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Sexual and gender diversity in SRHR

Towards inclusive sexual and reproductive health & rights through mainstreaming

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1 Mainstreaming as a pathway to change

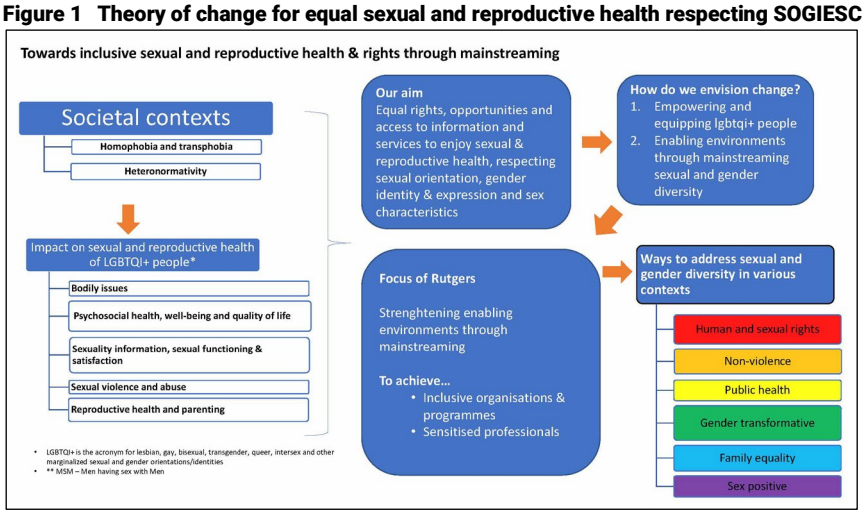
The term sexual and gender diversity refers to the broad variation in *sexual orientations*, *gender identities, gender expressions and sex characteristics*, also abbreviated as SOGIESC[1]. These variations are of all times and societies (Herdt 1997). Not everyone feels attracted to another sex or prefers another sex partner. Not everyone feels comfortable with the sex assigned at birth or with the expected gender role behaviour for men and women in their society. Not everyone is born with bodily sex characteristics that are wholly female or male, according to the norms in society.

Since many societies are homophobic and transphobic, or at least share a societal norm of privileging heterosexuality, LGBTQI+ people are vulnerable to being stigmatised, marginalised and excluded. LGBTQI+ is the acronym for lesbian, gay, bisexual, transgender, queer, intersex and other marginalised sexual and gender orientations/identities that is becoming commonly used in progressive international NGO contexts. Heteronormativity, the norm of heterosexuality, can impact on LGBTQI+ people's sexual and reproductive health and impede their full access to services, information and support. It can limit their opportunities to choose and live with their preferred partner(s), which ultimately prevents them from living to their full potential.

Rutgers upholds the right of everyone to enjoy a healthy sexual and relational life and to experience their own sexuality in a positive, safe way, free of coercion, discrimination, stigma and violence. We believe that people should be free to make sexual and reproductive choices, respecting the rights of others, in supportive societies.[2] Due to homophobia and heteronormativity, LGBTQI+ people can experience a lack of sexual and reproductive rights, specific sexual health problems and limited access to information and services. Attention must be paid to SRHR in relation to sexual and gender diversity. We aim for equal rights, opportunities and access to enjoy sexual and reproductive health and its related information and services *for all people*, respecting SOGIESC. This also includes freedom of partner choice and acknowledging relational diversity.

There are two pathways of change to improve SRHR respecting SOGIESC (Figure 1). The first pathway centres on empowering and equipping LGBTQI+ people and their communities and organisations to improve their sexual and reproductive health. The second pathway focuses on transforming mainstream societal, organisational and professional environments from homophobic, transphobic, heteronormative spaces into enabling environments that are open to and support and serve people respecting SOGIESC. We recognise the importance of both pathways of change and their complementarity.

Figure 1 Theory of change for equal sexual and reproductive health respecting SOGIESC



[1] Paraphilias are not comprised in the concept of sexual and gender diversity. Paraphilias are atypical sexual interests or preferences for specific activities or erotic goals or objects. Examples are BDSM, voyeurism, fetishism and paedophilia.
[2] Rutgers's strategy for 2017-2020 (https://www.rutgers.nl/sites/rutgersnl/files/PDF/20170726_Rutgers-Strategie_NL_LR_DEF.pdf).

Internal and external mainstreaming are twin strategies to create enabling environments. Mainstreaming sexual and gender diversity refers to the integration of a sexual and gender diversity perspective as a cross-cutting issue into the preparation, design, implementation, monitoring and evaluation of SRHR policies, regulatory measures, programmes and budgetary decisions, with the aim of promoting equality and inclusiveness on SOGIESC and combating discrimination. *Internal mainstreaming* focuses on organisations' policies and staff attitudes, behaviour and knowledge. *External mainstreaming* can be applied in programmes, research or advocacy in order to meet the needs and rights of all people respecting SOGIESC.[3] Successful mainstreaming focuses on organisations and programmes as well as sensitised professionals.

Rutgers is an SRHR organisation that combines a) programme implementation aimed at professionals and local partner organisations, b) research and c) advocacy. Because of our core principles of inclusivity and equality and our focus on professionals and organisations, our expertise lies in the second pathway of change: mainstreaming sexual and gender diversity to create enabling environments that are inclusive to all people. According to Rutgers, mainstreaming as a pathway to change will lead to SRHR programmes, information and services that provide inclusive SRHR, respecting SOGIESC, which is beneficial to the sexual and reproductive health of LGBTQI+ people. Rutgers aims to mainstream sexual and gender diversity through integrating the needs and rights of LGBTQI+ people in research, comprehensive sexuality education, service provision, community mobilisation, lobby and advocacy programmes.

One strength of mainstreaming is that it targets structural and fundamental change at the environmental and societal level while addressing both majority and minority people at the same time. However, we also acknowledge the risk of 'awaystreaming': when mainstreaming is not structurally embedded and is perceived as a mere technical process, the political processes that potentially transform existing (heteronormative|) power structures can remain untouched to avoid hostile or dissenting voices (Charlesworth 2005; Frobisher 2016). Despite the fact that many SRHR organisations feel sympathetic towards principles of inclusivity, equality and diversity, the practice of creating enabling environments through mainstreaming requires explicit attention.

In this paper, we first address the variety of legal and cultural contexts in relation to SOGIESC. Strategies to mainstream sexual and gender diversity will be different in societies with state-sponsored homophobia and transphobia compared to societies that promote legal equality. In the current global climate where the acknowledgement of sexual and gender diversity can be a sensitive issue, the use of concepts and language is important and evolves rapidly. Therefore, our paper presents up to date language used by international NGOs and provide the basic concepts on SOGIESC and related evidence-based prevalence. Subsequently, we present the most important themes on the sexual and reproductive health of LGBTQI+ people. The positive health model is useful to offer a positive and holistic view on health that acknowledges the relationship between health and environment. The impact of harming and non-inclusive environments on sexual and reproductive health is further elaborated by the concept of minority stress. We provide strategies for mainstreaming sexual and gender diversity in SRHR programmes and organisations that have been shown to be effective and we present examples based on our international and national work. Successful mainstreaming requires being sensitive to contexts and cultures and we introduce six ways to address sexual and gender diversity to create attention for inclusive SRHR, realise LGBTQI+ people's SRHR and mobilise support for mainstreaming sexual and gender diversity.

[3] The definitions of mainstreaming build upon previous Rutgers programmes and contributions in Share-Net Netherlands (2018) and SRHR Alliance (Bakker, Reinders, & Hofs 2016).

2 Homophobia, heteronormativity and diversity

Promoting inclusive SRHR through mainstreaming focuses on creating enabling environments. It is important to take into account that legal and cultural contexts relevant to sexual and gender diversity vary greatly. For example, sensitising healthcare professionals requires different messaging in an environment where homosexuality is criminalised or pathologised compared to an environment where homosexuality is legally accepted, yet remains marginalised.

Mapping the environment is an essential first step in mainstreaming sexual and gender diversity in SRHR programmes. This requires knowledge about the legal context, existing cultural attitudes and norms (see Knowledge file Culture, Religion and SRHR), understanding the difference between homophobia, heteronormativity and diversity and recognising intersectionality.

Legislation

Legislation on SOGIESC can be divided into criminalisation, protection and recognition (Carroll & Mendos 2017). The mapping of ILGA World on the legal situation of countries shows the following picture (October 2017[4]). At one end of the spectrum, there are 72 countries in which homosexuality is criminalised and 8 of these allow the death penalty to be enforced. In several countries there is growing opposition to equal rights for LGBTQI people and political support to further criminalise or deny the presence of LGBTQI+ people in their country. Eighty-five states have protection laws on one or more areas to protect LGBTQI+ people from discrimination or hate speech (e.g. constitution, employment, hate crime).

At the other end of the spectrum, there are countries that promote equality for all their citizens, respecting sexual orientation, gender identity and expression and sex characteristics. Twenty-four states allow same-sex marriage; 47 states recognise same-sex marriage and/or partnership and/or adoption. Some countries, including the Netherlands, consider it their duty to not only protect the sexual rights of their own citizens but also invest in improving SRHR of LGBTQI+ people in other countries.

In relation to SRHR, criminalisation of same-sex behaviour can severely impact access to SRHR services and information, because of legal sanctioning. For healthcare providers with positive or neutral attitudes, concerns may be raised as to whether they act illegally when offering services to LGBTQI+ people (see Knowledge file Culture, Religion and SRHR).
Legal definitions of family, marriage and parents are relevant too. For example, if sexual behaviour is only allowed in the context of marriage and procreation, it can be difficult to live openly with a same-sex partner, for LGBTQI+ people to be recognised as legal parents or to travel as a family, etc.

In the last decade, international and regional human rights instruments have become more important as an arena to fight for human rights for *all people* and to hold countries accountable to protect all citizens. A new chapter in the recognition and implementation of existing international human rights instruments is the UN Human Rights Council's appointment of the Independent Expert on Sexual orientation and gender identity on protection against violence and discrimination based on SOGI in 2016 (A/HRC/RES/32/2)

Cultural norms and attitudes

Feeling free and safe to openly express and live corresponding to one's sexual orientation, gender identity, gender expression and sex characteristics does not only depend on states' legislation. People's attitudes and cultural norms are important too. Attitudes are not only individual opinions but are embedded in societal and political structures (Kuyper, Iedema & Keuzenkamp 2013). See also Knowledge File Culture, Religion and SRHR.

[4] See this ILGA world map [https://ilga.org/maps-sexual-orientation-laws] for an overview of sexual orientation and gender identity laws per country in October 2017.

Three stages may be distinguished in relation to the level of equality and inclusivity on SOGIESC in societies and communities:

Homophobia and transphobia

In homophobic and transphobic societies, sexual and gender diversity is explicitly and openly regarded as a negative phenomenon. In such societies, violence, discrimination, exclusion and rejection are common and often institutionalised by the state. LGBTQI+ people are often considered a threat to family values or traditions. In homophobic and transphobic societies, information on SOGIESC in the media, education and religious communities is often limited to non-evidence based messages labelling homosexual people as psychiatrically ill or being a danger to society. In these societies it is relatively challenging to develop neutral or positive attitudes. The Knowledge File Culture, Religion and SRHR presents how Rutgers operates and works on sensitive issues including sexual and gender diversity in conservative societies.

Homophobia (and transphobia) can be manifested in two different ways (McCormack & Anderson 2014). In cultures that reflect *homoerasure*, homosexuality is erased and silenced through social and legal persecution. In such societies, identity politics are challenging and many LGBTQI+ people are likely to conceal their sexual orientation, gender identity or preferred gender expression. In cultures that express *homohysteria*, homophobic attitudes are strongly vocalised and people are policed into heterosexual behaviour and expressions; *homohysteria* achieves this through severe moral sanctioning of gender nonconforming people, accusing them in an offending and stigmatising way of being gay or lesbian, which is regarded as morally despicable. The moralistic disciplining of men to be masculine and heterosexual and fundamentalist messages that 'homosexuality is un-African' fall under this category. Homohysteria is present, for example, in Russia and Uganda. Particularly in societies characterised by homohysteria, there is an increased anti-homosexuality movement that has repercussions for the safety of LGBTQI+ individuals, organisations and communities (Beyrer 2014). The growing homophobic and transphobic backlash should be contextualised in terms of globalisation, global power shifts and anti-Western sentiments. In some homophobic non-Western countries, 'gay rights' are framed by anti-gay conservative communities and movements as an imposition of Western standards - with 'gay rights' as the ultimate example - upon non-Western countries as a new form of imperialism or neo-colonialism (Chang 2014; Gross 2013). This backlash goes hand in hand with a growing opposition to progressive SRHR in parts of the world (Council of Europe 2017). The Council of Europe (2017) addressed a trend that in some European countries existing protections of women's SRHR are being eroded and that laws and policies are being adopted that seek to roll back established entitlements. In light of globalisation, we note that to interpret pro- versus anti-gay values as the liberal West/North versus the conservative South/East is too simplistic. This polarisation does not reflect variety within societies and neglects long histories of colonialism (e.g. in several African and Asian countries homophobic legislation was imported and imposed by colonisers) (Duyvendak et al. 2016).

Due to discrimination, criminalisation and (self)-stigmatisation, LGBTQI+ people who experience homophobia, biphobia or transpobia can feel pressure to go 'underground' and have sexual encounters and relations with same-sex people below the radar. Homophobia and transphobia can impede LGBTQI+ people's access to information and SRHR services, not only because of lack of LGBTQI+-specific information and services, but also because of fear of discrimination and lack of support (Beyrer 2014; The Global Forum on MSM & HIV & OutRight Action International 2017). Their secrecy could also put them and others at risk or in vulnerable positions, since they cannot articulate or be open about their SRHR-related needs and demands.

Heteronormativity

In many moderately or progressively liberal countries, societies could better be characterised as heteronormative. Violence and discrimination may occasionally occur, yet are not institutionalised or supported by the general population. Homosexuality and being transgender are not generally devalued as unnatural, pathological, immoral, or unhealthy. In these societies, homosexuality is or has become *normalised* (Seidman, Meeks & Traschen 1999). Tolerance of homosexuality can be high in these societies. Nevertheless, in the mainstream of these societies, heterosexuality remains the norm and is implicitly or explicitly expected. In such societies, prejudice is more likely to be

subtle, yet can still have structural impact on LGBTQI+ people (Cramwinckel, Scheepers & Van der Toorn 2018). Examples of subtle prejudice are implicit negative attitudes, mild negative emotions, absence of positive behaviours and denial of prejudice (Cramwinckel et al. 2018). Strategies to reduce prejudice require different approaches for blatant versus subtle prejudice (Cramwinckel et al. 2018; Felten, Emmen & Keuzenkamp 2015; Felten & Vijlbrief 2018).

The Netherlands provides a good example of a liberal, heteronormative society. It has come a long way in the acceptance and equal justice treatment of lesbian, gay, bisexual and transgender people. In 2001, the Netherlands was first to open marriage to same-sex couples. A minority of the Dutch population openly reports negative attitudes towards homosexuality (6%) and gender diversity (9%) (Kuyper 2018). However, Dutch society remains heteronormative in nature and there remain many challenges. Family law is not equipped to provide full recognition of families in all their diversity. The grounds gender identity, gender expression and sex characteristics are in the process of being included in equality legislation.

Living in a homophobic or heteronormative society can affect people's health. LGBT people consistently report less perceived and actual safety and a lower sexual, psychosocial and mental health compared to heterosexual people (Van Lisdonk & Nikkelen 2017; Kuyper 2011, 2016, 2017, Sandfort et al. 2014). There is overwhelming evidence that stigma, victimisation and discrimination impact on health (see the minority stress model in Chapter 4). Stigma is 'a deeply discrediting attribute (Goffman 1963), also described as 'a social identity that is deeply devalued in a particular social context (Crocker, Major & Steele 1998). Stigma encompasses power dynamics and lowers social status, which is a fundamental cause of health inequality (Link, Phelan & Hatzenbuehler 2018).

Heteronormativity can impede LGBTQI+ people to access high quality information and SRHR services, because information and services may not be inclusive and tailored to the needs of LGBTQI+ people (The Global Forum on MSM & HIV & OutRight Action International 2017). Stigma and lack of adequate information and services could explain why even in societies with high levels of self-reported tolerance among its population, health disparities between LGBT and heterosexual cisgender people are consistently observed. Since the norm of heterosexuality centres on the notion that people are sexually oriented to people of the 'other psex/gender', it endorses the notion of two sexes and genders. Therefore, people who transgress the boundaries of male/man or female/woman categories can suffer from social sanctioning, including non-binary, transgender and intersex people. Attitudes on transgender issues are generally positive in the Netherlands, yet 45% agree that it is important for them to know the gender of someone they first meet (Kuyper 2018).

Sexual and gender diversity

In societies that embrace sexual and gender diversity, variations of sexual orientation, gender identity and gender expression are celebrated. In such societies, conceptualisations of sexual orientation and gender go beyond the binary of heterosexual or homosexual, masculine or feminine, man or woman. This allows for a critical reflection on patterns that reproduce heteronormativity or limit diverse expressions (Richardson & Monro 2012). Among young cosmopolitan people in liberal countries, there are growing spaces such as open-minded parties, festivals and communities, to express sexual orientations and gender in all their diversity. Some of them call themselves 'post-gay', since they perceive their sexual orientation to no longer be an essential marker or identity in their lives (Savin-Williams 2005).

Intersectionality

A post-gay life is not within reach for everyone. The normalisation of same-sex sexuality is more difficult for LGBTQI+ people who challenge expectations that intersect with heteronormativity, for example expressing gender in a non-conforming way, having a non-binary gender identity or not being exclusively oriented to one gender (hetero/homo thinking) (Van Lisdonk 2018).

Access to a post-gay life is also limited by the intersecting power dynamics related to social characteristics and stigmatised statuses, such as race, social class, ethnicity, nationality, religion, age, disability and illness, that all affect or define the positions and opportunities of LGBTQI+ people. The populations at relatively high risk of stigmatisation and victimisation that are prioritised by

Rutgers and other similar NGOs include young and older LGBT people and LGBT people who have a bi-cultural, refugee or migrant background (See Knowledge file Culture and Religion]). Internationally, we observe that NGOs focus more prominently on gay men and MSM over other populations in the LBTQI+ spectrum. Populations who are marginalised and invisible in the Netherlands are bisexual, non-binary, and intersex people, and LGBTQI+ people living in rural areas or with disabilities.

3 SOGIESC: Concepts and prevalence

LGBTQI+ and SOGIESC

In relation to sexual and gender diversity, we adopt international NGO language and current academic concepts. Those people who do not conform to normative sexual and gender orientations, identities and expressions are often referred to as lesbian, gay, bisexual and transgender people, or by the acronym LGBT. In human rights advocacy, LGBTI is becoming more standard (where the I stands for intersex people). We have observed that LGBTQI+[5] is becoming common in progressive international NGO contexts and we adopt this acronym to refer to all sexual and gender diverse people. When referring to research among populations, we will as a principle adopt the terms used by the authors.

In response to the need to point to universal rights and to be even more inclusive of all people, the acronym SOGIESC[6] (sexual orientation, gender identity and expression, sex characteristics) is increasingly used in human rights contexts. The acronym SOGI – for sexual and gender identity – gained international recognition through the launch of the Yogyakarta Principles on SOGI in 2007 (Narrain 2017). Soon after, gender expression and sex characteristics were added to the acronym.

One of the strengths of SOGIESC is that it refers to grounds that apply to all people: everyone has a sexual orientation, a gender identity and expression and has sex characteristics. In the Netherlands, SOGIESC grounds were used in the proposed Act for a new Equal Treatment Law that was recently passed to the Dutch Senate for further debate (last update 2018, July 22).
The term LGBTQI+ is useful to address the specific experiences and needs of sexual and gender minorities. It should be born in mind that LGBTQI+ can be associated with identities or activism, while not all people under the LGBTQI+ umbrella affiliate with LGBTQI+ identities, activism or movements. Hence, sometimes SOGIESC is a more neutral term to use.

Rutgers adopts SOGIESC terminology in relation to SRHR for all people, respecting the grounds of SOGIESC. We and refers to LGBTQI+ people to address specific issues or subgroups.

Sexual orientation, gender identity, gender expression and sex characteristics are separate concepts. Nevertheless, they are also strongly interrelated. For example, many stereotypes about lesbian and gay people are based on the cultural notion that heterosexual men should be masculine and masculine men are assumed to be heterosexual, with equivalent patterns for women. Hence, in many societies gay men are often depicted as 'not real men' or un-masculine, and feminine-looking men or masculine-looking women are assumed not to be heterosexual.

To address SOGIESC and to make SRHR more sensitive and inclusive to SOGIESC issues, it is important to be familiar with standard terminology used by NGOs. Here we present current standard terminology and provide prevalence based on Dutch studies.

Sexual orientation

Sexual orientation describes a person's capacity for profound sexual and/or romantic attraction to, and intimate and sexual relations with others; those may be individuals of a different gender, the same gender or more than one gender. *Heterosexual* people are consistently (sexually and/or romantically) oriented to people of a different gender than their own**.** Homosexual people, or *gay* (for men) and *lesbian* (for women) people, are consistently (sexually and/or romantically) oriented to people of the same gender as their own. People who are consistently (sexually and/or romantically) oriented to more than one gender are referred to as bisexual people**.**

Sexual orientation consists of several dimensions, such as attraction, sexual behaviour, self-identification and relationships. Individual's experiences can differ between dimensions and can

[1] Q for queer and + for other marginalized sexual and gender orientations/identities. Other letters that are sometimes added in progressive contexts and communities are Q (questioning), A (asexual), P (pansexual).
[6] The Dutch equivalent is SOGIESK: seksuele oriëntatie, gender identiteit, gender expressie en sekse kenmerken.

change over time. For example, some self-identified heterosexual people have sexual encounters with or feel attracted to people of the same gender.

The overarching term for sexual orientations to people of the same sex or gender is 'same-sex sexuality'. It is important to note that expressions of same-sex sexuality can be culturally specific, ranging from lesbian and gay identities, through rites of passage that entail same-sex practices in several African and Asian cultures (Herdt 1997; Sandfort et al. 2015; Morgan & Wieringa 2005), to modern 'rainbow' families. Sexual orientation labels and the connotations of labels vary across cultures. For example, 'homosexual' is considered derogatory in many Anglophone contexts, while it is generally not perceived as offensive in Dutch society.[7] The list of sexual labels and practices is immense, including queer, pansexual, tomboy, mati, heteroflex, same gender loving, genderblind, ancestral wives, questioning.

To be mindful of the discrepancies between same-sex sexual behaviour and openly identifying as lesbian, gay or bisexual (LGB), it is common to talk about MSM (men who have sex with men) or WSW (women who have sex with women) instead of LGB people when addressing sexual health issues, particularly in homophobic societies and in the context of HIV/AIDS programming.

It is difficult to estimate the number of same-sex oriented people in the world. Depending on research method, sexual orientation dimension, wording of questions and level of underreporting, the prevalence of same-sex sexuality differs between studies. Consistently, studies report higher levels of same-sex attraction and same-sex behaviours than of an LGB identity (Gates 2011; Kuyper 2016; Nikkelen & Vermey 2017). For the Dutch population, it is estimated that 4 to 6% of Dutch people are to some extent same-sex attracted (Kuyper 2016). Among Dutch youth between 12-24 years 7% of young men and 9% of young women report same-sex attraction to some extent (Nikkelen & Vermey 2017). Of the young men, 11% had ever had sex with a man, 3% identified as gay, 2% as bisexual and 4% were unsure how to identify. Of the young women, 10% had ever had sex with a woman, 1% identified as lesbian, 3% as bisexual and 5% were unsure how to identify (ibid).

In countries with high levels of homophobia, it is difficult to collect reliable data on same-sex sexuality since underreporting is expected to be high. Nevertheless, since same-sex sexuality is a universal reality there is no reason to assume substantially lower estimates of same-sex orientations in these countries. Yet, due to hostile or non-accepting environments, same-sex sexuality is less visible and less expressed in public life.

Gender identity

Gender identity refers to a person's deeply felt internal and personal experience of gender. Many people identify as man/boy, woman/girl. Other gender identities include trans man, trans woman, non-binary gender (i.e. a gender that is neither man or woman or is both), gender fluid, transsexual, transgenderist, genderqueer, gender variant, third gender, bahkla, hijra and genderless.

A person whose gender identity fits the sex assigned at birth is called cis-gender (with 'cis' meaning 'on the same side'). This applies to the majority of people. A person whose gender identity is different from the sex assigned at birth, is referred to as transgender. They may or may not wish to openly live in congruence with their felt gender identity. Some transgender people remain 'in the closet'. Transgender people who transition socially (e.g. in name, clothes, manners) and/or medically (hormone treatment, surgery) sometimes, but not always, call themselves transsexual. Typically, transgender people ultimately seek to make their gender expression match their gender identity, rather than their sex assigned at birth. Transgender people can have any sexual orientation.

In several countries such as Sweden, the USA and the Netherlands, transgender movements have introduced gender-neutral nouns and pronouns that fit the needs of non-binary people. Examples in

[7] ORAM (Organization for Refuge, Asylum & Migration) developed a useful language tool on international SOGIESC-related terminology for the humanitarian sector with many concepts defined in English, French, Turkish, Farsi and Arabic (2016).

English are ‘they’ used as a third person singular pronoun and derivative forms ‘them’ or ‘their’. In Dutch *hen, die* and *hun* are equivalents.

According to Dutch studies, approximately 0.6-0.7% of adults and secondary school pupils have transgender feelings (Kuyper & Wijsen 2014; Kuyper 2017; Scholte et al. 2016). The prevalence of people who experience their gender identity as being somewhere on the gender spectrum, gender fluid or who are not sure is higher: in the Netherlands studies report 1.7% of young men and 2.9% of young women aged 12-24 (Nikkelen & Vermeij 2017).

Gender expression
Gender expression refers to how people express their gender to the world, such as through names, clothes, hair, body posture, how they walk or speak, communication, societal roles and behaviour. Gender expressions are often interpreted as “masculine” or “feminine”. Similar expressions may have other interpretations between cultures. There are many terms for people who do not conform to societal norms of what is expected of men and women, including gender nonconforming, gender diverse gender variant, androgynous, genderless, agender, genderflex, gender fluid and genderqueer.

Sex characteristics and intersex
Sex characteristics are bodily characteristics people are born with or develop later in life, such as genitalia, anatomical features, body shape, hormones, chromosomes etcetera. Based on fysical sex characteristics at bith, a person’s sex is assigned: male, female or something else (e.g. unknown or intersex). The term intersex is used to describe people who are born with sex characteristics that are different from what is considered (entirely) male or female. In other words, they do not fit typical normative notions of male or female bodies, based on societal norms and/or medical standards. Medical professionals distinguish between dozens of variations of sex development. Examples of people who fall under the umbrealla of ntersex are women who are born with vaginas and XY chromosomes, women without a uterus, men with a micropenis, girls who develop ‘atypical’ sex characteristics in puberty and babies who are born with ‘ambiguous’ genitalia.

Other terms for intersex are variations of sex development, differences of sex development, disorders of sex development (DSD, mostly used in medical contexts). Based on research methods and how intersex is defined, estimates range from 2% (broad definition) to 0,5% (based on medical DSD classifications) or 0,02% (restricted to ambiguous genitalia at birth) (Van Lisdonk 2014). In the Netherlands, the estimate commonly used is 1 in 200 people (SCP/Van Beusekom & Kuyper 2018; Movisie 2018, NNID/Van der Have 2018, Van Lisdonk 2014).

Many people who fall under the definitions of intersex do not identify as intersex, though the label is more and more appropriated, particularly by activists. In the Netherlands, people often identify with the specific name of their (medical) condition, for example CAH, XY-DSD, MRKH, Klinefelter Syndrome, or Turner Syndrome[8]. In the Netherlands there is a growing sense of community building among organisations focused on intersex and DSD. However, it should also be noted that a number of people who would fall under the umbrella of intersex or DSD are not familiar with these terms or even distance themselves from them (Callens, Motmans & Longman 2017; Van Lisdonk 2014; Van Lisdonk & Callens 2017). In human rights and equality activism and policies, intersex is more and more linked to LGBTQ+. For advocacy purposes we applaud this trend to respond to underlying shared normative perspectives on sex, gender and sexual orientation. However, we also acknowledge that – at least in the Netherlands - many individuals do not feel comfortable (yet) to be placed in the LGBTQI+ spectrum, as they do not identify as intersex or recognise linkages with homosexuality and transgender issues. This should be taken into account in implementation.

[8] CAH (Congenital Adrenal Hyperplasia) = people with CAH have problems with hormone regulation and in some forms of CAH this impacts on the appearance and functioning of external genitalia and fertility; XY-DSD = people with XY-chromosomes and sex development in genitalia and reproductive organs that does not look wholly ‘male’ and that causes infertility; MRKH = women who are born without (complete) vagina and/or uterus; Klinefelter Syndrome = mostly men with 47,XXY chromosomes that can impact on appearance of external genitalia and fertility; Turner Syndrome = mostly women with 45,X0 chromosomes that impact on the development of ovaries and the production of sex hormones.

As a result of some non-Western societies' non-binary conceptualisations of gender, expressions of *neither-male-nor-female* gender status are sometimes culturally embedded and not medicalised. Examples are *guavedoce* in the Dominican Republic, *kwolu-Aatmwol* in the Sambia living in Papua New-Guinea, *serrer* (derogatory term) in Kenya, *nadlehee* or *berdache* in the Navajo culture of North America and *hijra* in India (for an overview, see Lang & Kuhnle 2008).

Stigmatisation, silencing and shame are commonly faced by intersex people (Callens, Motmans & Longman 2017; Van Heesch 2015; Van Lisdonk 2014; Van Lisdonk & Callens 2017). Some of these people need medical surgery or hormone treatment. Some undergo cosmetic surgery – to change bodies to conform more to medical standards of what are considered 'male bodies' and 'female bodies'. Intersex and human rights activists and organisations are becoming more vocal and outspoken that such 'cosmetic surgery' performed without informed consent of the individual, and particularly at an early age, is a severe human rights violation (e.g. Council of Europe 2017, Human Rights Council 2017; Yogyakarta Principles plus 10 2017, see also chapter 4).

4 Sexual and reproductive health of LGBTQI+ people, MSM and WSW

Sexual and gender diversity are universal realities

There is no consensus or strong evidence about the origins of variations in people's sexual orientations, gender identities, expressions and sex characteristics. The presence of variations in SOGIESC is widely acknowledged as a universal reality by most respected health organisations such as the World Psychiatric Association (WPA 2016), the World Medical Association (WMA 2013, 2015), the World Professional Association for Transgender Health (WPATH 2011). Homosexuality and being transgender are not considered mental illnesses in the International Classification of Diseases (ICD-11) of the World Health Organisation (WHO) or in the Diagnostic and Statistical Manual of Mental Disorders (*DSM-5*).

Positive sexual health

To understand sexual health issues of LGBTQI+ people and to address them in mainstreaming sexual and gender diversity in SRHR, we introduce the 'positive sexual health model', based on the positive health model of Machteld Huber and colleagues (2011, 2016). Positive health goes beyond illness and disorder. Health is approached in holistic and dynamic ways and is defined as 'the ability to adapt and to self-manage, in the in the face of social, physical and emotional challenges' (Huber et al. 2016, p.7).[9] Since this conceptualisation of health underscores the individual's relation to the environment it provides a useful framework on sexual health issues, due to societal homophobia and heteronormativity. Clearly, people's immediate environment and the society they live in play an essential role in their health. According to the European Commission (2009), health is unequally distributed, as "health inequalities refer to the avoidable and unfair differences in health that are strongly influenced by the actions of governments, stakeholders, and communities and can be addressed by public policy" (in Zeeman et al. 2017, p. 16). Thus, health disparities are not random but can have societal causes and in that case structural health improvement for marginalised groups requires change at the societal level. The positive health model pays attention to societal root causes of poor health outcomes and emphasises individual resilience to deal with health problems. In the Netherlands, the positive health model is recognised by national health institutes.[10, 11]

Minority stress

LGBT people consistently report less perceived and actual safety and lower sexual, psychosocial and mental health compared to heterosexual people (Kuyper 2011, 2016, 2017, Sandfort et al. 2014; Van Lisdonk & Nikkelen 2017). The widely recognised minority stress model demonstrates the impact of homophobia and heteronormativity on LGBT individuals' health and wellbeing and explains health disparities between sexual orientation and gender identity groups. Minorities – in this case sexual and gender minorities (LGBT, MSM, WSW) - risk the experience of additional and unique stress because of structural stigma, victimization and discrimination because of their sexual orientation or gender identity. This stress can lead to health problems (Dentato 2012; Meyer 2003). The effect of a stigmatised social status on minority stress which can impact health also applies to other social minorities such as racial minorities and people who are overweight (Dovidio et al. 2018).

The minority stress processes which are commonly distinguished are a) the experience of prejudice, discrimination and violence, b) the expectation of rejection and negative reactions, c) concealing a

[9] It has been developed as a response to the WHO definition of health defined as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (2006). The WHO definition was considered groundbreaking and has been widely adopted. However, critical voices state that the definition may unintentionally reproduce a medicalisation due to its focus on 'complete' well-being; it pays little attention to the role of human capacity to cope autonomously with challenges and to function with fulfilment; and the definition is difficult to operationalise (Huber et al. 2011, pp. 1-2).

[10] RIVM (the Dutch National Institute for Public Health and the Environment) and by ZonMW (the Netherlands organisation for health research).

[11] In the original positive health model, six health dimensions relevant to chronic diseases were identified (Huber et al. 2011, 2016). Since this categorisation does not offer the optimal structure to present the most relevant sexual and reproductive health issues for LGBTQI+ people, we do not adopt these dimensions in this White Paper.

minority sexual orientation or gender identity, and d) internalised homophobia or transphobia (i.e. the internalisation of negative attitudes towards homosexuality or being transgender (Dentato 2012; Kuyper 2011; Meyer 2003).

The literature offers convincing evidence that higher prevalence of mental health problems among LGBT people (e.g. Kuyper 2011; Major et al. 2018; Sandfort et al. 2014) and higher substance use among MSM (Gevonden et al. 2013) are not a result of a so-called pathological sexual orientation or gender identity, but in fact a result of a stigmatised status in society.

Minority stress is not limited to people living in homophobic societies. Subtle prejudice, which is more common in tolerant societies, is hard to prove and tackle because of its ambivalent character. People can be generally positive and also be reluctant to stand up against, recognise or even play down subtle stigmatisation. Such lack of support implicitly emphasises the stigmatised status which can negatively impact on health (Cramwinckel et al. 2018; Major et al. 2018), while an open discussion about limited tolerance or prejudice is difficult (Cramwinckel et al. 2018; Van Lisdonk 2018).

Here we address five key themes on sexual and reproductive health of LGBTQI+, MSM and WSW and highlight specific health problems and how lack of access to information and services can impact on their sexual and reproductive health. To provide a coherent picture, percentages based on population or survey studies originate mostly from studies in the Netherlands.

Bodily issues

A major issue for LGBTQI+ people is 'bodily integrity', the universal human right of having personal autonomy and self-determination over one's own body.

In many countries, including the Netherlands, MSM and transgender people have a higher risk of sexually transmitted infections (STIs), including HIV (David et al. 2018; Van Lisdonk & Nikkelen 2017; The Global Forum on MSM & HIV & OutRight Action International 2017). This can be related to limited access to information on sexuality and STIs, or barriers to testing and treatment due to homophobia or transphobia, or internalised fears of stigmatisation by care providers. In the Netherlands, Sexual Health Centres for high-risk groups, including MSM and transgenders, provide easily accessible care (David et al. 2018).

Bodily integrity can be at stake for transgender and intersex people in different ways. In healthcare, transgender and intersex people report facing unwilling medical attention and pressure to conform to normative images of 'male/masculine' and 'female/feminine' bodies and expressions. Medical criteria on how bodies and sex characteristics should look and which gender identities are normalised or are considered to need treatment are based on restrictive societal norms. Medical protocols that leave little space for non-binary (neither wholly female or male) bodies or genders can lead to limited bodily autonomy and access to medical treatment. For example, transgender people who do not desire a 'full' 'male-to-female' or 'female-to-male' transition can be refused treatment if a medical centre operates on the basis of a binary gender ideology (i.e. ideology that people are or should be either a man or a woman). Transgender people in the Netherlands sometimes seek medical treatment abroad to speed up treatment or because protocols are more based on self-determination.

Intersex people – also called DSD (see chapter 3) have different experiences with healthcare to transgender people. Their entry point to seek healthcare is often due to experiencing physical health problems or because their body function or appearance differs from the societal norms for male or female bodies. Some need hormonal treatment to start or delay puberty and the development of secondary sex characteristics. The removal or transformation of external or internal sex characteristics to improve quality of life or sexual functioning is often based on gendered, heteronormative medical standards for bodies. For example, medical norms that exist in some medical centra are that boys should be able to urinate standing up and girls should to be able to be sexually penetrated. Medical diagnoses can take place prior to or just after birth, in early childhood, adolescence or in adulthood (e.g. in case of fertility problems). In case of early diagnosis, medical

treatment can take place in childhood or adolescence, with informed consent given by parents. There is growing awareness and agreement that the removal or transformation of sex characteristics – sometimes with a loss of reproductive opportunities - is a violation of the human rights of bodily autonomy and self-determination, in the case of non-life threatening situations and without informed consent by the affected person (Council of Europe 2017, Human rights Council 2017; Yogyakarta Principles plus 10 2017). Intersex activists assert that medical interventions imposed on children without their full consent because of societal normative standards about male/female bodies is intersex genital mutilation (NNID/Miriam van der Have 2018, OII Europe, stopIGM). Malta was the first country to ban such medical surgeries. Against the backdrop of a lacking national standards of care, Dutch medical centres vary in their stance on this type of early surgeries.

Many societies do not offer legal gender recognition for transgender and intersex people. Countries that do not offer legal recognition, or offer it only after psycho-medical diagnosis, third-party opinion or sterilisation violate human rights of self-determination and bodily integrity (Yogyakarta Principles plus 10 2017). In the Netherlands, legal gender recognition is possible, with some limitations. The requirement for an expert statement and the minimum age of 16 limits people's self-determination for legal gender recognition. In addition, the state provides two options for sex registration – male or female – which can be problematic for some non-binary people.

In countries where homosexuality and being transgender are criminalised, LGBTQI+ can risk physical investigations or (sexual) violence by the police or during detention.

Psychosocial health, well-being and quality of life

LGBT people report more psychosocial and psychiatric health problems, depression and suicidality compared to heterosexual and cisgender people (Kuyper 2017, Nikkelen & Vermey 2017, Pröderl & Tremblay 2015; Sandfort et al. 2014). Internalised homo-, bi- or transphobia can affect mental health (Kuyper 2011, 2017). Many LGBTQI+ people internalise societal heteronormative norms and expectations and have to go through a process of self-acceptance of their sexual orientation, gender identity or sex characteristics, even in tolerant countries (Kuyper 2015, 2017 Van Lisdonk 2014). Among Dutch 12-24 years old LGB people, 22% of the boys and 12% of the girls had wished not to feel same-sex attraction (Nikkelen & Vermey 2017). Life satisfaction of Dutch LGB youth and young adults is considerably lower than that of their heterosexual peers (Kuyper 2015). In addition, LGBT-related victimisation, criminalisation or not feeling safe because of being LGBT have been associated with lower mental health outcomes (Bockting et al. 2013; Kuyper 2017; The Global Forum on MSM & HIV & OutRight Action International 2017; Van Bergen et al. 2013).

There is mixed evidence for whether openly expressing a same-sex sexual orientation or transgender feelings positively impacts on quality of life. On the one hand, concealment may impact on internalised homo-, bi- or transphobia and mental health problems, yet on the other hand openness can expose people to exclusion, discrimination, violence or – in hostile states - even arrest and prosecution. Bisexual people experience more difficulties than gay or lesbian people in disclosing their sexual orientation and being comfortably open (Barker et al. 2012; Van Lisdonk 2018). For LGB people living in homophobic societies or in controlling contexts – including certain bi-cultural people living in Western countries - negotiating their identities and being selectively open can be more positive for their well-being (Cense & Ganzeboom 2017; Legate, Ryan & Weinstein 2011) (See also Knowledge file Culture and Religion]).

When LGBTQI+ people need support or mental and sexual health treatment, it is important that psychologists, psychiatrists and sexologists are supportive; if these health professionals are prejudiced or ill-informed about sexual and gender diversity and LGBTQI+ people's lifestyles the result is additional stigmatisation and inadequate treatment and care. In the case of hostile or homophobic environments, limited availability and access to care providers that guarantee safety and professional confidentiality may further hamper treatment for mental health issues.

Sexuality information, sexual functioning & satisfaction

It can be more challenging for LGBTQI+ people to find information on positive sexuality and relational issues that resonates with them. In homophobic environments, positive attention to sexuality and

sexual and gender diversity is generally absent. In heteronormative societies, messages can be limited to the recognition of sexual and gender diversity, while not providing actual information on sexuality and sex that is relevant to LGBTQI+ people. For example, an emphasis on 'acceptance of LGBT people' implicitly communicates the message that heterosexuality and male/female bodies is assumed (i.e. heterosexuality does not need to be accepted), thus treating same-sex sexuality, being transgender or intersex as special and different from the norm. In the Netherlands, sexuality and sexual diversity education is mandatory for schools. Yet schools can determine their own curriculum and what messages they communicate. The evaluation of sexuality education by Dutch LGB youth is lower than by their heterosexual peers (additional analysis on Nikkelen & Vermey 2017).

Dutch bisexual and transgender people generally report more sexual and relational problems compared to heterosexual people. On a positive note, experiences of gay and lesbian people do not differ from heterosexual men and women (Nikkelen & Vermey 2017; Van Lisdonk & Nikkelen 2017). Among Dutch LGB and heterosexual youth, sexual satisfaction and sexual confidence is similar (Nikkelen & Vermey 2017; Van Lisdonk & Nikkelen 2017). Having negative attitudes towards one's own homosexual or bisexual orientation (internalized homo/biphobia) is associated with having less positive feelings about sex (Van Lisdonk & Nikkelen 2017).

For transgender people, opportunities for gender-confirmation treatment on request can be beneficial to their sexual health and may positively affect sexual feelings and satisfaction, particularly when a person's body image is positively affected (Van de Grift 2017; Nikkelen & Kreukels 2018). Hormone treatment and medical surgery to align their body to their felt-gender identity generally impacts positively on their body image (Nikkelen & Kreukels 2018). For intersex people, genital surgery varies in the effect on the evaluation of genital appearance and function, and sexuality, the latter being generally more negatively evaluated (Van de Grift 2017)/

Sexual violence

Globally, LGBT people risk sexual harassment and abuse. In Dutch LGB adults and LGBT youth populations, bisexual women, gay and bisexual men and young men with transgender feelings report more experience of sexual harassment and abuse (Nikkelen & Vermey 2017 Van Lisdonk & Nikkelen 2017). Perpetrators of sexual violence are generally more likely to be men (Van Berlo & Twisk 2017), also for LGBT victims (De Haas 2015).

In conservative and hostile environments, lesbian and bisexual women, and to a lesser extent gay and bisexual men, are also at risk of gender-based sexual violence, including corrective rape. In some cases there is an additional risk for STIs, HIV or unwanted pregnancies.

In homophobic and conservative societies or communities, LGBTQI+ people can feel pressure to conform to traditional family norms, including choosing a partner who is culturally accepted but who goes against their sexual orientation or denies their gender identity. Such pressure can encompass forced marriages and structural sexual violence in the setting of such marriages. As a consequence, the need to hide romantic or sex partners can hamper free and unstigmatised access to SRHR information or services.

Reproductive issues and parenting

For LGBTQI+ people who are openly engaged in romantic relationships, the step to marriage or parenting can be challenging or legally impossible. Same-sex marriage is legal in only 24 countries (ILGA/Carroll & Mendos, October 2017). Same-sex parenting opportunities can be limited in countries that do not allow the formalising of same-sex relationships. Assisted reproduction is not always open to same-sex couples. Worldwide joint adoption by same-sex couples is only legal in 26 countries (ILGA, October 2017).

LGBTQI+ people who live in tolerant societies can also face barriers to parenting. Among Dutch LGB 12-24 year olds, 48% of boys and 63% of girls have a (future) desire to become a parent. Of this group, 46% of the boys and 32% of the girls expected problems or were unsure they would be able to realise this desire (Nikkelen & Vermey 2017). Nevertheless, same-sex parenting and 'rainbow

families' are becoming more visible in the Netherlands. Rainbow families vary from a single lesbian woman with a child, two men raising children, to co-parenthood of three or four parents with at least one LGBT parent. A Dutch study shows that children raised in a female or male same-sex parent household do not differ in well-being from children raised by a different-sex parent household (Bos et al. 2018). Due to heteronormativity, institutional or societal stigmatisation or discrimination is possible, for example in having fewer legal entitlements as parents including parental leave, being unable to fill in forms as a same-sex parent household, being confronted with discriminatory treatment by healthcare professionals as same-sex parents or as the non-biological mother.

Transgender people can face additional problems in fulfilling their desire to become parents. In many countries legal recognition requires sterilisation to prevent people who are legally men becoming mothers.

For some intersex people, biological parenthood is difficult or impossible because they were born infertile or because they became infertile after surgical treatment (e.g. partial removal of genitalia or internal sex organs). Sometimes biological parenting is possible after hormone treatment or assisted fertility techniques such as surrogacy, egg cell donation, sperm donation or an artificial ovary. However, legal barriers can stand in the way. Furthermore, practices of prenatal diagnosis with the potential option of termination of pregnancy, and pre-implantation genetic diagnosis (PGD) with the potential for embryo selection and the possible outcome of not selecting an intersex embryo impact on the right to life. Both practices take place in the Netherlands.

5 Possibilities of mainstreaming sexual and gender diversity in our programmes

At Rutgers, we focus on sexual and reproductive health and rights with equality and inclusivity as important principles. Mainstreaming sexual and gender diversity in our SRHR programmes includes the transformation of restricting attitudes, reducing heteronormativity, creating awareness of non-binary thinking and addressing harmful norms on sex, gender and sexual orientation.

However, there is generally little empirical evidence of the effects of these kinds of interventions (e.g. Cramwinkel et al. 2018 about prejudice reduction). We therefore feel it crucial to share our experiences of mainstreaming sexual and gender diversity to provide examples of implementation and to contribute to filling important gaps in the literature. In the next section we will talk more about how Rutgers applies mainstreaming sexual and diversity to some of its existing and recent programmes. Furthermore, we will elaborate on the strategies we can use by Rutgers and present several ways to address sexual and gender diversity, to create attention for LGBTQI+ people's SRHR and mobilise support for mainstreaming.

Rutgers's programmes

Rutgers has a history of working with local organisations in Europe, Africa and Asia that fight for equal rights for youth, including girls and LGBTQI+ people, and promotes recognition and openness on the topic of sexual and gender diversity. Despite the fact that many mainstream SRHR organisations feel sympathetic towards the principle that LGBTQI+ people deserve equal treatment, their experience and technical capacity is often limited. To pursue inclusive educational and healthcare environments, we consider that Rutgers, all other SRHR organisations and all SRHR service-providing professionals must be equipped with basic knowledge and be capable to communicate non-judgmentally on sexual and gender diversity.

As leader and member of alliances on SRHR worldwide and in the Netherlands, Rutgers aims to contribute to equal SRHR by creating enabling environments and access to SRHR information and services for *all* people. Both nationally and internationally, Rutgers implements programmes that strengthen enabling SRHR environments that consist of both inclusive organisations/programmes and sensitised professionals. We use a mainstreaming perspective in which attention to sexual and gender diversity is considered necessary to improve SRHR for *all* people. Rutgers usually focuses on organisations, professionals and networks in healthcare, education, human rights and broader SRHR settings as a way of improving the SRHR of LGBTQI+ individuals. In recent years this has been done in different ways.

International programmes

Get up, Speak out for Youth Rights (2016-2020)

Inclusiveness is a guiding principle of the Get up, Speak out for Youth Rights (GUSO) Consortium. This inclusiveness means that the GUSO Consortium equally respects and meaningfully involves people who are vulnerable and marginalised, including young people, women, LGBT, young people living with HIV (YPLHIV), disabled youth, out-of-school youth and young people living in remote rural or high-density urban settings. It means that we emphasise their particular needs and address the root causes of vulnerability and marginalisation such as gender inequality, criminalisation, poverty, stigma and cultural norms. GUSO's inclusiveness principle is translated into specific strategies. An example of such a strategy is to assess whether activities ensure non-discrimination and promote inclusiveness. Where relevant, specific activities are developed to adhere to the rights of hard-to-reach and vulnerable groups. Besides non-discriminatory activities, the GUSO programme also promotes sexual diversity by supporting CSOs to create a more enabling environment.

Right Here, Right Now (2016-2020)

The Right Here, Right Now strategic partnership (RHRN) implements a five-year programme on SRHR of young people in 10 countries in Asia, Africa and the Caribbean sub-region. It aims to impact on access to comprehensive youth-friendly sexual and reproductive services, including safe abortion;

access to comprehensive information and comprehensive sexuality education (CSE) and meaningful participation of young people in national, regional and international advocacy. This is achieved by building inclusive national advocacy platforms.

Inclusivity is a core principle in the RHRN programme and is promoted in several ways. First, inclusive cooperation at national level is reflected in the diverse composition of the platforms, which brings together different types of CSOs including youth organisations, LGBT organisations, women's organisations and human rights organisations. Thus LGBT organisations work together and are equal partners in the platforms with other partners. At the inception phase, the more than 100 platform member organisations sign a value clarification which addresses inclusivity and other core principles relevant to comprehensive, progressive and inclusive SRHR advocacy. Several platforms organised Value Clarification and Attitudes Transformational Change. Second, the RHRN programme specifically focuses on the inclusion of youth, LGBT people, girls and young women, since these groups are among the most marginalised, and pays great attention to making their participation meaningful. Third, inclusivity is cross-cutting in the RHRN strategies on advocacy and capacity strengthening for advocacy to achieve comprehensive, progressive and inclusive SRHR outcomes. The RHRN explicitly focuses on inclusive SRHR advocacy outcomes that are available to *all* people, including marginalised and minority groups and particularly LGBT people.

Unite for Body Rights! (2011-2015)
The Unite for Body Rights (UFBR) programme focused on SRHR in nine countries in Asia and Africa. The SRHR Alliance followed a multi-component approach: improving access and quality of SRHR education, improving access and quality of SRH services and shaping an enabling environment that is more positive towards young peoples' sexuality and diversity. The reduction of sexual and gender-based violence (SGBV) and the acceptance of sexual and gender diversity (SGD) were mainstreamed in all these areas.

During the UFBR programme the Dutch SRHR Alliance, Rutgers and several country SRHR Alliances ran programmes to support in-country partners and LGBT organisations in their efforts to address and mainstream sexual and gender diversity in a context of homophobia, transphobia and criminalisation. Best practices and strategies to mainstream sexual and gender diversity into programmes and services were explored and evaluated in Indonesia, Kenya, Malawi and Tanzania. As a result, the SRHR Alliance published a booklet about the lessons learned during their sexual and gender mainstreaming initiatives. This publication reflects the work of strongly motivated, courageous and mostly non-LGBT change makers, who have proven to be strong advocates and frontliners. They took part in the learning process of mainstreaming sexual and gender diversity (MSGD) and helped their own organisations and networks become more LGBT-inclusive. This magazine [https://www.rutgers.international/what-we-do/sexual-and-gender-diversity; Bakker, Reinders, & Hofs 2016) shows the tools they developed, the results achieved and the lessons learned from SRHR Alliances in Indonesia, Kenya, Malawi and Tanzania.

National programmes

Towards Gender and LGBTI Sensitive Healthcare (2018 – 2022)
The Alliance 'Personalised healthcare' is a five-year collaboration between COC Netherlands, Rutgers and WOMEN Inc., in a strategic partnership with the Ministry of Education, Culture and Science. The Alliance aims to promote and improve tailor-made, gender and LGBTI-sensitive healthcare. The programme's theory of change contributes to the following long-term objective: 'In the consulting room, difference is the norm, which means that clients and care professionals are able to request and provide gender-sensitive and LGBTI-sensitive care.' Through the three pathways of change of making knowledge, transferring knowledge and securing knowledge on gender and LGBTI-sensitive healthcare, both patients and healthcare professionals are targeted to become more aware and well-equipped to receive and offer positive and inclusive healthcare.

This Alliance is unique in its aim to focus on the intersections of gender, sexual orientation and age in relation to health problems, access to healthcare and treatment by healthcare providers. It also

brings attention to the specific sexual and reproductive health issues LGBTQI+ people can face and to the obstacles to seeking general healthcare treatment, which are different in each life phase.

As a result (1) the general public will become more aware of the intersection between diversity and health, and specific groups are capable of asking for positive, inclusive healthcare that is sensitive to their diversity profile; (2) healthcare professionals have the knowledge, attitudes and skills to provide customised diagnoses and treatment, and are capable of offering positive, inclusive healthcare that is sensitive to diversity profiles of patients; (3) healthcare professionals endorse the importance of attention to gender, sexual orientation and age, and address the need for 'personalised healthcare' within their occupational groups and associations as well as its embeddedness in training modules, guidelines and standards of care; (4) the Dutch government stimulates and supports programmes and research that underpin and promote the implementation of gender and LGBTI-sensitive guidelines and standards of care.

Mainstreaming sexual and gender diversity (2012 – 2018)
Since 2012 Rutgers has invested more explicitly in mainstreaming sexual and gender diversity in its national SRHR programming. Several specific activities and projects were initiated and implemented, all aimed at making programmes more inclusive for LGBT people by addressing their specific needs and integrating sexual and gender diversity into Rutgers's research and implementation programmes. One of the results of this has been research on the SRHR-related information needs and experiences of LGB youth and adults: Rutgers developed the first Dutch LGBT Survey on Sexual Health and we have ensured that other SRHR surveys and studies are inclusive to LGBT people, tailoring them where necessary. This allows us to compare data on different sexual orientation groups and to identify sexual health risks specific to LGB, MSM, WSW and transgender people. More in-depth studies were carried out on topics of the experience of sexual violence among transgender people (Doorduin & Cense 2014), strategies and agency related to expressing same-sex orientations and identities among bi-cultural LGBT youth (Cense & Ganzevoort 2017), and online dating norms and communication strategies among young MSM (Van Lisdonk et al. 2017). Based on all the research findings, several information websites (including sense.info, seksindepraktijk.nl) and teaching packages for primary and secondary schools have been supplemented with LGBT specific information and their existing content was revised to be less heteronormative. Since 2017 Rutgers also focuses on diversity in sex characteristics in order to be more inclusive to intersex people and people with variations of sex development. This total package of mainstreaming efforts led to more inclusive (and less heteronormative) national programming and more sensitised professionals.

In holding ourselves to the dictum 'nothing about us without us' (i.e. that policy should not be decided without the full representation and involvement of the group affected by it), we value working with LGBTQI+ organisations in developing and implementing programmes.

6 Strategies to mainstream sexual and gender diversity

Mainstreaming sexual and gender diversity refers to the integration of a sexual and gender diversity perspective as a cross-cutting issue into the preparation, design, implementation, monitoring and evaluation of SRHR policies, regulatory measures, programmes and budgetary decisions, with the aim of promoting equality and inclusiveness on SOGIESC and combating discrimination. According to Rutgers, mainstreaming as a pathway to change requires enabling environments of inclusive organisations and programmes as well as sensitised professionals. This means that explicit attention is given to sexual orientation, gender identity and expression, and sex characteristics (SOGIESC) when needed and that SRHR programme implementation positively impacts on (sexual) health, well-being, access to information and services for LGBTQI+ people. This also includes freedom of partner choice and acknowledging relational diversity.

To create an enabling environment, internal and external mainstreaming are the two main strategies Rutgers applies, focusing on programme implementation, research and advocacy.

Internal and external mainstreaming
Internal mainstreaming refers to mainstreaming of sexual and gender diversity in an organisation's policies, including their human resource policies, and its staff attitudes, behaviour and knowledge related to SOGIESC. Put differently, internal mainstreaming is capacity strengthening at the level of the individual level, and human resource development and agenda setting at the organisational level. Its prioritisation by the top of the organisation is crucial. To promote more diversity among managers, studies show that explicit prioritisation and individual engagement of higher management of the organisation is essential, and more effective than diversity training or reducing social isolation of minority groups (Kalev, Dobbin & Kelly 2011; Opportunity in Bedrijf 2011).

Rutgers has always been open to sexual and gender diverse people and celebrates diversity in its organisation. Recently, formalisation of policies took place in the organisation's new Code of Conduct. Rutgers now has gender neutral toilets and has declared its intention to revise its Diversity Policy and work toward inclusive language as standard.

Because of sexual and gender diversity being mainstreamed in Rutgers regular programmes and activities, many employees have experience in developing information and educational material, doing activities or conducting studies that involve sexual and gender diversity. Sexual and gender diversity experts in the organisation support employees through informal and formal advice and feedback. Rutgers intends to keep its expertise on sexual and gender diversity updated and to work structurally on capacity strengthening within the organisation.

External mainstreaming refers to mainstreaming sexual and gender diversity in programmes, research and advocacy, in order to meet the needs and rights of all people, respecting SOGIESC. The needs and rights of LGBTQI+ people are addressed in external programmes that Rutgers implements abroad and in the Netherlands, for example in comprehensive sexuality education, service provision, community mobilisation, lobbying and advocacy. You can find examples of external mainstreaming of sexual and gender diversity in several Rutgers programmes in the previous section.

To create an enabling environment, combining internal and external mainstreaming is important. Internal mainstreaming - addressing organisational attitudes and practices regarding SOGIESC - is considered to be a necessary basis for external mainstreaming (IPPF 2011). Internal support of management, staff and board is crucial and a precondition for successfully performing external mainstreaming (Bakker, Reinders, & Hofs 2016). The result of focusing solely on or starting with only internal mainstreaming is a lack of immediate improvement in inclusive SRHR and slower progress of external mainstreaming, leaving the needs of LGBTQI+ unmet which can have severe implications. In contrast, external mainstreaming in programmes, research or advocacy without efforts to mainstream within the organisation can lead to a lack of sustainable outcomes, organisational

ownership, and professional expertise beyond a programme or project. Therefore, the two mainstreaming strategies should be combined from the start.

Meaningful participation of LGBTQI+ people

A precondition to create an enabling environment for internal and external mainstreaming is the meaningful participation of LGBTQI+ people. Meaningful participation requires that individuals are entitled to participate in the decisions that directly affect them, including in the design, implementation, and monitoring of health interventions (WHO 2008). This enhances the effectiveness of policies and programs, because LGBTQI+ people are in the best position to identify and articulate their specific needs, challenges and skills (Howard et al. 2002). Efforts should be undertaken to foster relationships and support the capacity of LGBTQI+ people. Meaningful participation ranges from co-creation or participatory research to participation of LGBTQI+ people in advisory boards or project coordination committees in agenda-setting positions. When LGBTQI+ people have a sense of ownership, new and exciting innovations in project implementation can lead to increased effectiveness (IPPF 2011).

Meaningful participation of LGBTQI+ people can furthermore contribute to empower and sensitize non- LGBTQI+ professionals. Rutgers analyzed the results of a study on meaningful youth participation in our SRHR programmes in which many young people expressed their own attitudes and perceptions around sexuality and sexual rights and how these had changed through their engagement with the programme (Reeuwijk & Singh 2018). The findings showed that meeting, interacting and working with diverse young people, including those with different sexual orientations or gender identities, let to awareness of their myths and misconceptions, and deepened their understanding of SRHR for *all* people. This example demonstrates that meaningful participation of LGBTQI+ not only contributes to the effectiveness of policies and programmes, it also contributes to the sensitization of professionals on sexual and gender diversity, which is crucial for internal mainstreaming.

Inclusive organisations

Organisations and companies, regardless of their field of work, have an important role to play in fostering inclusion at the workplace. Protecting employees from discrimination and having policies in place relevant to LGBTQI+ employees are essential when creating inclusive environments. For NGOs and like-minded organisations active on SOGIESC, putting their own core values into practice cannot be taken for granted and may require explicit attention. Being an inclusive organisation should leverage diversity, foster inclusion, and increase awareness, accountability, and action within the organisation. This leads to a broader understanding of LGBTQI+ marginalisation, heteronormative or homophobic elements in the organisational culture and power dynamics in the workplace. A way to promote substantial change in organisations or programmes is the mobilising and training of 'change makers'. They become 'champions' and experts on sexual and gender diversity (Bakker, Reinders, & Hofs 2016). This strategy is part of capacity development at an organisational level. Diversity champions at management level have been proven to be effective at increasing diversity among managers (Opportunity in Bedrijf 2011). The role of a change maker is not an easy one. It is evident that change makers must be open to change themselves and preferably come forward voluntarily as candidates (Bakker, Reinders, & Hofs 2016). In order that success in the process is not highly reliant on the commitment and skills of key individuals, the mobilisation of change makers should run parallel with the sensitisation of other staff members (Moser & Moser 2005).

Sensitisation of professionals

Sensitisation of professionals on sexual and gender diversity is crucial for internal mainstreaming. One way to increase sensitisation is to put non-expert employees in charge to develop or carry out activities on SOGIESC – possibly mentored or advised by an expert. Such a 'learning by doing' activity can increase awareness and ownership: staff adopt and internalise a diversity perspective and benefit from opportunities for informal capacity strengthening. A second way to enhance the sensitisation of employees or professionals is to work with codes of conducts, value clarifications and training or reflective sessions on organisational core values and attitude transformation. Similar to most competencies in the area of social change, successful sensitisation and capacity

strengthening on sexual and gender diversity require a combination of positive attitudes and adequate knowledge and skills.

Build alliances

Cooperation between LGBTQI+ and mainstream organisations is also an effective way to establish sensitivity towards mainstreaming sexual and gender diversity. Building alliances is an evidence-based intervention to reduce sexual and gender identity prejudice (Cramwinckel et al. 2018). Facilitating direct contact and promoting affiliation with LGBTQI+ people proves to be crucial to shifts in opinions and attitudes. Having local LGBTQI+ organisations structurally embedded in alliances and networks as equal members will contribute to building personal bonds and networks with other organisations and staff thanks to experiences gained and shared. LGBQT+ organisations can function as a centre of expertise on SOGIESC within the alliance or network and provide informal or formal capacity strengthening (Bakker, Reinders, & Hofs 2016). In addition, LGBTQI+ organisations could take the opportunity to continuously promote the SRHR needs of their communities. At the same time, their own capacity and knowledge can be strengthened by other organisations in areas such as health, sexual rights, research, public campaigning or applying for funding.

Being embedded in a network of established and larger SRHR organisations can provide a safety and security net for LGBTQI+ organisations. It is safer to address sensitive issues together than alone (Bakker, Reinders, & Hofs 2016). Moreover, through inclusive partnerships and alliances, SOGIESC issues are more likely to become mainstreamed in non-LGBTQI+ organisations. This may lead well-known mainstream SRHR organisations to advocate for change on SOGIESC issues. Alliances can also be established within one organisation, for example at the workplace or a school. In the Netherlands, hundreds of secondary school have developed a gender and sexuality alliance (GSA) of pupils and teachers of various sexual orientations and gender identities to promote social acceptance and visibility of sexual and gender diverse people at their school. International studies shows that such alliances have a positive effect on LGB students' well-being (McCormick, Schmidt & Clifton 2014; Toomey et al. 2011).

Planning, monitoring, evaluation and learning (PMEL) cycle

Mainstreaming sexual and gender diversity should be viewed as an ongoing cyclic process rather than an end goal (Moser & Moser 2005). Planning, monitoring, evaluation and learning (PMEL) is therefore a crucial component of successful gender and sexual diversity mainstreaming in SRHR programmes. In order to determine strategies and prioritise mainstreaming activities, it is vital to have a clear and thorough understanding of the context and policies (societal, organisational) regarding SOGIESC, as well as the (unmet) needs of LGBTQI+ people and communities. Instruments or tools can be used to assess or map the initial situation and desired directions for change. In our planning, monitoring, evaluation and learning cycle, we usually conduct a baseline in our external programmes, consisting of desk studies mapping contemporary research, (legal) documents and data on sexual and gender diversity (and gaps in knowledge), the local context and relevant national and/or local policies. At organisational level, baseline studies or organisational scans can be used to explore the levels of staff awareness, attitudes, knowledge and skills, the state of organisational culture and policies as well as the extent to which activities and programmes already address sexual and gender diversity and are inclusive. It is important to distinguish majority and minority perspectives. In addition to survey-based mapping of organisational performance, in-depth interviews and focus group discussions can further identify specific issues, unmet needs of LGBTQI+ people, barriers in organisational cultures and opportunities for change.

Based on the assessment, a Theory of Change, with expected pathways of change and outcome measures, can be developed and translated into programmes, measurable indicators or PMEL systems. A review of successful gender mainstreaming practices found that a lack of evaluation makes it difficult to know the effects of mainstreaming in people's lives (Moser & Moser 2005). Therefore, strategies need to be linked to clear outcomes. Next to the monitoring framework and the baseline, mid-term and end-line evaluations measure progress and provide insights on the programme strategy. Monitoring and evaluating is standard practice in NGOs' programmes, but less common in internal programmes or policies aimed at organisational change or strengthening employees' competencies. A PMEL cycle could be useful to transform ad hoc internal mainstreaming

activities into a cohesive project or programme that enhances the synergy of activities and outcomes of internal mainstreaming to create a more enabling environment.

Furthermore, research with the purpose of learning during implementation - operational research – is essential to better understanding the challenges in mainstreaming or meaningful participation of LGBTQI+ people to improve programme implementation. An example is operational research in the RHRN partnership (see paragraph Right Here, Right Now) that focuses on how working in diverse platforms, including LGBT organisations, and prioritising meaningful participation of LGBT people contributes to comprehensive, progressive and inclusive SRHR outcomes. Observing and documenting successes and lessons learned benefits new, evidence-based programming.

7 Ways to address sexual and gender diversity in various contexts

Several angles may be used to address sexual and gender diversity in SRHR. Each offers a unique approach to sexual and gender diversity, highlighting different issues concerning LGBTQI+ people's SRHR and the need to mainstream sexual and gender diversity within SRHR programmes. An important step in talking openly about sexuality is to differentiate between health, rights, cultural norms and law in relation to sexual behaviour, gender expression, gender norms etc. By differentiating between perspectives of health, rights, culture and law it becomes clear that what individuals perceive as natural or socially accepted sexual behaviour is influenced by cultural and religious norms. Deconstructing discourses can be useful to reveal 'hidden' norms. For example, beliefs that homosexuality is unhealthy are often grounded in cultural norms.

Different contexts require different approaches to address sexual and gender diversity (See also Knowledge file Culture and Religion). Strategic decisions on which type of message to use in which context depend on what language and topics are expected to foster or trigger positive transformation in a specific setting or community. For example, in healthcare settings a public health or no-violence principle could be useful. In school education, a gender transformative and human rights perspective may be effective. In conservative communities which consider homosexuality a psychiatric illness, the no-violence principle could resonate more than the right to health.

Based on literature and practices in the Dutch national and international NGO and CSO sector we identified six messages to address sexual diversity in various contexts:

- Human rights
- No-violence
- Public health
- Gender transformative
- Family equality
- Sex-positive

Human and sexual rights

Human and sexual rights messages address SRHR on the basis of universal human rights for *all* people. Box 1 sums up the most relevant human rights related to SOGIESC and LGBTQI+ people's SRHR:

Box 1 Important human rights on SOGIESC and LGBTQI+ people's SRHR

All people, regardless of their age, sexual orientation, gender identity or expression or sex characteristics have:

- the right to equality (SDG goal 10; UDHR, Article 7; ICCPR #2; Yogyakarta Principles, Principle 2)
- the right of freedom of discrimination (UDHR 7, ICCPR #2; Yogyakarta Principles, Principle 2)
- the right to well-being and the highest attainable standard of health (SDG goal 3; Yogyakarta Principles, Principle 17)
- the right to privacy (UDHR, Article 12; ICCPR #17; Yogyakarta Principles, Principle 6)
- the right to support and information so that they may live accordingly to their sexual orientation and gender identity (Yogyakarta Principles, Principle 28)
- the right to protection against torture, inhumane or degrading treatment (UDHR 2016; Yogyakarta Principles, Principle 10)
- the right to found a family (Yogyakarta Principles, Principle 24)
- the right to legal recognition (Yogyakarta Principles plus 10, Principle 31)

Information or education on human rights can create awareness and sensitise people in mainstream society to SOGIESC and LGBTQI+ issues and the promotion of inclusive SRHR. A rights message can also encourage action when rights have been violated (for example, in cases of sexual abuse, discrimination or denial of access to SRH services). In tolerant societies, where heteronormativity and stigma is more subtle, a human rights perspective may not always resonate immediately since

many people consider themselves 'equal'. *Sexual rights* are an evolving set of entitlements related to sexuality that contribute to the freedom, equality and dignity of all people. The recognition of sexuality as a central aspect of being human (IPPF 2008) is grounded in the view that all (young) people have the right to explore their sexuality and should be able to voluntarily express their sexuality without fear, shame or guilt, while respecting other people's rights. Nevertheless, we must take into consideration that using the concept of human rights to address SOGIESC is often too confronting, might endanger local LGBT NGOs and people and can even block the SRHR agenda as a whole (Share-Net Netherlands 2018). Therefore, if necessary we also make use of other ways to address sexual and gender diversity to introduce discussions and negotiations, like the no-violence principle, public health and family equality.

No-violence

The no-violence principle is a basic element of human rights. Messaging that focuses on human dignity, respect and no-violence, without incorporating the full raft of human rights terminology, sometimes resonates better with religious and conservative organisations and communities as a way to initiate discussion of the protection of LGBTQI+ people[12] In keeping with this principle, we can argue that *all* people deserve respect, compassion, justice and protection from harm. This perspective can be used as a first step towards creating an enabling and inclusive environment in religious settings. Furthermore, it can help religious and faith-based NGOs and communities to support and empower LGBTQI+ people in accessing SRHR information and services. The Episcopal Church – with the help of organisations such as Integrity USA – and the South African Council of Churches, applied this perspective to work towards becoming a more inclusive church. A no-violence principle also offers strategic possibilities for building bridges and coalitions between movements, exploring how different discourses of subordination intersect and jointly confronting obstacles and oppression.

Public health

Another way to address and argue for attention to the needs of LGBTQI+ people in SRHR, is to use a public health message. LGBTQI+ people can feel excluded from SRHR services due to a lack of inclusive SRHR information and services and high prevalence of unequipped and prejudiced healthcare providers, while their need for such services may be relatively high. In many societies, they have poorer access to information on STIs, HIV and safe sex practices, prevention, testing, treatment, care and support. This leaves them, and particularly MSM and transgender people, at a higher risk of contracting HIV (UNDP/PGA 2017). Even when information and services are available, in countries where consensual same-sex sexual behaviour is punishable by law, LGBTQI+ people may not seek SRHR services out of fear of being arrested and prosecuted (WHO 2015).

The public health message is used to advocate for better SRHR information and services for MSM, WSW and LGBTQI+ people to prevent (self)stigmatisation, STIs and sexual violence and to facilitate prevention, treatment, care and support. This message has also been adopted to argue for a healthy and HIV/AIDS-free society in which the needs of most at risk populations (MARP) - to which MSM and transgender people belong - must be addressed and directly linked to mainstream society (Factsheet Rutgers & StopAidsNow 2013). The argument to invest in LGBTQI+ people's health is based on the fact that discrimination, stigmatisation and legal barriers result in increased high-risk behaviours and limited access to and use of SRHR and other health services. The underlying rationale of using the MARP or key-population strategy is sometimes to prevent HIV being easily transmitted. It acknowledges the importance of including high-endemic groups such as MSM in developing a country's HIV/AIDS strategy. The MARP or key-population strategy is a good way in to mainstreaming sexual and gender diversity and has been successful in many African countries in reducing HIV transmission and reaching MSM and transgender communities with information, prevention and treatment (USAID Ghana 2011).

Despite the successes of MARP strategies in agenda setting and implementing SRHR, two remarks are important to take into account. First, public health messages can be counterproductive when homosexuality or being transgender is considered a psychiatric disorder by healthcare providers,

[12] Conference 'Finding commong ground to dialogue on faith, sexuality and human rights' 2015.

since treatment based on this premise could actually do harm. Second, the high political and public interest in STIs and HIV may cause disproportionate attention to the sexual health of MSM and transgender people, while risks to other subgroups in the LGBTQI+ spectrum are ignored. From a public health perspective, the attention to the sexual and reproductive health needs of lesbian and bisexual women and intersex people is usually limited because they are not considered a risk group for STIs and HIV-transmission.

Family equality

Family equality should focus on the realities of diverse families, while the restrictive societal, legal and cultural norms do not reflect or support diverse families. According to a European group of movement leaders, experts and advocates in the field of LGBTI, women's rights and progressive faith, family equality is 'the recognition and protection of diverse forms of family by the state and society (Selun et al. 2017, p. 5). Family equality aims to contribute to social justice and inclusivity (Selun et al. 2017). The strength of this perspective is that is does not centre on individual rights or minority groups, but on family, which speaks to many people. The family equality perspective reclaims and redefines 'the family', altering it from a restrictive and conservative moral concept into an idea of 'society's common good' (Selun et al. 2017, p.6). Diverse families can appeal to many people, including those who do not know any LGBTQI+ people, yet who can relate to or are part of non-traditional families. Non-traditional family members can suffer from fewer rights and entitlements, limited protection, social stigmatisation, lack of recognition or representation. A focus on family diversity and family equality can connect struggles and bridge movements that fight to alter restrictive traditional gender, sexual and family norms, which can also be harmful to LGBTQI+ people. Advocacy that targets family equality uses messaging based on shared values and lived experience of families, such as love, care and belonging, rather than emphasising identity and ideology. Such messaging could create new cross-movement alliances including progressive liberal, LGBTQI+ and faith-based organisations (Selun et al. 2017). The message of family equality relates to human rights in terms of the right to family life and reproductive rights. Examples are the limited reproductive and family planning opportunities and services for non-traditional families such as legal restrictions and social stigma on adoption, fertility treatment and parental recognition.

Gender transformative

Gender transformative SRHR messaging (also called the Gender Transformative Approach, GTA) aims 'to reshape gender relations to be more gender-equitable, largely through approaches that free all people from the impact of destructive gender and sexual norms at all levels of the socio-ecological model'. The gender transformative approach (see Knowledge file Gender Transformative Approach) focuses on raising critical awareness of unhealthy, rigid and harmful gender norms and power relations and aims for mutually redefined positive gender norms and equal rights and opportunities. Since stigmatisation of LGBTQI+ people is often based on harmful and restrictive gender and sexual norms, the gender transformative approach could be a useful perspective, promoting attention to contextual, structurally restricting norms and redefining these to create more equal and inclusive environments. Ideally, a gender transformative approach based on human rights focuses both on duty bearers, such as government institutions, and on the empowerment of marginalised groups, such as LGBTQI+ people. In transforming heteronormative societies or organisations into more enabling environments, it is important to replace binary thinking with diversity thinking. The world does not exist only of men and women. Rutgers uses the gender transformative approach in several of its programmes.

Sex-positive

Sex positivity centres on sexuality as a positive and enhancing part of life that brings happiness, energy and celebration. It is sometimes misconceived for promoting that 'all sex is good'. However, the approach is more nuanced. It brings forward the importance of a healthy sexual development and advocates positive, consensual, pleasurable and safe sexual experiences (Van Reeuwijk 2010). This requires a positive and respectful approach to sexuality and sexual relationships, free of coercion, discrimination and violence. Realising the fact that sexuality is an integral part of people's well-being and health, a sex-positive approach can be a starting point to implement SRHR information and services. Sex-positive messaging empowers people to make informed choices as well as respecting the rights of others. It acknowledges and tackles the various risks associated with sexuality without

reinforcing fear, shame or taboo of people's sexuality, sexual identity and gender inequality (IPPF 2012). This message provides opportunities to emphasise and celebrate diversity and to communicate that sex and sexuality are normal and positive for all people's (sexual) well-being.

8 Conclusion

Rutgers upholds the right of everyone to enjoy a healthy sexual and relational life and to experience their own sexuality in a positive, safe way, free of coercion, discrimination, stigma and violence. We have identified the mainstreaming of sexual and gender diversity as an important pathway of change to improve LGBTQI+ people's SRHR. Through adopting a positive sexual health model, we apply a positive and holistic perspective on sexual health. We fight for the recognition and implementation of equal SRHR, respecting SOGIESC, sometimes in highly politicised societies and contexts. In more tolerant societies, we address subtle prejudice and the impact of heteronormativity on people's SRHR in their lives. By implementing these strategies in our work as leader and member of alliances on SRHR worldwide, Rutgers aims to create enabling environments and access to SRHR information and services for *all* people.

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