countries such as Finland, Belgium, Ireland, and the Czech Republic (Goldman, Shihm O'Brien & Devine, 2018). Following years of advocacy against blood donation discrimination by organisations such as Stonewall UK, in 2018, the UK's 12-months deferral policy for blood-donation was finally turned into a 3 months deferral policy. France also recently reduced its 12-months deferral policy into a 4 months deferral policy. Nevertheless, some European countries, such as Denmark, Austria and Croatia, still hold a permanent-deferral policy in place.



Overall, MSM living with HIV face double stigma due to fear and ignorance surrounding HIV transmission. This double stigma can cause MSM – both HIV-positive and HIV-negative – to avoid or fear accessing health services, including counselling and testing, treatment, prevention and support (GNP+, 2010). Improving the current situation entails challenging criminalisation, discrimination, and stigma directed at all GB men and other MSM. Moreover, it entails building open, effective and sensitive delivery of information and services, which are tailored to their specific needs and priorities, even within political and cultural environments that are unwelcoming or hostile to GB men and other MSM (GNP+, 2010).

Gonorrhoea and Syphilis

According to a Public Health England report from June 2019, cases of gonorrhoea and syphilis among gay and bisexual men are surging in the UK. syphilis and gonorrhea are two bacterial infections that are transmitted through oral, vaginal and anal sex. According to the Public Health England report (2019), cases of gonorrhoea are the highest on record since 1978 and GB men account for 3 quarters of all syphilis diagnoses in England and nearly half for gonorrhoea. Public Health England argues that this increase may be “driven by behavioural changes” among men who have sex with men. Among these “behavioural changes” Public Health England addressed a specific concern towards the link between STI diagnosis and rise of condomless anal intercourse, ‘chem-sex’ and group sex facilitated by geosocial networking applications (GNas). A 2015 cross-sectional MSM Internet Survey Ireland (MISI) also supported the argument that STI diagnosis among MSM testing for STIs is associated with GSNa use, as well as sexual behaviours.

Chemsex and adressing STIs

Qualitative reports suggest that 'chem-sex' is becoming an increasingly popular practice among some gay, bi and other men who have sex with men (BMJ, 2016). Chemsex refers to gay and bisexual men using any combination of drugs that include crystal methamphetamine, mephedrone (and other cathenones) and/ or GHB/GBL specifically in the context of sexual encounters. These three substances are used in combination to make users feel relaxed and aroused (New Statesman, 2016). The particular inhibition provoked by the drugs can lead bisexual and gay men to have unprotected sex and to sharing needles, reason why public health authorities have been increasingly concerned with the possible link between chem-sex and HIV and other sexually transmitted infection (STI) transmission like hepatitis (BMJ, 2016; New Scientist, 2017). However, attributing this directly to dating apps or changes in sexual practices is only speculative and more research needs to be undertaken in order to understand these interlinkages.

To properly address STIs affecting GB men, there is an urgent need for targeted programs. Given existing differences in health-care access on a gender basis, a possible lack of male-centred knowledge regarding SRH issues, and higher feelings of embarrassment related to being seen at a health centre or discussing concerns about sex and sexuality, leads men to disclose their STI concerns differently. Many may initially refer to their symptoms as a general "headache" without addressing an STI concern (IPPF and UNFPA, 2017). Because of this, it is essential that healthcare providers receive adequate sensitivity training around working with GB men.

Cancer

Studies have shown that gay men are at risk (and in some cases, increased risk) for several types of cancer, including testicular, prostate and anal cancer, with prostate cancer being the most present one found in men (Cancer network, 2010).

Prostate cancer is the most prevalent invasive cancer as it affects nearly one in eight men generally older than 50 (Center for Disease Control, 2018). Despite prostate cancer being the most common cancer in GB men, prostate cancer in GB men is still very under-researched: as of 2016 there were only 30 published articles in English on this issue (a rate of 1.9 articles per year) and most of the literature was limited to case studies or anecdotal reports (LGBT Health, 2016). This is particularly worrying because of some evidence of a link between HIV-positive status and

prostate cancer (LGBT Health, 2016). Based on this admittedly limited literature, GB men appear to be screened for prostate cancer less than other men and even though they are diagnosed with prostate cancer at about the same rate as other men, they have poorer sexual function and quality-of-life outcomes (NBC News, 2018). Men who have sex with men (MSM) are less likely to get regular prostate cancer screenings, and those who are diagnosed are less likely to have familial and social support (NBC News, 2018; American Cancer Society, 2019). Moreover, if their health-care provider is not competent, gay and bisexual men are much less likely to understand how treatment will impact their lives (NBC News, 2018).

Although there are many ways in which these types of cancer can be prevented and treated when identified in time, researchers claim that gay and bisexual men get less routine healthcare than other men (LGBT Health, 2016). Fearing stigma, discrimination and culturally insensitive care, gay and bisexual men tend to avoid accessing both screening and health-care services. This has a significant impact on the health of GB men especially in the case of anal cancer.

Anal cancer is predominantly caused by chronic or persistent human papillomavirus (HPV) infection. HPV infection can lead to the development of anal precancer which, if remains undetected or not adequately treated, may lead to anal cancer (The Conversation, 2017). To avoid being infected with HPV, GB men need to use protection such as condoms. Nevertheless, it is important to point out that HPV can be contracted through skin to skin contact (when the skin around genitalia or the anal area are not covered by condom).

In order to prevent HPV, HPV vaccines are strongly recommended up to age of 26 for men who have sex with men. Moreover, a simple and inexpensive anal Pap test could easily detect the virus (National LGBT Cancer Network, 2019). As a matter of fact, age-specific anal precancer management, including post-treatment HPV vaccination, can potentially lead to an 80 percent decrease in lifetime risk of anal cancer and anal cancer mortality among gay and bisexual men (The Conversation 2017).

Unfortunately, few physicians are performing anal screening exams and offering anal pap smears to gay men, resulting in anal cancer rates as high as those of cervical cancer before the use of routine Pap smears in women (LGBT Cancer Network, 2019). Observed increase in anal cancer is a concern for gay and bisexual men, who are at substantially greater risk for the disease than heterosexual men (Reed et. Al, 2010). Thus, increased screening could play a

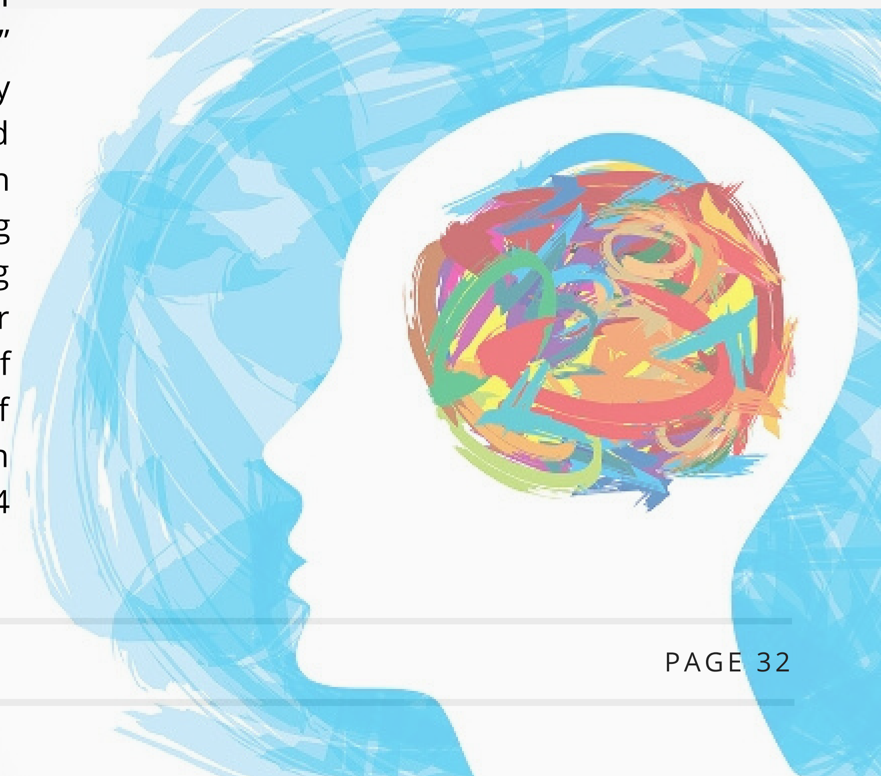
role in anal cancer prevention for gay and bisexual men regardless of whether they receive HPV vaccination. Statistical models suggest that regular screening gay and bisexual men for anal cancer through anal Papanicolaou (Pap) testing (also called anal cytology) would increase life expectancy similarly to other accepted prevention measures, such as cervical cancer screening, and would be cost effective. However, few gay and bisexual men have undergone anal Pap testing (Reed et al. 2010).

Other Health Considerations: Mental Health, Suicide and Sexual Violence.

Living in a homophobic and/or heteronormative society can impact both gay and bisexual men's well-being and mental health (Link, Phelan & Hatzenbuehler, 2018). Overall, the existing literature offers convincing evidence of higher prevalence of mental health problems among LGBTIQ people (Kuyper 2011; Paul et al. 2011). According to a great amount of studies, gay and bisexual men experience higher rates of substance abuse, depression and suicide compared to their heterosexual counterparts (Paul et al. 2011).

Depression is the most common neuropsychiatric complication for people living with HIV, affecting 42 percent of those living with the virus (Nanni et al. 2015). However, HIV is not a catalyst per se as suicide among HIV-positive gay and bisexual men is most likely associated with the stigma, rejection, violence and harassment associated with a HIV-diagnosis (Nanni et al. 2015). Because of their sexual orientation both gay and bisexual men face higher rates of stigma, discrimination and violence, which usually leads to both a higher percentage of substance abuse among MSM and higher risks for depression (Psychology Today, 2018).

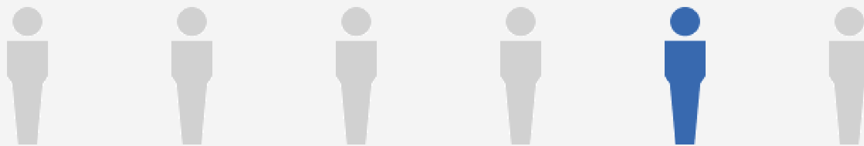
Factors such as verbal and physical harassment, negative "coming out" experiences and lack of family acceptance, substance use and isolation of gay and bisexual men and youth all contribute in leading to higher rates of suicide among gay and bisexual men (Cancer network, 2010). A British survey of gay men found that 50 percent of those who experience depression had contemplated suicide and 24 percent had already attempted to



take their own lives because of low self-esteem or homophobic bullying (Paul et. al, 2011). The high rates of depression, substance abuse, and suicide tendencies amongst gay and bisexual men are especially worrying because suicide itself has been considered the biggest killer of men under the age of 45 in several countries (BBC Future, 2019). Studies across the world have consistently shown that male suicide rates are several times higher than females (American Foundation for Suicide Prevention, 2019).

Lack of public awareness around depression and suicide among men, lack of research on the issue and general reluctance of men in accessing health-services and seeking help, further emphasise the concern that mental well-being among GB men has yet to be addressed effectively (BBC Future, 2019).

Sexual and Intimate Partner Violence



"At least 1 in 6 men have been sexually abused or assaulted."

Source: https://1in6.org

Sexual and intimate partner violence is another factor that negatively impacts gay and bisexual men's psyche and mental health. Sexual violence affects every demographic and every community including men.

According to 1in6 (2019), one in six men has experienced or will experience some form of sexual violence assault in their lifetime. Historically, male sexual assault has been shrouded in secrecy and stigma, reason why many male survivors never report their assault out of fear of being blamed for their own attack, being disbelieved, ridiculed, shamed, accused of weakness or ignored (AASAS, 2019).

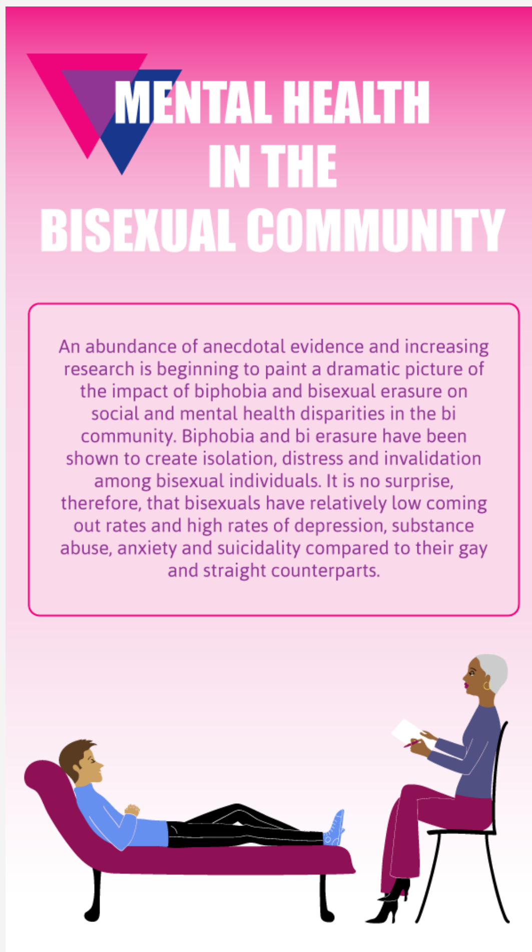
Besides experiencing many of the same feelings and reactions as other survivors of sexual assault, many men and boys who have been sexually assaulted or abused may also face additional challenges because of social attitudes and stereotypes about men and masculinity (AASAS, 2019). Additionally, there is a general lack of recovery services and support groups for male survivors and law enforcement and justice systems are often ill-equipped to deal with this type of crime when it is committed against men (AASAS, 2019).

Because of this, the reporting rate for male survivors of sexual assault is even lower than the already-low rates of reports by females (AASAS, 2019). Gay and bisexual men experience sexual violence at similar or higher rates than their heterosexuals counterparts (Human Rights Campaign, 2019; John Hopkins Medicine, 2019).

However, gay and bisexual men rarely talk about their experiences of both sexual and intimate partner violence and are mostly hesitant to seek help because they fear discrimination from supposed support mechanisms such as the police, hospitals, shelters or rape crisis centres (Human Rights Campaign, 2019). Even in cases where survivors of violence choose to report the assault experienced, intersections between systems of inequality, discrimination and absence of accessible LGBTIQ-affirming services, lead to most of these crimes going unpunished and to an increased marginalisation of gay and bisexual men survivors (NSVRC, 2012).

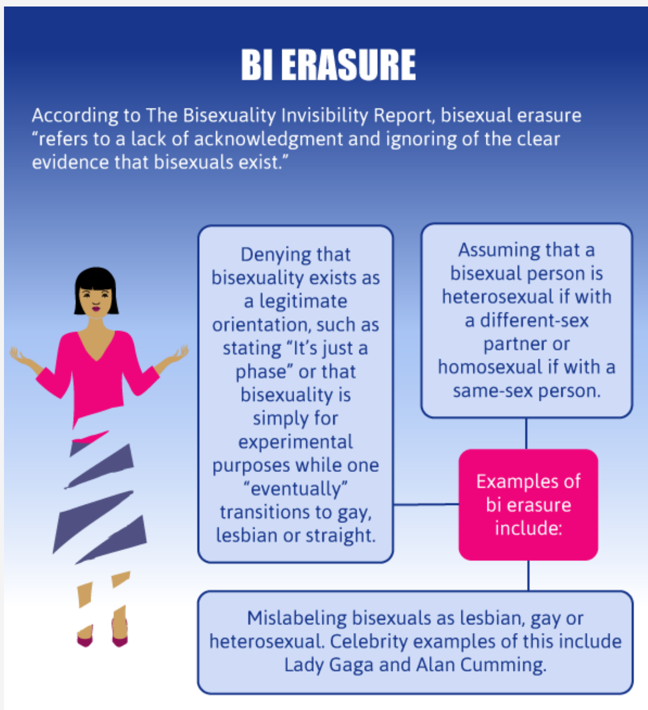
Bi erasure

Besides facing the same amount of stigma and discrimination as gay men, bisexual men often endure specific prejudicial attitudes. As a matter of fact, there are several myths and prejudices that surround bisexual men.



Besides facing the same amount of stigma and discrimination as gay men, bisexual men often endure specific prejudicial attitudes. As a matter of fact, there are several myths and prejudices that surround bisexual men. Many, deny bisexuality as a sexual orientation, rather defining bisexuality as a steppingstone before “fully” identifying as gay (Bustle, 2016). Others, believe that bisexual men are sexually greedy, confused, less inclined towards monogamous relationship and not able to maintain long-term relationships (Zivony & Lobel, 2014, Bustle, 2016, Pride, 2016).

Overall, bisexual men are constantly faced with both social stereotypes and public and political invisibility (McLean, 2007; Ochs, 1996; Rust, 2002; Eliason, 1997; Steinman, 2000). Denial of bisexuality as a sexual orientation combined with harmful



stereotypes towards bisexuality and assumptions of one's sexual orientation based on the gender of their current partner, leads to increased invisibility and marginalisation of bisexual men (Barker et al. 2012a, b; Diamond 2008; Eliason 1997; McLean 2008; Rust 2002). These marginalisation processes often operate unintentionally in a "taken-for-granted world" and socially exclude people who are not part of the mono-normative world (Kitzinger 2005, p. 478; Robinson 2012). Bisexual men are rarely represented by the media and their issues remain relatively unknown to the general public, which eventually leads to even higher rates of health issues and inequalities (Barker, 2007; Miller, Andre, Ebin, & Bessonova, 2007). Compared to gay and lesbian-identified people, bisexual-identified people are less open about their sexual orientation to people in their social network, report more internalised homonegativity, report more mental health problems, score higher on suicidality, and show lower LGB community identification and community involvement (Barker et al. 2012a; Cox et al. 2010, 2011; D'Augelli et al. 2005; Herek et al. 2010; Kertzner et al. 2009).

The Right to Health and the Right to Education as cornerstones

According to **Yogyakarta Principle 17**, the **Right to the Highest Attainable Standard of Health** "*Everyone has the right to the highest attainable standard of physical and mental health, without discrimination on the basis of sexual orientation or gender identity.*" **YP 17** also stresses that: "*Sexual and reproductive health is a fundamental aspect of this right.*"

Because gay and bisexual men face even higher risks of contracting HIV, STIs or contracting cancer, as **YP 17** stresses, States need to *"ensure that all persons are informed and empowered to make their own decisions regarding medical treatment and care", "ensure that healthcare facilities, goods and services are designed to improve the health status of all persons without discriminations and that medical records are treated with confidentiality" and "ensure that all sexual and reproductive health, education, prevention, care and treatment programmes and services respect the diversity of sexual orientation and are equally available to all without discrimination".*

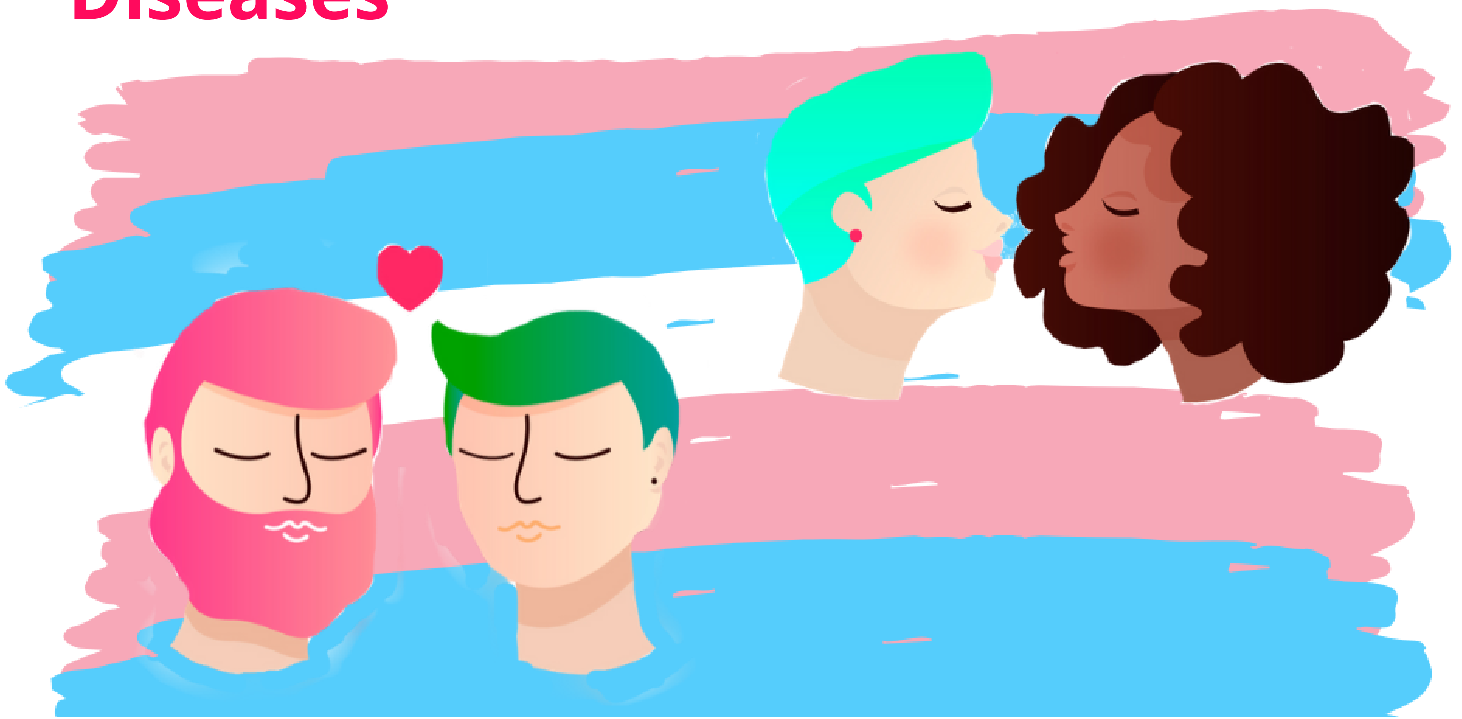
In order to achieve this, there is an urgent need to create an environment that specifically addresses gay and bisexual men's different SRH needs (IPPF, 2012). Both staff and SRH-care service providers should be trained to both be knowledgeable about gay and bisexual men's needs and to create a safe and welcoming environment for them to access without the fear of stigma and discrimination (IPPF and UNFPA, 2017). Moreover, a wide range of SRH-related services should be offered to address issues from HIV and other sexually transmitted infections to positive prevention, noncommunicable conditions (such as male-specific cancers), sexual dysfunctions, family planning, and parenting choices. Moreover, in order to help gay and bisexual men attain higher standards of mental health, service providers should also be able to refer clients to related services, such as harm reduction, mental health and/or other social services (IPPF, 2012).

Finally, for both gay and bisexual men and healthcare service providers to be knowledgeable of GB men sexual and reproductive health and care, there is a need for radical change within the field of sexual education. Yogyakarta Principle 16 on "The Right to Education" sets forth that states need to: "ensure inclusion of comprehensive affirmative and accurate material on sexual, biological, physical and psychological diversity and the human rights of people of diverse sexual orientations, gender identities, gender expression and sex characteristics in curricula taking into consideration the evolving capacity of a child."

Conclusion

It is high time to recognise that restrictive sexual and reproductive rights policies are just as harmful in practice to gay and bisexual men, if not even more so, since their access to these rights are a challenge to start with.

De-pathologising Trans-people: WHO removes transgender as mental disorder from the International Classification of Diseases



In 1980, the third Diagnostic and Statistical Manual of Mental Disorders (DSM-III) introduced the disparity between anatomical sex and gender identity as a psychopathological condition of gender identity disorder. Ever since, this psycho-medical classification of trans persons' identities as pathological has justified violations of human rights at every turn.

Over the years, this institutionalised transphobia has impacted trans-people's access to safe and adequate health care; reinforced stigma and discrimination, and has accounted for an indefinite amount of violence, harassment and abuse.

The ICD-11: The World Health Organisation (WHO) finally de-pathologizes trans identities

During the 72nd World Health Assembly (WHA), taking place from 20 – 28 May, the World Health Organisation (WHO) officially adopted the 11th Revision of the International Classification of Diseases (ICD-11).

Up until now, the International Classification of Disease, a standard diagnostic tool published by WHO, listed what it defined as "transsexualism" and other "gender identity disorders" in the chapter of mental and behavioural disorders.

In May, finally, all trans-related categories were deleted from the ICD Chapter on Mental and Behavioural Disorders. Instead, it has introduced new trans-related categories in another section of the ICD, namely, Chapter 17 on Conditions Related to Sexual Health, introducing "Gender Incongruence of Adolescence and Adulthood" and "Gender Incongruence of Childhood". This means that from May 2019 on, the WHO no longer categorises trans or gender diverse persons as individuals with a mental disorder.

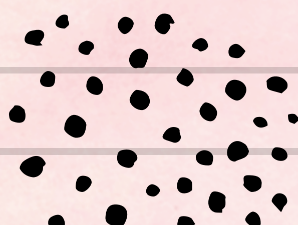
The recent victory that came with the de-pathologization of trans identities in the ICD-11 was not an easy battle to win. Until the 1950s, homosexuality and gender identity disorder and associated conditions were not singularly taken into consideration but mixed together and all regarded as forms of sexual perversion. After the 1950s, sexologists and doctors started to refer to the disparity between anatomical sex and gender identity as the psychopathological condition of gender identity disorder. Since then, diagnostic tools such as the DSM and the ICD started to used the diagnostic name of "gender identity disorder" in their manual.

The term was first officially introduced in the DSM-III in 1980 and later adopted by the ICD-10 in 1990. Since the ICD is only periodically updated, for over 29 years, trans activists have been campaigning to make sure that trans identities would effectively be de-pathologized when the latest version of the ICD, the ICD-11 would be published.

Although this is a landmark achievement for trans activists, there are many social and legal barriers to break in order to achieve full de-pathologization and inclusivity of trans and gender diverse people.

Over the many years of campaigning, trans activists have emphasised the necessity to remove trans-related categories from the list of mental disorders. Failing to do so meant condoning human rights violations perpetrated against trans persons.

Joining the activists' cause, the UN and trans activists have for long denounced violations against trans people such as forced sterilisation, non consensual genital surgery, lack of legal gender recognition, harassment, violence and discrimination in the areas of education, employment and of access to healthcare and justice.



A Human Rights Issue

Trans activists have pointed out that trans rights have somewhat been too scarcely discussed in the context of international human rights law. According to them, international human rights law should universally ensure that trans rights are upheld at State level.

The 2006 Yogyakarta Principles for example, have set the perfect example in showing why trans rights are fundamental and undeniable human rights that every individual should enjoy.

The Yogyakarta Principles

Yogyakarta Principle 18, the principle of **"Protection from Medical Abuses"** and **Yogyakarta Principle 31**, **"the Right to Legal Recognition"**, are two examples of how international human rights law applies to trans-people.

YP 18 sets forth that:

"*No person may be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity. Notwithstanding any classifications to the contrary, a person's sexual orientation and gender identity are not, in and of themselves, medical conditions and are not to be treated, cured or suppressed."*

Moreover, **YP 31** marks that:

"*Everyone has the right to legal recognition without reference to, or requiring assignment or disclosure of, sex, gender, sexual orientation, gender identity, gender expression or sex characteristics. Everyone has the right to obtain identity documents, including birth certificates, regardless of sexual orientation, gender identity, gender expression or sex characteristics. Everyone has the right to change gendered information in such documents while gendered information is included in them."*

The current situation of SRHR related Trans-Rights in Europe & Central Asia.

Transgender Europe (TGEU) publishes a yearly map on Trans Rights in Europe and Central Asia. As it can be seen analysing the 2019 map, 36 countries in Europe and Central Asia still require a mental health diagnosis before trans persons can have their identity documents adapted. Such a requirement violates the right of every person to self-determine their gender identity.

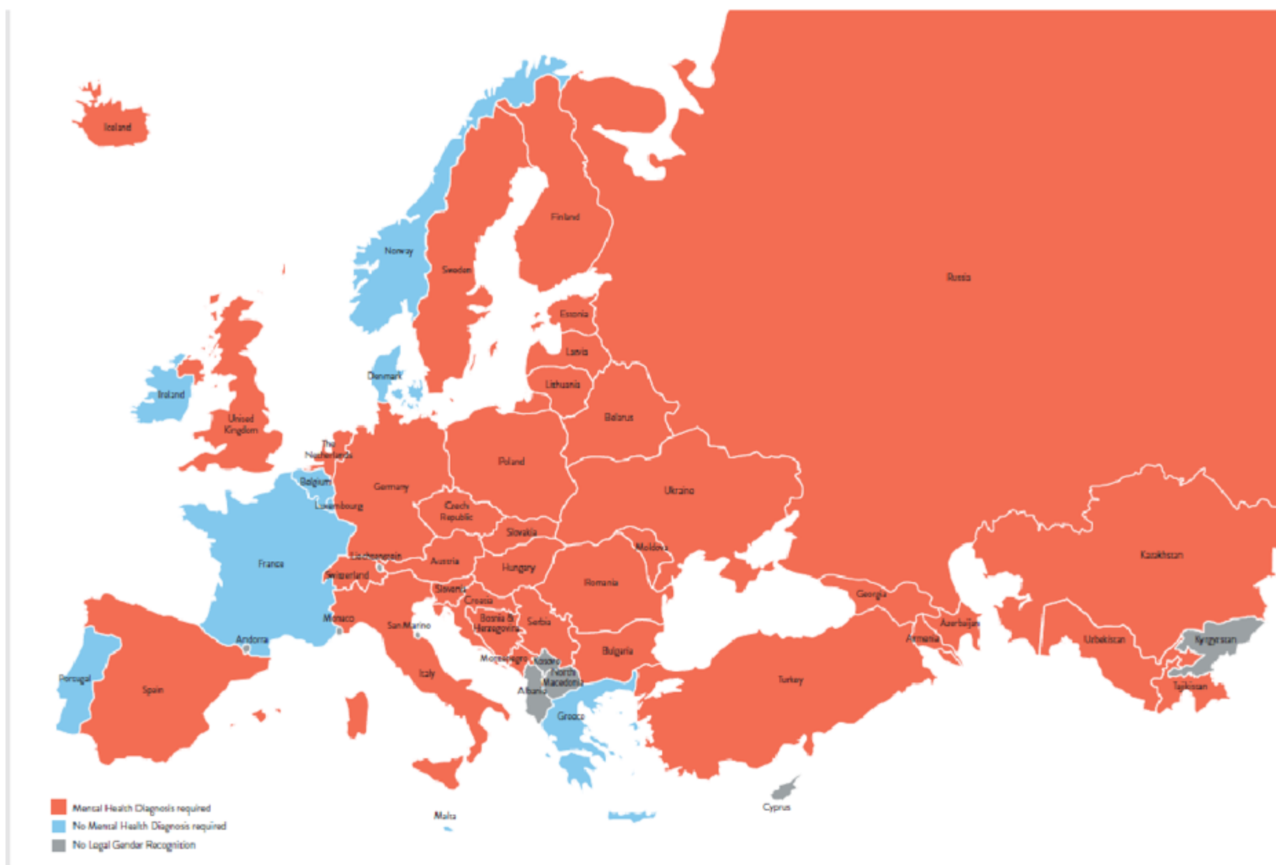
A mandatory diagnosis further drives stigma, exclusion and discrimination as it relies on the false notion that being trans is a (mental) illness.

Unfortunately, this is not all. At the moment:

- 16 countries still require sterilisation of trans persons seeking recognition of their legal gender recognition;
- 4 countries (only) recognise the gender identity of a trans parent;
- 19 countries (only) offer express protection against discrimination in healthcare;
- 2 countries (only) prohibit conversion therapy on ground of gender identity.

TRANS RIGHTS EUROPE & CENTRAL ASIA MAP 2019

36 countries in Europe and Central Asia require a mental health diagnosis in legal gender recognition.



Source: *Trans Rights Europe and Central Asia Map 2019, Transgender Europe,* *https://tgeu.org/trans-rights-europe-central-asia-map-index-2019/,* *Retrieved 18.11.2019*

***Source, Forced Sterilisation Europe and Central Asia Map 2019, Transgender Europe, https://tgeu.org/wp-content/uploads/2019/05/MapB_TGEU2019.pdf** Retrieved 18.11.2019*

***Source: Trans Rights Europe & Central Asia Index 2019, Transgender Europe, https://tgeu.org/wp-content/uploads/2019/05/index_TGEU2019.pdf**, Retrieved 18.11.2019*

Preliminary Conclusions

Although the WHO's de-pathologisation of trans identities should have a positive impact on future implementations of trans rights in national and international settings, the current-dire situation of trans rights in Europe and Central Asia, calls for collective action to ensure that Sexual and Reproductive Health and Rights are accessible to trans and gender diverse people across the region.

The ICD-11's removal of trans-identities as mental disorder should be the first of many steps taken in order to definitely remove cisnormative and harmful gender stereotypes. Ensuring that legal gender recognition is accessible without medical requirements, is one of those many steps.

In order to ensure that trans and gender-diverse people can fully enjoy their fundamental rights and gain full equality, we encourage partners and allies in the SRHR community to join forces with the LGBTIQ community in order to increase information exchange and build SRHR projects inclusive of trans and gender diverse people. We also encourage the SRHR community to develop language and approaches going beyond cisnormativity and binary understandings of gender.

The need for a trans-specific focus within SRHR

The 72nd World Health Assembly (WHA), taking place from 20 – 28 May 2019 marked a historical moment for human rights, LGBTIQ rights and, in particular for the trans and gender diverse people as a whole. During this Assembly, the WHO officially adopted the 11th revision of the International Classification of Diseases (ICD-11), in which trans-identities were taken out of the list of mental disorders.

As we explained in the previous article, WHO's move to de-pathologize trans people should play a decisive role in future national and international implementation of trans rights. However, looking at the current state of trans people's access to rights across the world, it is clear that there is a great amount of work to be done in order for trans and gender diverse people to truly enjoy the same fundamental human rights as their cisgender counterparts.

In this article we discuss ways to be more inclusive of trans and gender diverse persons in SRHR work.

The need for a trans-specific focus within SRHR

Historically, human reproduction, reproductive health and reproductive practices have focused on cissexism. In its recent publication, “Gender Identity and Reproductive Autonomy”, GATE (Global Action for Trans* Equality), emphasises that the reproductive practices of transgender and gender queer people are almost invisible both in transgender studies and in reproductive health studies. According to GATE, reproductive health studies have “mainly focused on whether or not trans people should be offered assisted reproduction services and/or fertility preservation before starting medical transition. Also, in the context of discussions regarding procreative liberty, trans individuals have until recently been neglected in such discourse.”

In May 2019, Alabama’s decision to impose the strictest US abortion ban (including in case of rape or incest), revived a global debate on abortion. One of the flaws attached to this discussion is that trans and non-binary people continue to be excluded from the conversation.

While giving a graduation speech at Pitzer College, actress Laverne Cox pointed out that framing the right to abortion as a (cis)-women’s rights issue, automatically erases trans men from the discussion *(watch the inspirational speech here)*. This particular case shows that there is an urgent need to go beyond a cisnormative binary understanding of SRHR. Only by conducting more research on trans reproductive health and taking into account the lived experiences of trans men, women and gender diverse people, the SRHR field can be truly inclusive.

When individuals, communities and advocates exclude trans men and women from conversations around pregnancy, abortion, contraception etc., they inevitably make reproductive health yet another obstacle that trans-people have to overcome.

Naomhán O’Connor, Communications Officer at **GATE** (Global Action for Trans* Equality) points out that stigma against trans men, coupled with misinformation and institutionalised transphobia, makes attaining safe and adequate health care incredibly difficult:

“In most social settings trans people are forced to conform to binary gender ‘norms’ that deny us the right to pursue, or express our desire for, genetic parenthood. This includes trans men/trans masculine people becoming pregnant, and trans women/trans feminine people impregnating another person. With regards to the right to not have a child, unwanted pregnancies can affect trans men and trans masculine people in a similar way to how it can affect ciswomen. However, in addition to issues with accessing abortion and accessing consented sterilisation, trans people who become pregnant can face further difficulties. ”

"What if I were a transgender man? And I find myself a trans man, all of a sudden pregnant, unintentionally, and all of the language, and all of the policies, and everything that's been designed is about people who identify as women.
If I have to terminate that pregnancy, I go to a health care facility and I'm presenting as someone who appears to be male who identifies as male, and the health care practioners have no understanding, no idea of how to handle this situation.
If I were that trans man, I would really want to have language that incorporated and included my experience.
Thinking about this reminded me that language is also a place of struggle but that isn't just about being politically correct. This is not just about virtual signalling, that when we use language that exclude groups of people on pertinent issues it can jeopardize their health and well-being.
As you go out in the world you are going to be faced with a lot of difficult decisions, a lot of things that will make you uncomfortable, that are complicated and nuanced issues and sometimes you might just want to keep it simple and just focus on one part of the issue and say leave a group of people out. What I would like to remind you of today is that when we are leaving people out we are not really doing the work to be inclusive."

Laverne Cox,
Pitzer College Commencement Keynote, 2019

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The historical institutional psycho-pathologization of trans and gender diverse people combined with a general lack of focus and information about trans and gender diverse people from the SRHR community, have also resulted in little-to-no funding for research that focuses on the sexual and reproductive health of trans people. In the meantime, the small research data that is available, points out that there is an urgent need for a SRHR focus on trans and gender diverse people's health and rights.

The Need for increased research & Information Sharing

According to the research available, trans men are reported to avoid getting pap smear tests, which could account for the higher instances of cervical cancer identified in trans male populations. In addition to this, trans men and AFAB (assigned female at birth) nonbinary people can still develop breast cancer even after top surgery and/or while taking testosterone. It is essential to note that the current research about trans men and breast cancer, is only based on case-to-case reports. There is a lack of data available around the frequency of breast cancer amongst trans men.

Another reproductive health concern is caused by both a lack of and spread of misinformation on the necessity of birth control for trans men when on hormone replacement therapy (HRT). Transmasculine persons, who can get pregnant, should be offered similar contraceptive methods as their cis female counterparts. Testosterone is not a form of birth control. Because transmasculine persons can become pregnant even while on testosterone (a teratogen), it is important for medical professionals to make sure that their patients are accurately informed about their contraceptive options. Since there are no contraindications to concomitant use of oestrogen/progesterone with testosterone, it is important to inform transmasculine persons that they can indeed make a safe use of hormonal contraceptives.

These are just some of many reproductive and sexual health concerns of trans men, women and non-binary people. In order to make SRHR inclusive of trans people, advocates, policy makers and researchers should jointly collaborate in social, cultural, legal and political settings in order to break local, national and global barriers.

The Right to be Intersex

Intersex individuals have been and are being subjected to recurrent sexual and reproductive health and rights violations across Europe and the rest of the world. Being individuals born with sex traits and characteristics that 'do not fit' medical and social norms for female and male bodies, they are one of the communities, whose life has been profoundly impacted by the "man" and "woman" dichotomy and by a structurally cisgender and heteronormative society.

The United Nations reported that there have been as many as 131 million people born with intersex traits, which amounts to at least 1.7% of the population (ILGA Europe & OII Europe, 2019).

Throughout the decades, the fundamental human rights of intersex individuals have been repeatedly violated, as they have been subjected to coercive "normalising surgeries" and medical interventions since infancy, have endured everyday discrimination and have been stigmatised for not conforming to the established societal dichotomy (Carpenter, 2018).

Ever since the first protest against medical harm to intersex people on the 26th October 1996, activists have called for the end to sexual and reproductive health and human rights violations towards intersex people (Advocate, 2019).

Although some international policies, acts and statements have recently pushed for an end to medical abuse, intersex communities across Europe have yet to witness the implementation of promises made on their behalf.

As the intersex movement reclaims its rights to bodily autonomy, self-realisation and an end to stigmatisation, it is essential for the SRHR community to be a strong ally.

Who is an intersex individual?

"Intersex' stands for the spectrum of variations of sex characteristics that naturally occur within the human species. In the past two decades, the term has been reframed and established by intersex human rights defenders and their organisations as the human rights-based umbrella term use to describe a wide range of natural bodily variations. (IGLYO, 2018).

Intersex individuals are born with sex characteristics that do not fit medical norms of male or female bodies. Intersex people's sex characteristics and bodies are healthy variations of the human sexes. For some intersex people, their intersex body becomes visible at birth, for some during childhood and with others their body shows itself to be intersex during adolescence or even adulthood.

Coercive Medical Interventions

Intersex people recurrently lack the protection needed for their right to health across Europe and the rest of the world (ILGA, 2019). Their right of bodily autonomy is recurrently violated by ongoing harmful medical practices, intersex genital mutilation (IGM) and other human rights violations on the basis of sex characteristics (ILGA Europe & OII Europe, 2019). Due to a huge lack of information, Europe is still not a safe place for intersex people, as no other European country besides Malta, has enacted provisions to ensure the physical integrity, bodily autonomy and self-determination of intersex individuals is protected (Ghattas, 2015).

Intersex people are routinely subjected to unnecessary and non-consensual "normalising surgeries" which often lead to irreversible consequences such as genital insensitivity, sterility, chronic pain, urinary infections and malfunctions, massive internal and external scarring, osteoporosis, life hormone replacement therapies and repeat surgeries, as well as trauma and depression (Cabral Grinspan, 2019; Carpenter, 2018).

It is essential to point out that there is not clinical evidence or consensus that support the need of such coercive practices (Cabral Grinspan, 2019). Clinicians tend to present so called “normalising surgeries” such as clitoridectomies, vaginoplasties and labioplasties as lifesaving and medically necessary procedures. These procedures are usually presented by doctors as painless, harmless and positive solutions designed to prevent subsequent psychosocial suffering and difficulties in integrating within society (Cabral Grinspan, 2019). However, it has been widely reported that such cosmetic surgeries can cause physical and psychologically suffering and procedures such as removing testes and ovaries result in involuntary sterilisation which will then require lifelong hormonal replacement therapy (Open Society Foundation, 2019; ILGA Europe & OII Europe, 2019). As a matter of fact, a 2007 clinical Germany study showed that out of the 439 intersex adults whom had undergone surgeries, two-thirds of adults linked sexual problems to those surgeries (Carpenter, 2016). On the contrary, an increasing number of intersex people who have not had medical interventions are leading healthy and happy lives free from physical, sexual and reproductive impairment (IGLYO, 2018).

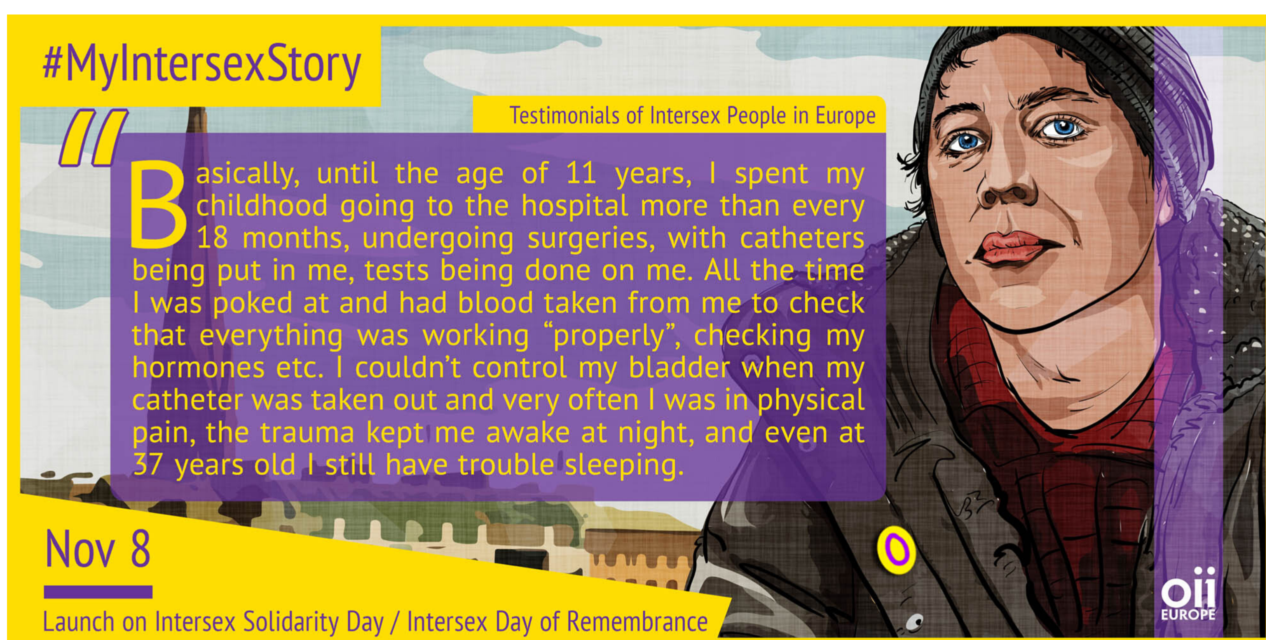
Despite this growing evidence, many doctors continue to hold on to ethical guidelines for interventions that suggests that the body of a human being needs to fit the notion of male and female that persists in society as a norm (ILGA Europe, 2017). When a body does not fall within these two categories, guidelines suggest that immediate sex assignment surgery can prevent the psychosocial risk of the consequences of being raised with “non-conventional” sex traits (Carpenter, 2016). According to a ground-breaking 2015 FRA focus paper on the fundamental rights situation of intersex people in the European Union, ‘normalising’ surgery have been reported to being carried out on intersex children in at least 21 EU member states (ILGA Europe, 2017).

Shortly after childbirth, parents are usually subjected to heavy pressure from authoritative figures like doctors, who urge the parents to opt for an immediate “normalising” surgery in order to fix the sex of the baby within infancy (Open Society Foundations, 2019). Parents of intersex babies are often ill-informed by professionals who present “corrective surgery” as a positive “normalisation” of the child. Often, parents are pressured to make an urgent decision shortly after childbirth, which is not a rational time to make such an impactful decision on the life of your child (IGLYO, 2018).

Of course, there are specific cases in which immediate medical intervention may be necessary: when a child is born with a closed urethra (where urine cannot leave the body), immediate surgery might be needed to prevent the child’s body from poisoning; or in the case of salt wasting, which can occur with a bodily variation called Congenital Adrenal Hyperplasia (CAH), when immediate medical intervention is needed to substitute the lacking minerals within the child (IGLYO, 2018).

However, immediate intervention is unlikely to be necessary or urgent in the case of removal of gonadal tissue (the tissue of which the testis and ovaries are made) or in the case of genital surgeries (IGLYO, 2018).

Genital Surgeries, are often carried out cosmetically to have genitals that look like they fit better in a society as male or female, to have a sexual life by having genitals that function according to societal expectations, to reproduce and to have a family (Intersex child year). Such practices are often referred as Intersex Genital Mutilation (IGM), an intervention performed on a healthy intersex body which is performed when, according to societal and medical notions, a person's external genitals do not look "normal" enough to pass as "male" or "female" genitals (ILGA Europe & OII Europe, 2019).



While IGM and Female Genital mutilation (FGM) share many common characteristics, the way in which they are legally addressed within Europe varies widely (ILGA Europe & OII Europe, 2019). For example, clitoral cutting is considered female genital mutilation, a harmful practice and a form of gender-based violence, which is prohibited in many countries. However, when clitoral cutting is performed in feminising interventions through clitoridectomies and related genital surgeries in IGM, the same laws do not apply to intersex girls (Carpenter, 2016).

Thankfully, there is now a growing awareness among practitioners that surgeries should be postponed to when children grow up and are able to make their own informed decision over the self-determination of their body (ILGA Europe & OII Europe, 2019). Nevertheless, there still exists a tendency within the medical establishment to consider early cosmetic treatment as beneficial for intersex children with XX-chromosomes and a CAH26 diagnosis (Ghattas, 2015).

Access to Sexual and Reproductive Healthcare Services

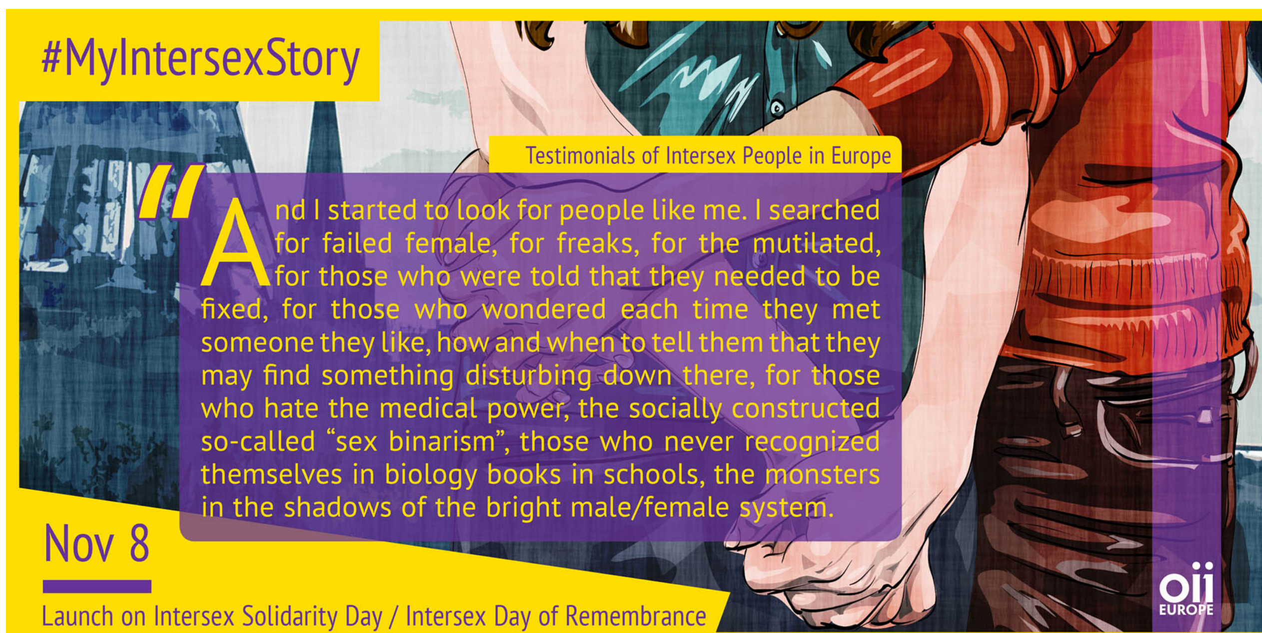
Embedded discrimination and stigmatisation of intersex people combined with decades of ongoing medical abuses has significantly influenced intersex people's access to both general and sexual and reproductive healthcare services.

Recurring disbelief, prejudices and lack of knowledge of healthcare professionals has significantly hindered intersex people's willingness to seek healthcare. When intersex individuals do try to access healthcare, they encounter several barriers such as fear of discrimination and (re) traumatising experiences. This, is often caused by health professionals' lack of training and severe lack of knowledge on intersexuality. Moreover, across Europe, OII Europe and its member organisations have also reported that healthcare professionals have denied intersex people access to health services.

Structural Societal discrimination of intersex people

The current failing state of intersex body rights, combined with rooted structural societal conceptions around the meaning to be a "man" and/or a "woman", have led to a further social isolation of intersex people throughout their everyday life.

Generally, society does not recognise the existence of intersex people, as their existence itself challenges social norms and understandings of sex and gender as binaries (Dazed Digital, 2019). Intersex people and their traits are (almost) never discussed within a sex education curriculum in school, and the lack of awareness surrounding them, leads to the development of feelings of shame or secrecy especially within school environments. The perhaps, visible differences of their sex characteristics have been reported to lead to higher instances of bullying, which is one of the many reasons why intersex people are reported to increasingly dropping out of school. Everyday indirect discrimination based on their physical appearance or gender expression is reinforced within employment, casual social interactions and inaccurate gender recognition (Ghattas, 2015).



Reccomendations

Ensuring the respect of the rights of bodily integrity of intersex people, should be a priority of sexual and reproductive health and rights movements, as the full respect of intersex health have been proven to have been repeatedly abused.

The elimination of harmful practices, the right of intersex people not to undergo medical intervention for social and cultural reasons must be recognised, while intersex people should be ensured the right to make autonomous and informed decisions on their body. In order for a significant change to occur, forefront organisations such as OII Europe and ILGA-Europe have recommended the creation of a law, which protects a person from any non-emergency interventions on the person's sex characteristics until such person is mature enough to express their wish for surgical or other medical intervention and provide informed consent. Only such a legislation would be capable of ending the violation of the bodily integrity of intersex people and ensure their right to self-determination (ILGA Europe & OII Europe, 2019).

However, change should not be solely relied on actuating legislative measures, but also on ensuring the development of a welcoming and empowering society where intersex people can grow without the fear of not fitting in. For such change to happen, there is an urgent need for specific training on bodily diversity for both school staff, health practitioners, social services, police officers, prosecutors, judges, lawyers and all relevant professionals, so that they provide inclusive quality services and address discrimination where it occurs (ILGA Europe & OII Europe, 2019). Moreover, establishing obligatory and comprehensive up-to-date training for medical

professionals, such as doctors, midwives, psychologists and other professionals working in the health sector should also be essential to ensure that intersex individuals and families have overall access to adequate healthcare (ILGA Europe & OII Europe, 2019). Intersex individuals' protection should also be focused on supporting parents, who could need counselling to avoid societal pressure and make informed decision on what truly entails the overall wellbeing of their child (ILGA Europe & OII Europe, 2019).

Another recommendation to improve the current state of intersex rights, revolves around the importance of raising awareness on intersex rights issues. The general lack of knowledge on intersex people and their characteristics is one of the key reasons for the human rights violations and the discrimination intersex people endure. Integrating the "I" into the conversation is essential to speak about bodily diversity, to provide comprehensive medical information on the health of intersex individuals and to ultimately convey the message that having an intersex body is none other than a natural variation in sex development that does not need to be modified (ILGA Europe & OII Europe, 2019).

Even though intersex led advocacy groups and NGOs should be at the heart of the work to ensure intersex body rights, the SRHR community should support intersex groups through research, funding, by joining expertise to assist them with strategies with helping them create new alliances. In order for these organisations to be appropriately supported, funding and addressing research gaps are two key components for integrating intersex into the SRHR world (ILGA Europe, 2017). Sustaining organisations through funding and developing fact finding research to build information and knowledge should be viewed as priorities to advance the rights of intersex people.

The Importance of Education

Like it has been previously implied, knowledge and education are essential foundations to ensure the fulfilment of human rights.

To make informed decisions on their body and to grow up in an empowering environment, intersex people need a comprehensive education free from misogyny, homophobia and transphobia (Teen Vogue, 2019).

Within a school setting, intersex people are not included in educational curriculum, and when they are, they are often mentioned as products of mythology (hermaphrodite) while sex education itself does not refer to their existence or their bodily experience. Growing up in a dichotomous heteronormative society, individuals are taught to view sex as a penetrative act, and that “penis to vaginal sex” is the only (or most important way) in which they can be sexual beings (Teen Vogue, 2019).

When intersex individuals are constantly told that they need to be fixed in order to fit in, be normal or experience "pleasure", they are forcibly pressured into consenting to a surgery that they may not truly want (let alone need). In order for individuals to truly make informed decisions on their bodies, they should be educated on the existence of more than two biological sexes in a positive and empowering way (Teen Vogue, 2019). A sex positive sex education that teaches about bodily diversity, gender fluidity and all comprehensive sexual anatomy is not only essential for intersex youth to make informed decisions on their body, but also for non-intersex individuals to flourish in an inclusive, empowering and non-discriminatory environment (Huffpost, 2015; GALE, 2016). Because of this, education should be extended not only to students but also to teachers, parents and doctors.

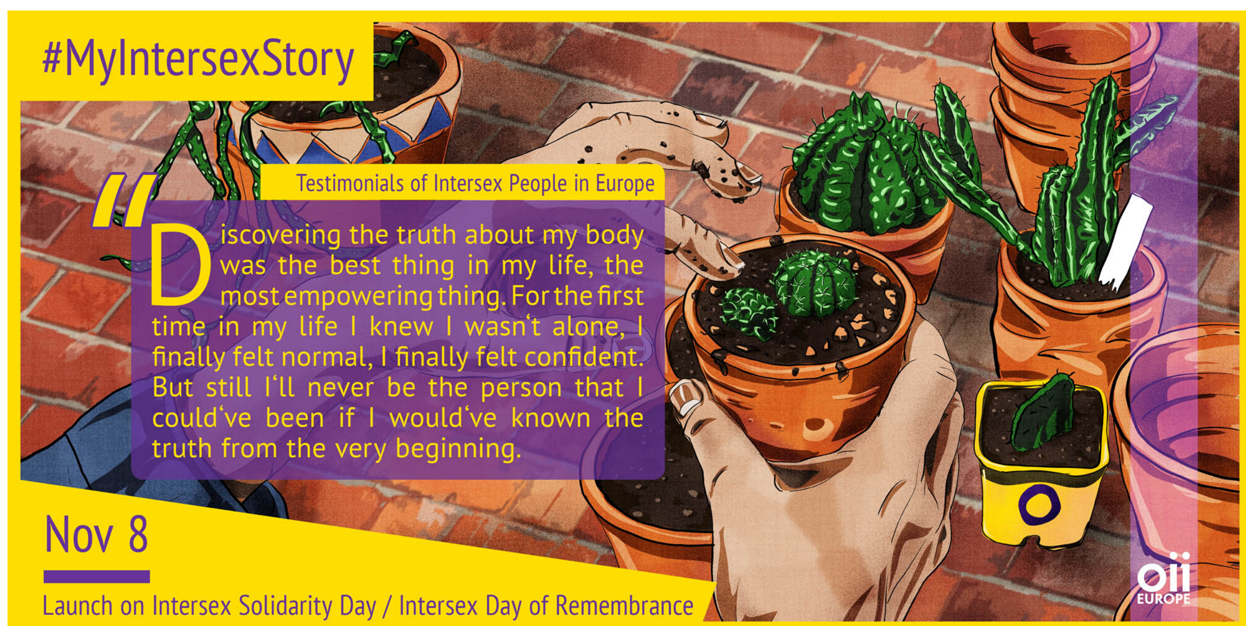
Legal steps towards the fulfilment of Intersex rights

Over the past few years national and international intersex advocates have drafted and formulated statements, measures and resolutions that can help States and Regions to put all of these recommendations into law. Amongst these, the 2015 Maltese Gender Identity, Gender Expression and Sex Characteristics Act, the 2013 landmark Malta Declaration, the 2014 Riga Statement and the 2017 Vienna Statement, thoroughly summarised the demands and objectives of the actions that need to follow to ensure the protection of intersex rights (ILGA Europe & OII Europe, 2019).

The Maltese Act, adopted in April 2015, is currently the leading example of best practice worldwide on how to ensure the protection of intersex individuals. The Act provides protection on the ground of sex characteristics in equal treatment legislation and in anti-hate crime and hate speech provisions in the Criminal Code. Importantly, the bill outlaws any "medical intervention which is driven by social factors, without the consent of the individual concerned" (Ghattas, 2015).

On a European level, earlier on the 14th February 2019, the European Parliament set an unprecedented standard within the European Union by adopting a resolution on the rights of intersex people, which stipulated that European Union Member States should legislate better policies that protect intersex individuals, especially from unnecessary surgery, discrimination and violence (Inspire, 2019).

This resolution finally called for better support for intersex children, for more research, training and funding and called for the prohibition of sex "normalising" surgery and other treatments practised on intersex children without their informed consent in national law among their respective Member States (Watermark, 2019). As of now, on a national level only Malta (2015) and Portugal (2018) have established protections for intersex people from violations of their bodily integrity and, together with Greece (2016), protection against discrimination on the ground of "sex characteristics". (For more information on the historic resolution, you can access the full document *here*).



Protection, Truth, and the right of Bodily Integrity as cornerstones of Intersex Sexual and Reproductive Rights

in terms of international human rights law, the Yogyakarta Principles constitute a fundamental supporting document to further the needs of a comprehensive legislation that ensures the rights of intersex people. As **Yogyakarta Principle 18 Protection from medical abuses** sets forth:

"No person may be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity. Notwithstanding any classifications to the contrary, a person's sexual orientation and gender identity are not, in and of themselves, medical conditions and are not to be treated, cured or suppressed."

Because intersex people, are at high risk of coercive non-consensual medical interventions, states shall "take all necessary legislative, administrative and other measures to ensure that no child's body is irreversibly altered by medical procedures in an attempt to impose a gender identity without the full, free and informed consent of the child in accordance with the age and maturity of the child and guided by the principle that in all actions concerning children, the best interests of the child shall be a primary consideration".

To further the Yogyakarta Principles, 10 additional Principles were provided in the 2017 YP plus 10 document, to further recognise the distinct and intersectional grounds of gender expression and sex characteristics. In particular, **Yogyakarta Principles 32** and **37** settled fundamental measures that need to be implemented to protect the sexual and reproductive health and rights of intersex people.

As **Yogyakarta Principle 32**, **The Right to Bodily and Mental Integrity** sets forth:

"everyone has the right to bodily and mental integrity, autonomy and self-determination irrespective of sexual orientation, gender identity, gender expression or sex characteristics. Everyone has the right to be free from torture and cruel, inhuman and degrading treatment or punishment on the basis of sexual orientation, gender identity, gender expression and sex characteristics. No one shall be subjected to invasive or irreversible medical procedures that modify sex characteristics without their free, prior and informed consent, unless necessary to avoid serious, urgent and irreparable harm to the concerned person."

Moreover, according to **Yogyakarta Principle 37**, **The Right to Truth:**

"*every victim of a human rights violation on the basis of sexual orientation, gender identity, gender expression or sex characteristics has the right to know the truth about the facts, circumstances and reasons why the violation occurred. The right to truth includes effective, independent and impartial investigation to establish the facts, and includes all forms of reparation recognised by international law. The right to truth is not subject to statute of limitations and its application must bear in mind its dual nature as an individual right and the right of the society at large to know the truth about past events."*

Conclusion

It is high time to recognise that dichotomous social-cultural norms on sex characteristics have been the source of decades of human, sexual and reproductive rights violations.

The current dire situation of intersex rights across Europe and the world calls for an urgent need to support intersex rights organisations to jointly make the sexual and reproductive conversation queer and inclusive.

Training the medical community to escape from preconceived ideas of sex traits is essential to ensure a safe and welcoming space where intersex people can affirm their rights (Carpenter, 2016). Joining forces to ensure a structural social change over the pathologisation and stigmatisation of intersex bodies and ensure that effective implementation of policy and change in the clinical practise, should remain a priority of the both the intersex and SRHR community (Carpenter, 2016).

As SRHR organisations, we need to escape from recurrent heteronormative and cisgender dichotomies and review our discourses and narrative around sexual and reproductive health in order to make the conversation all inclusive. Because of this, the SRHR community should work jointly with the intersex community to ensure the full realisation of sexual and reproductive rights of every individual.

We would like partners and allies in the SRHR community to take these issues on board, and to fight for all, let's work together on queering SRHR, to make it as inclusive as possible and to go beyond the binaries.

Together let's work on Queering SRHR!

*On behalf of **OII Europe,** Inspire invites all intersex organisations, intersex people and intersex allies to sign on to the Vienna Statement. Be and ally and fill in this form: https://www.surveymonkey.com/r/signvienastatement*

Conclusion

In May 2019, Inspire decided to launch the report 'Queering Sexual and Reproductive Health' to raise awareness on the many barriers that stand between the LGBTIQ+ community and access to healthcare and respectful treatment. In particular, the goal of the report was to fill the gaps in LGBT-centered SRHR programs scrutinising how a dichotomous, cisgender and heteronormative discourse surrounding healthcare plays an effect on this community.

When analysing the language used within organisations and healthcare facilities and when discussing SRHR and those affected, it became clear that the general discourse around SRHR is often times tainted by heterocentric / binary systems that prevent LGBT people from accessing the care they need and to fully realise their sexual and reproductive health and rights.

While analysing in depth the SRHR of lesbian and bisexual women, gay and bisexual men, trans men and women and intersex people, it soon became clear that there are serious gaps that need to be addressed by the SRHR community through a holistic approach.

Even though significant progress has been made towards the inclusion of SRHR for LGBTIQ people on both a social and legal level, it is essential for SRHR organisations to develop and lead on programmes that look at the rights of individuals taking into account all different intersections. To do so, it is not only important to raise awareness and to address the SRHR issues that affect this community, but also to contribute through funding, research and collaboration.

Inspire hopes that the "Queering SRHR" Report will serve as a starting point for SRHR partners, actors and organisations to take on these issues in collaboration with concerned communities in order to align programs with actual needs.

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An Inspire SRHR Partnership Original Report.

All the original graphics present in this report have been designed using ***Free Pik*** *Vectors*

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