YOU ACT
EUROPEAN YOUTH NETWORK ON SEXUAL AND REPRODUCTIVE RIGHTS

2021

Sexual and Reproductive Health and Rights Training Programme

Pass the mic!
Time to give underrepresented SRHR topics the limelight!

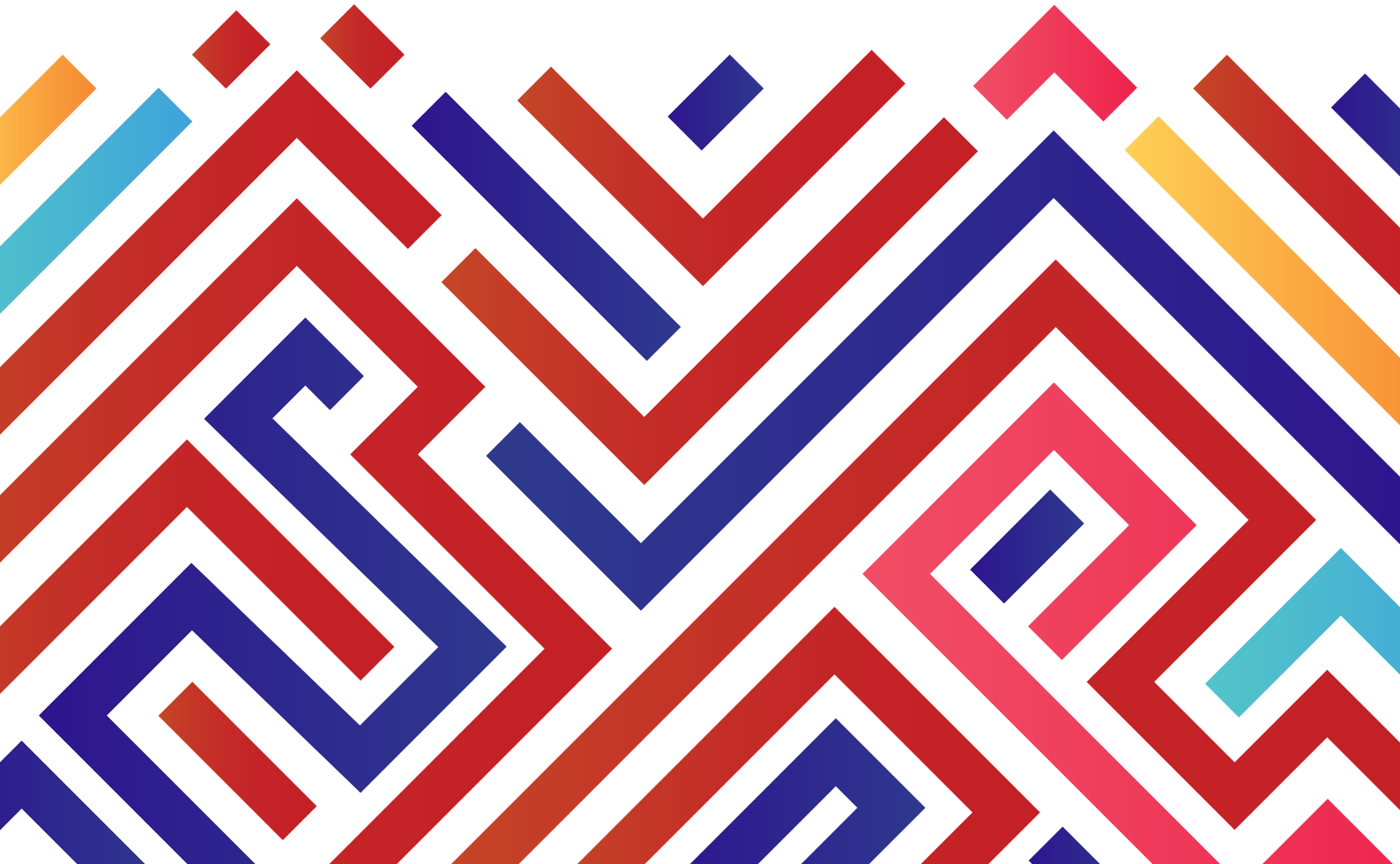

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TABLE OF CONTENT

ACRONYMS

AIDS	Acquired immunodeficiency syndrome
CRPD	United Nations Convention on the Rights of Persons with Disabilities
CSE	Comprehensive Sexuality Education
EIGE	European Institute for Gender Equality
EU	European Union
FRIES	Freely given, Reversible, Informed, Enthusiastic and Specific
HIV	Human Immunodeficiency Virus
ICF	International Classification of Functioning, Disability and Health
ICPD	International Conference on Population and Development
IGM	Intersex Genital Mutilation
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex
MDGs	Millennium Development Goals
MSI	Marie Stopes International
NGOs	Non-governmental Organisations
PoA	Programme of Action
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

YouAct Sexual and Reproductive Health and Rights training programme

PASS THE MIC

TIME TO GIVE UNDERREPRESENTED SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS TOPICS THE LIMELIGHT!

As a youth-led organisation, YouAct recognised the need to focus more on young people's skills and capacities on various Sexual and Reproductive Health and Rights (SRHR) topics. It is clear that we are leaving young people behind and as one of the only European youth-led organisations working on this topic, we must be part of this change. Access to safe, inclusive, and adapted information on SRHR has always been a major challenge as we target young people. For that reason, we focused our programmes on underrepresented themes in SRHR for young people.

During this training, we will address identified underrepresented SRHR issues, such as:

- consent and rape culture,
- disabilities and SRHR,
- decolonizing SRHR and harmful practices,
- approaching SRHR with an intersectional lens,
- transgender experiences and trans rights.

A training programme by and with young people to pass on the microphone to underrepresented voices.

Our vision of inclusivity and intersectionality guides our work and ensures that the topics and discussions created can exist in a safe environment, with the participation of young people.

OBJECTIVES OF THIS TRAINING PROGRAMME

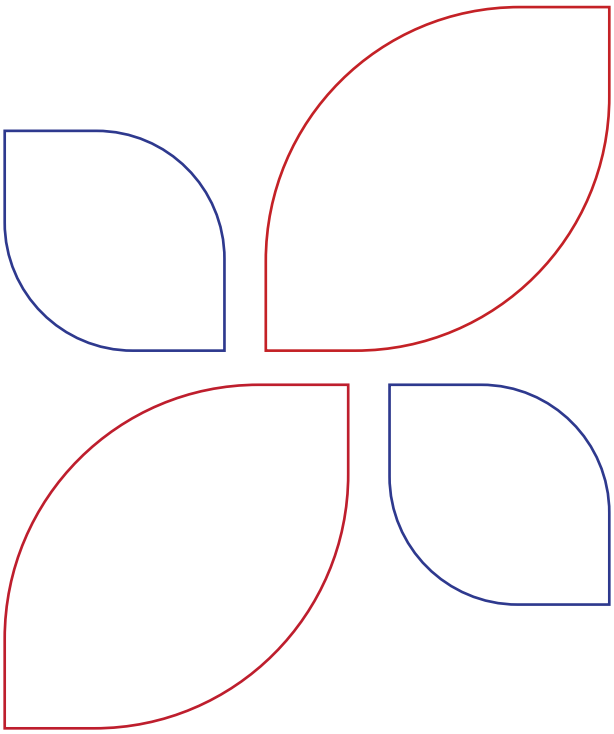
The training programmes will gather young people from all across Europe with different perspectives, perceptions and knowledge on the topics that we will address. Ensuring the same understanding of definitions, concepts, and key words is the objective of this introduction session. Young experts will collectively share their knowledge and develop

a first introductory session to the training programmes.

What do we want to achieve?

By the end of the session:

- Participants have a strong understanding and knowledge of key terminology.
- Participants know about the importance of a safe and anonymous space.
- Sense of group belonging is created.
- Participants use the glossary.



CHAPTER 1: INTRODUCTION

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GENERAL INTRODUCTION - DISCUSSING SRHR

CREATING A SAFE SPACE

Talking about SRHR is not always easy and comfortable. Some topics might be considered taboo in certain cultures or contexts. When talking about sensitive SRHR topics, it is essential to foster a safe and supportive environment that is inclusive, challenging, caring, engaging, and interactive. This space needs to enable participants to feel comfortable when sharing opinions and participating in activities and discussions if they choose to do so. For this training module we propose a participant trust agreement, a guardian figure and a questions mailbox, among other activities, to foster a safe space.

GUARDIAN FIGURE

For ensuring that the participants' trust agreement is put into practice, the guardian figure should be present in all modules. The responsibilities should include observing and mediating the participants' chat when needed for guaranteeing the trust agreement, as well as managing the anonymous questions mailbox.

It is possible that throughout the modules some participants might feel uncomfortable, trigger, or experience some sort of online bullying when talking about certain topics. In this case, the guardian figure will also be available to all participants who may feel in need of support to manage any situation.

THE QUESTION EMAIL/BOX

Participants can have questions during the sessions that they might be afraid or ashamed to raise in front of others. The question mailbox is a tool that allows those questions to be raised. Participants can write questions anonymously and send them through a google form, managed by the guardian figure (see above), who will share the questions with the speakers at the end of the module. Speakers can address them publicly.

INTRODUCTION TO SRHR

DEFINING SRHR?

SRHR is about the ability of each individual, regardless of gender, ethnicity, age, culture or religion, to make informed decisions and choices when it comes to their sexuality and reproduction. This includes, but it is not limited to, being able to access contraceptive methods, deciding when and with whom to have children or get married as well as having an enjoyable and pleasurable sexual experience.

In 2018, the Guttmacher-Lancet report defined SRHR as a "...state of physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infertility. The definition of SRHR highlighting aspects fundamental to all people's – including adolescents' – rights to:

- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;
- decide whether, when, and by what means to have a child or children, and how many children to have."

Therefore, SRHR combines four connected and interlinked concepts: sexual health, reproductive health, sexual rights and reproductive rights.

According to the World Health Organisation (WHO) (2002), sexual health is "a state

of physical, emotional, mental, and social well-being related to sexuality: not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled".

Reproductive health is complementary to sexual health, according to the United Nations (UN) (2017) it is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes". The reproductive system not only includes access to safe, effective, affordable, and acceptable contraceptive methods, but also managing menstrual health in privacy and dignity and preventing and managing sexually transmitted diseases, including the Human Immunodeficiency Virus and the Acquired immunodeficiency syndrome (HIV/AIDS).

Sexual rights are the rights of all persons to receive information about sexuality, to have their bodily integrity respected and to decide whether to be sexually active and to engage in consensual sexual relationships. Some other rights included are access to comprehensive sexuality education (CSE), consensual marriage or access to sexual and reproductive health (SRH) care services.

Finally, reproductive rights are the rights of all individuals to decide the number, spacing, and timing of having or not children. To simplify, reproductive rights are all rights relating to your reproductive health.

SRHR WITHIN THE HUMAN RIGHTS FRAMEWORK

As you may have observed in the previous section, SRHR relies on human rights. The Universal Declaration of Human Rights (UDHR) defines human rights as the rights inherent to all human beings, regardless of gender, nationality, sexual identity, ethnicity, language, religion, or any other status, without discrimination. Some of the rights included in this framework is the right to life and liberty, freedom of opinion and expression, the right to work and education, and many more.

Therefore, SRHR are human rights, as everyone has the right to decide if, when and with whom to have kids and get married, to have access to CSE and to be able to have an enjoyable and healthy sexual life, among others. It is important to accept / define

SRHR as a fundamental human right to ensure that such a right is universally protected. This establishes that an individual whose SRHR is violated can raise a claim to the court and hold stakeholders or infringers accountable for violating the law. The relation between SRHR and human rights was first discussed at the International Conference on Population and Development (ICPD) in Cairo, in 1994. In particular, they introduced the term SRHR to declare it as a fundamental human right for everyone. However, still today, there is much to accomplish, as highlighted, for example, in the 2030 Agenda for Sustainable Development Goals (SDGs), which includes a specific target for achieving universal access to SRHR (Gender Equality Goal 5) (Griffin 2006).

Despite the important efforts to create consensus around human rights frameworks and steps to secure universal access to SRHR, there is still a long way to go in the achievement of those universal rights, especially when applied to young people. For that reason, the next modules will focus on underrepresented themes in SRHR for young people and the need to address them.

GLOSSARY AND EXPLANATION OF KEY TERMINOLOGIES

Cisgender:	To identify with the gender one was assigned at birth, as opposed to transgender.
Consent	Sexual consent is an agreement between two or more people to engage in a sexual activity made voluntarily and at free will. Consent is all about communication (verbal, physical etc.) and continuing to engage in a sexual activity where someone has not consented (including if they are below the age of consent, too intoxicated, or it is a situation where they feel pressured to comply) is sexual assault and is criminally punishable in many places. Note that how sexual consent is legally or socially defined varies greatly geographically. Also note that while consent does not need to be verbal, explicitly agreeing to something makes it easier for all parties to respect each other's boundaries. Consent is required every time people engage in a sexual activity, even if they have previously consented at an earlier time.
Decolonizing	Decolonizing refers to the practice of deconstructing and reversing the racist and dehumanizing thought process brought about by colonisation.
Empowerment	The act of granting the power of self-determination and autonomy for oneself or individuals and communities
Gender	Social attributes and opportunities associated with being a girl, women, boy, man or non-binary. These are socially constructed and are learned through socialization. The social construct of gender determines what is expected, allowed, and valued in given context and culture.
Gender equality	Equal rights, responsibilities, and opportunities of all genders.
Gender expressions	The ways a person presents gender through their actions, dress, and demeanor and how those presentations are perceived by others and interpreted based on gender norms (Genderbread.org).
Gender identity	a person's internal and individual experience of gender, which may or may not correspond to the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical, or other means) (European Institute for Gender Equality (EIGE), 2021).
Gender norms	Standards and expectations to which people generally conform, within a range that defines a particular society, culture, and community at that point in time (EIGE, 2021).
Gender roles	Gender roles are the socially prescribed behaviors that are considered normal based on a person's real or perceived gender identity and expression, and/or biological sex.
Gender stereotypes	Preconceived ideas whereby people are arbitrarily assigned characteristics and roles determined and limited by their gender (EIGE, 2021).
Intersectionality	Intersectionality is a concept and tool of analysis coined by Kimberlé Crenshaw (1994) describing power and domination as systems and dynamics that intersect and feed each other. Individuals are never exposed to one form of power only, rather all the different aspects of their identity put them at the intersection of different power relations in which they can be privileged, marginalised or subordinated. For example, a lesbian migrant woman will not alternate experiences of xenophobia, homophobia and sexism, rather she will face discriminations linked to all of these forms of oppression simultaneously. Intersectionality has gained more and more credibility as an approach allowing for a better assessment of the situation of individuals and their specific needs.

Intersex	Intersex stands for the spectrum of variations of sex characteristics that naturally occur within the human species. Intersex individuals are born with sex characteristics that do not fit medical norms of male or female bodies. Intersex people's sex characteristics and bodies are healthy variations of the human sexes. For some intersex people, their intersex body becomes visible at birth, for some during childhood and with others their body shows itself to be intersex during adolescence or even adulthood. See more here.
Non-binary	To have a gender that is neither fully woman nor fully man. Non-binary refers to being outside the binary (meaning made up of two parts) understanding of gender. Non-binary genders are under the transgender umbrella.
Rape	non-consensual vaginal, anal, oral penetration of a sexual nature of the body of another person with any bodily part or object. Consent must be given voluntarily as the result of the person's free will (EIGE, 2021).
Rape culture	A culture where the societal attitudes relating mainly to sexuality and gender result in sexual assault being both normalized and trivialized. It inhabits the collection of ideas, practices, structures, images and other representations of societal values (i.e. laws) that make it easy for perpetrators to commit and continue to commit violence whilst making it hard for victims to speak out or get justice.
Rape myths	False beliefs about rapes and sexual assaults that put the blame on the victim rather than on the aggressor.
Sexual Rights	Sexual rights are their rights of all people to decide freely on all aspects of their sexuality free from coercion, discrimination, and violence. This includes the highest attainable standard of sexual health, including access to SRHR, to seek, receive and impart information related to sexuality, to receive sexuality education, have respect for bodily integrity, have a free choice of partner, decide to be sexually active or not and whether or not and when or how often to have children, pursue a satisfying, safe and pleasurable sexual life and the right of all people to participate in decision making processes that affect these rights. (YouthDoIt, n.d.) See more here.
Sex	Biological and physiological characteristics that define humans as female, male or intersex.
Social norms	In general, social norms are rules of action shared by people in a given society or group. They define what is considered normal and acceptable behaviour for the members of that group (Cislaghi & Heise, 2018). Many cultures reflect their social norms on sexuality by identifying what is considered as 'normal' and 'acceptable' sexual behavior within society (UKessays, 2018).
Transgender	To have a different gender than what one was assigned at birth, as opposed to cisgender.

SUGGESTED ACTIVITIES

INTRODUCTORY ICE BREAKER

Mention questions to introduce the participants. Some questions to ask:

- Where are you from? /Where are you joining from?
- How old are you?
- Today I feel... (maybe give some options)/ Which color would best describe your current state of mind?
- I am excited to start this training because...
- Using one word, what do you expect from this training?

Tools: Mentimiter/zoom poll/Kahoot

CREATING A SAFE SPACE AND SETTING GROUND RULES

The aim of the activity is to draw up an agreement between the participants and the facilitators. The content of the programme is built and shared with the group. Educators present the training modules, its context and the aims.

It could be done using the Trust Agreement template of the Gender ABC project coordinated by End Female Genital Mutilation European Network (End FGM EU).

Steps:

1. The group has access to the mural/miro document and have a few minutes to discuss and write in groups of three some ground rules they consider important.
2. Participants discuss the rules and the educators mark the rules on which everyone agrees with on the poster (using miro/mural).

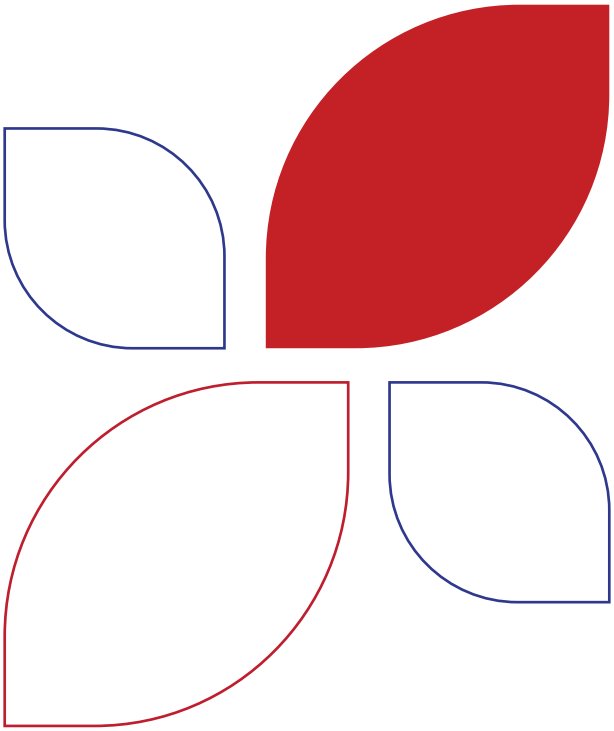
Trainers: Possible questions to ask during the discussion

- Which are the effects of these rules within the group?
- What do they provide?
- Having established these rules, what is now easier? What is challenging?

Considering the answers, the trainer highlights why it is important to draw up an agreement and establish together rules that preserve privacy and ensure mutual respect within the group.

Important rules that should come up in the agreement are:

- One must respect one's privacy and one should not tell others what a companion says or does in the circle of trust.
- Participants are never forced to say or do something that makes them uncomfortable.
- They must always listen when others talk.
- They must not judge others.
- They must respect everyone's differences and points of view.



CHAPTER 2: CONSENT AND RAPE CULTURE

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CONSENT AND RAPE CULTURE

OBJECTIVES OF THIS CHAPTER

- Strengthening the participants' understanding of consent.
- Promoting the use of consent-seeking practices.
- Promoting sexual health with a deeper understanding of safer sex through exploration of one's own boundaries and respecting others' boundaries.
- Familiarizing participants with the concept of rape culture.
- Strengthening the understanding of how rape culture impacts both on a societal and individual level.
- Providing participants with a toolbox of consent-seeking practices and ways to fight rape culture and promote consent culture.

UNDERSTANDING CONSENT AND RAPE CULTURE

Consent and rape culture are important topics to explore in order to promote health and pleasure, better communication, and to combat sexual violence. Although many factors contribute to why sexual assault happens, one of the aspects many young people highlight is the lack of CSE as an arena to learn about consent and communication. Understanding bodily autonomy and boundaries at a young age encourages positive experiences and increases understanding of what consent involves. Children might start out learning to ask before you hug someone, and that you can decline a hug. Older youth will generally find it more relevant to discuss sexual consent. It is of utmost importance to bring awareness to what consent is, how to obtain and express it, as well as to be aware of the ways we have been taught to think about these topics through naming and understanding rape culture. Our cultures and societies play a role in defining our realities, and therefore it is essential that young people are aware of and understand how rape culture influences the way we approach sex and rape.

Culture, and specifically rape culture, shapes, and influences our society, including our laws. An example of rape culture hindering progress is the status of consent-based rape laws in Europe. The Istanbul convention, short for the Council of Europe Convention on

preventing and combating violence against women and domestic violence, addresses how rape laws center around the lack of consent as a determining factor in defining rape. A consent-based rape law explicitly states that lack of consent from a person involved in the sexual act is equivalent to rape. If rape law is not consent-based, the act of rape might only be defined through sexual assaults where explicit physical violence was used, threatened violence, or if the victim was unconscious due to either sleep or substances. Although the Istanbul Convention has been signed by 45 countries, only 12 countries have consent-based rape laws[1]. The fact that most of the countries in the Council of Europe does not have consent-based rape laws is largely a result of misguided beliefs in society about what rape actually is.

An important disclaimer to make regarding this topic is that a focus on ensuring consensual sexual relations and working on eradicating rape culture will likely not deter those that are committed to consciously being sexually violent towards someone else. Instead, the purpose is to empower young people to consciously create safer sex situations, examine one's own social conditioning and beliefs, and build a better society so that those who are victims and survivors of sexual assault receive the support and justice they deserve.

CONSENT

WHAT IS CONSENT?

In general terms, consent is when a person voluntarily agrees to a proposal or suggestion someone else is putting forth. There are different types of consent and different contexts for consent, such as sexual consent, medical consent, research, and legal consent, as well as consent in everyday life and relationships. Our focus will be on consent in sexual and intimate relationships as it relates to bodily autonomy. Sexual consent is defined as expressing an explicit desire to engage in sexual activity with someone, either verbally or nonverbally. Sexual consent is essential in sexual and intimate situations to ensure bodily autonomy and positive sexual experiences, as well as to avoid sexual assault.

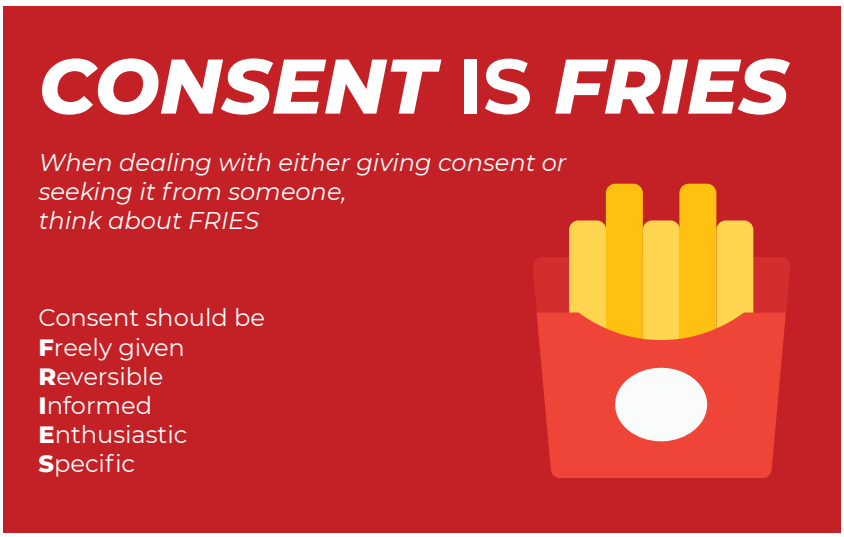
Exercise: Watch the Tea consent video[2] to see how understanding consent can be compared to offering a cup of tea.

1 https://www.amnesty.org/en/latest/campaigns/2020/12/consent-based-rape-laws-in-europe/
2 https://www.youtube.com/watch/oQbei5JGiT8

HOW CAN CONSENT BE GIVEN AND RECEIVED?

A valuable acronym to keep in mind when dealing with either giving consent or seeking it from someone is FRIES. FRIES refers to that consent should be Freely given, Reversible, Informed, Enthusiastic and Specific[3].

To be Freely given, we must ensure there is equal footing between those involved in the situation regarding power dynamics and positions of authority. In addition to this, it is critical that everyone involved can consent and not under the influence of alcohol or drugs or below the age of consent. This also includes not being coerced into a sexual act through repeated asking.



To be Reversible, we must ensure that the person(s) involved is comfortable, so that the person who gives consent feels they are able to change their minds, as saying yes initially is in no way a binding contract. This can include verbally providing opportunities to stop.

To be Informed, we must ensure that those involved know what they are saying yes to – what will happen and how.

To be Enthusiastic, we must confirm that the other person(s) is an active participant in the situation and enthusiastically saying yes. Someone being a passive recipient and the absence of a no is not enough.

To be Specific, consent, a "yes", is only applicable in the moment to a specific situation or action, which means that consent at one time to one thing does not mean consent to several times or several different actions. In other words, it is ongoing.

Sexual consent in the context of FRIES is generally given verbally or through body language, although verbal communication is encouraged. In concise terms, it is all about asking about and ensuring an enthusiastic "yes!" before you act, rather than the simple absence of a "no".

3 https://www.plannedparenthood.org/learn/relationships/sexual-consent

CONSENT IS TEA

Consent can be compared to offering a cup of tea - if you offer someone a cup of tea and they don't want it, don't make them drink it!

Exercise: Watch the What if someone does not want to have sex? video[4] to understand how to respectfully handle rejection if you are not given sexual consent.

RAPE CULTURE

To thoroughly promote consent, it is vital to understand the culture that surrounds us and informs our ideas about the world. We must be aware of the assumptions and expectations about sex and sexual assault that are omnipresent in our society when we aim at tackling sexual violence and ensure safer sex. One of the things that shape so many of our ideas and beliefs on this topic is rape culture. Rape culture refers to a culture where the societal attitudes relating mainly to sexuality and gender result in sexual assault being both normalized and trivialized. It inhabits the collection of ideas, practices, structures, images, and other representations of societal values (i.e., laws) that make it easy for perpetrators to commit and continue to commit violence whilst making it hard for victims to speak out or get justice[5][6].

One way rape culture is produced and perpetuated is through media. In movies and television, sex scenes rarely explicitly address consent. It is common that a character initiates physical intimacy or sex without any apparent consideration to consent, but the character on the receiving end frequently becomes enthusiastic despite this. There are also countless instances of a man trying to force himself onto a woman where she resists for a few seconds, but then ultimately gives in, implying that that is what she truly

4 https://www.youtube.com/watch?v=QSDjSetIGiw
5 https://www.youtube.com/watch?v=QSDjSetIGiw
6 https://everydayfeminism.com/2014/03/examples-of-rape-culture/

desired. These kinds of situations do not reflect real life, leading to false ideas of what healthy sexual and romantic situations look like, for example that it is not necessary to ask for consent, and that someone will become enthusiastic automatically after starting. Furthermore, in many songs and music videos, sexual assault is normalized through lyrics casually insinuating rape to a catchy melody. Advertisements in mass media, often for fashion or perfume, objectify women's bodies in sexual ways to sell products, which helps create an underlying idea of automatic access to women's bodies. Comedians joke about rape where the punchline is rooted in victim-blaming. Mainstream pornography displays rough sex with no conversation about boundaries and consent. These are merely a few examples of rape culture being upheld in popular media. There are many more examples to find, as well as many other arenas for rape culture to flourish.

A large part of rape culture are rape myths. They influence how society and individuals view rape. Rape myths are a widespread or common, but flawed, understanding of rape. They contribute to downplaying the seriousness and pervasiveness of sexual assault. The concept of rape myths was developed to shine light on and combat the idea that

victims are responsible in any way for their assault. Rape myths in society contribute both to poorer health of those who have been sexually victimized, as well as have tangible effects on functions such as the court and policing[7][8]. They contribute to portraying rape as something less serious and less common than it is in reality, as well as add to a hostile culture for those who have been exposed to sexual violence. This has ramifications that

7 Lea, S. J. (2007). A Discursive Investigation into Victim Responsibility in Rape. Feminism & Psychology, 17(4), 495 - 514

8 Anderson, I. & Doherty, K (2008). Accounting for rape: Psychology, Feminism and Discourse Analysis in the Study of Sexual Violence. East Sussex: Routledge

range from internalized shame, social stigma, and re-traumatization for the victim, to reluctance to report rape and lesser sentences for the relatively few rapists that get prosecuted[9][10]

Rape myths are false ideas that are widely believed to be true in many societies. By understanding what they are, it is easier to get information and arguments to combat them with. Some examples of common rape myths are:

- What someone might wear or their physical qualities, their level of intoxication (from either alcohol or drugs), their sexual history, or degree of resistance (whether someone says no, physically fights back, etc.) has any bearing on whether the victim shares any blame in being assaulted. Only the perpetrator who assaulted someone bears responsibility for the assault taking place. This myth unfortunately encourages both victim-blaming and slut-shaming.

- That most sexual assaults are committed by a "stranger in a dark alley after the sun has set". This myth displays how sexual violence statistics have been distorted, as nine in ten rapes are committed by someone the victim knows[11] . It also shows the unwillingness to accept that most victims actually know their perpetrator. Rapes committed by strangers are commonly sensationalized and over-reported in the media, greatly influencing the public's perceptions of who can be a perpetrator of sexual violence. This leads to people not easily believing victims when their perpetrator is someone they know or from the community.

- That only (cis) men sexually assault. Although cis men are most frequently the gender that perpetrates assault, they are by no means the only gender who can. All genders can be perpetrators of sexual assault. This is also important to emphasize as to not minimize that sexual assault also happens within the LGBTQIA+ community.

- That only (cis) women can be victims of sexual assault. This myth contributes to erasing that all genders can be victims of sexual assault and can be victimized by any gender. For example, this myth adds to the stigma around being a male victim, as well as erasing people of other genders.

9 Lea, S. J. (2007). A Discursive Investigation into Victim Responsibility in Rape. Feminism & Psychology, 17(4), 495 - 514

10 https://everydayfeminism.com/2014/03/examples-of-rape-culture/

11 Serisier, T. (2017). Sex Crimes and the Media. Oxford Research Encyclopedia of Criminology and Criminal Justice

- That sex workers cannot be raped. This myth grows out of a notion that someone selling sexual services is already dealing with sex and therefore a sexual assault isn't really assault. It is very detrimental as it mixes sex with rape, foregoes the sex worker's right to consentual relations, and dehumanizes them.

- That marriage and committed romantic relationships constitute automatic and perpetual consent. These do not, in any way, imply sexual consent at any time. Sexual consent can only be given and received in a FRIES context.

These examples only start to scratch the surface of the many consequences of rape culture. A 2016 report from the European Commission detailing a survey done about gender-based violence exemplifies how rape myths actively take root in society. 27% of respondents across the EU "believe that having sexual intercourse without consent may be justified in certain situations", referencing one or more of the following scenarios: if the person is drunk or using drugs, voluntarily goes home with someone, wears "revealing, provocative or sexy clothing", doesn't clearly say no or physically fight back, flirts beforehand, has several sexual partners, is out walking alone at night, or if the assailant does not realise what they were doing or "regrets his actions"[12].

JAMES IS DEAD

Victim-blaming and rape myths are both absurd and incorrect, even though they are often normalized

Watch the James is Dead video

12 https://ec.europa.eu/commfrontoffice/publicopinion/index.cfm/Survey/getSurveyDetail/search/449/surveyKy/2115

Although the statistics from each country vary , with some countries being more heavily influenced than others by these myths, the fact that over one in four respondents believe these myths is more than enough reason to combat rape myths and help change the culture we live in for better.

Exercise: Watch the James is dead video[13] to understand that victim-blaming and rape myths are both absurd and incorrect, even though they are often normalized.

WAYS TO FIGHT RAPE CULTURE AND PROMOTE CONSENT CULTURE

One of the ways to fight rape culture is to actively promote the opposite - consent culture! Normalizing consent in our everyday lives is one way to start changing societal attitudes. One of the benefits of consent culture is rejecting rape myths. As one of the common rape myths is that one must actively be resisting sexual advances both physically and verbally for it not to be rape, many of those who have been subjected to sexual violence unfortunately experience feelings of guilt and shame for not doing “enough” to resist. This is due to the misplaced expectation that they should and could have stopped it from happening. In a culture of consent, where everyone is expected to make sure all parties involved consent to a given sexual activity, there is no ambiguity as to who is at fault for the sexual violence taking place – that being the one who perpetrated it and didn’t seek and ensure consent.

SEXUAL CONSENT IN PRACTICE

Even though a culture of consent promotes consent in many different situations and relationships, we have been mainly addressing sexual consent in this text. To fully understand sexual consent, we must understand what sex even encompasses, so that we know in what situations consent is something we should be aware of and seeking. As mentioned in the section about rape myths, penile-vaginal intercourse between a cis, heterosexual, and able-bodied woman and man is at the center of the mainstream societal understanding of what sex is. This assumption and cultural norm reinforces the idea that this sexual act is the only one which requires consent. Instead, we must challenge norms about what sex is expected to look like.

13 https://www.youtube.com/watch?v=Op14XhETfBw

Exercise: Read the What is sex resource and reflect on how "sex" can mean different things to different people.

Sexual consent in practice is all about communication. Regardless of what kind of sex you are engaging in or with who, it is necessary to have a clear understanding of what everyone involved desires and is comfortable with. Ways we communicate consent and desires will naturally vary based on for example whether we are with a long-term partner or a new partner, whether we are adding new elements to the sex or not, or simply depending on how we feel that day. Therefore, it is important to have several ways of creating a safer and enjoyable space together. The following examples are ways to enhance communication, pleasure, and safety:

1. Create a Yes/No/Maybe list either by yourself or in dialog with partner(s). In this exercise you establish what activities you know you want to do, which ones you are sure you do not want to do, and which might be of interest. The Yes/No/Maybe exercise is a tool for understanding your own desires, to see interests you have in common with a partner(s), and to set clear boundaries for what you do not want.

2. Check in with your partner during sex. Providing alternative things to do can be helpful and creates a safer space for communication. It can be as simple as "I want to make sure you want to do this. Should I keep going?", "Would you like to change what we are doing?", "Can I do something differently to help you feel good?", "Do you want to take a break?", etc. Another way to check in is agreeing to use the traffic light system. Here green is go/continue like this, yellow is caution/slow down/something needs an adjustment, and red means stop immediately/a break is needed. You or your partner can say a color unprompted, or you can ask each other. If they say yellow or red, it is important to understand what their needs are.

3. Identify a safe word with your partner(s). This can be red like above or something completely different, but preferably a word you generally do not use in a sexual situation. In general, saying the safe word means stop.

4. Create a safer and comfortable experience with after-sex care, such as cuddling or affirmations if wanted. You can also check-in about their experience with a question about how they are doing or how it was for them.

A consent-seeking practice to keep in your toolbox is the 4 Questions we should ask ourselves before we have sex with someone[14]:

1. What do I know? If I want to have sex, do I know that the other person(s) does as well? Do I know what they like and do not like? What they want to do and do not want to do?

2. How do I know? Am I assuming things perhaps based on things I have seen in the media, what people around me think is common, or based on my previous experience with other people? Or have I spoken with this specific person(s) about it?

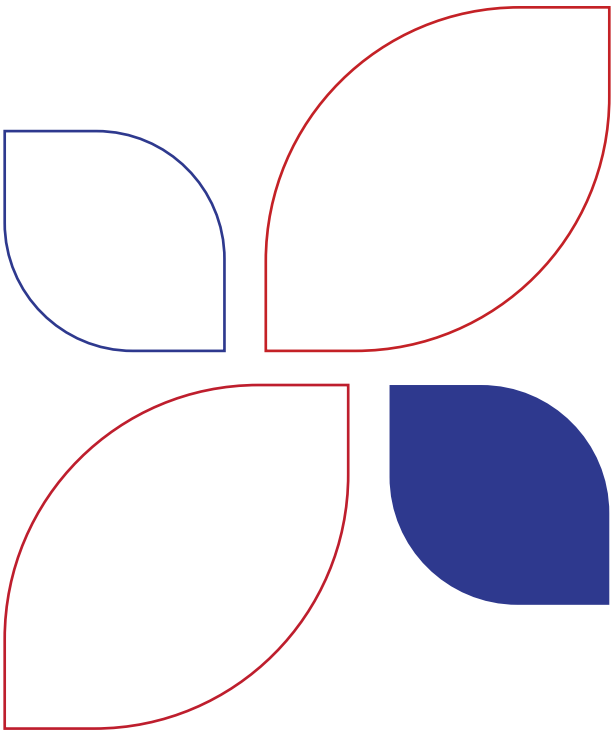
3. Could something have changed? If we spoke about it, could something have changed, and if so, what should we speak about now? People are always changing and have every right to do so, so how can we check in with each other?

4. What do I want? Have I checked in with myself about what I feel like and do not feel like doing? Do I feel like I am able to express what I want and do not want, and that I am heard and respected?

In this brochure we have covered what rape culture is and how it works, as well as what sexual consent is and how to practice and promote it. There are many ways to fight rape culture and help move society into a consent culture, and many arenas where this shift is taking place. On a larger scale we can promote implementation of CSE for all ages, where children learn in age-appropriate ways that they own their own bodies and that we must ask to know what others want. We can work towards consent-based rape laws across Europe, so that it is clear to everyone that sexual intercourse without consent is rape, and that this can be prosecuted in court. We can make sure those who have been sexually assaulted have easy access to dignified support programs. On a more individual level, we can educate and stand up against rape culture when those around us perpetuate it, including listening to and believing those who have been sexually assaulted. We can practice speaking openly and honestly about our boundaries and sexuality, and step away from shaming ourselves and others regarding these topics. We can make sure that we speak about consent in both sexual and non-sexual situations. We can do this through focusing on our responsibility to ensure consent, rather than

14 Questions were developed by the Restart project/Queer Youth Norway: https://skeivungdom.no/

putting the responsibility on others to have to say no. We can ask about and listen to each other's boundaries in all kinds of situations. Through normalizing consent-seeking practices in different relationships and everyday situations we take a huge step in the direction of a consent culture. All these suggestions and more help create safer, healthier and more pleasurable communities and societies.



CHAPTER 3: DISABILITIES AND SRHR

Authors

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DISABILITIES AND SRHR

OBJECTIVES OF THIS CHAPTER

- Distinguish the difference between disability and impairment and how different models view the concept of disability.
- Identify the barriers, needs and challenges to enjoy SRHR for youth with disabilities.
- Answer the questions: What are the specific barriers and challenges that young people with disabilities face regarding SRHR? Do they have different needs compared to their peers without a disability? How can we accommodate these needs, and lower the barriers to ensure their equal enjoyment of SRHR?
- Explain the SRH risk factors for persons with disabilities. What are the consequences of these barriers and challenges for persons with disabilities, and what are the risks of those consequences?

DEFINING DISABILITY

Disability is a complex, dynamic, multidimensional and - sometimes - controversial concept. Perceptions on what it means to be disabled differ across cultures, religions, countries, and people. Over the past couple of decades, it has been defined in the literature in various ways. There are people that consider disability as a medical problem that need treatment, or perceive it as a category of inferiority, others see it as an aspect of human diversity and social construct (Peta, 2017; Bruijn et al., 2012). In some ways, one could say that disability looks like sex or race as a philosophical topic as it concerns the classification of people based on observed or inferred characteristics (Stanford Encyclopedia of Philosophy, n.d.)

The different understandings of the relationship between impairment and limitation inform contrasting approaches or models towards disability. The medical model views disability as a physical or mental impairment of the individual and it's personal and social consequences. On the other hand, the social model sees disability as a relation between an individual and the social environment, meaning that their exclusion from aspects of social life are manifested in a built environment and organized social activity that restricts the full and equal participation of people with disabilities.

From a health perspective, the WHO defines disability as

'an impairment that may be cognitive, developmental, intellectual, mental, physical, sensory or some combination of these. It substantially affects a person's life activities and may be present from birth or occur during a person's lifetime. Disability is an umbrella term, covering impairments, activity limitation and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while participation restriction is a problem experienced by an individual in involvement in life situations. Disability is thus not just a health problem. It is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives' (WHO, 2019).

The social and human rights model of disability 'focuses on the high barriers created by the environment (rather than by bodily impairment), including in physical, information and communication contexts, the attitudes and prejudices of society, policies and practices of governments and the often-exclusionary structures of health, welfare, education, and other systems' (United Nations Population Found (UNFPA), 2018; United Nations Children's Fund (UNICEF), 2012).

In-betweens are definitions which assert that both the individual impairment and the social environment are jointly causes of limitation. The tension that existed between the medical and the social models of disability was reconciled when the International Classification of Functioning, Disability and Health (ICF) was adopted by the WHO in 2001.

The ICF gives appropriate weight to the different aspects of disability, from both a medical and a social perspective. The ICF is promoted as a bio-psycho-social model that addresses disability as an umbrella term for impairments, activity limitations and participation restrictions.

In doing so, the model refers to the challenging aspects of the interactions between an individual (with their health condition) and their contextual factors (personal

and environmental). Stakeholders therefore must include a focus on improving social participation, by addressing the environmental barriers (attitudinal, physical, communicational, policy and institutional) which hinder persons with disabilities in their everyday lives, rather than seeing the disability as an attribute of the person.

Therefore, it is essential to view a person's disability because of the interaction between the person with the impairment, and the barriers that hinder their full and effective participation in society on an equal basis with others.

GLOBAL SITUATION

All children and young people develop sexually throughout the course of their lives, this includes children and young people with disabilities. Although SRHR is considered as a determining factor in human well-being and an essential element of human rights, the sexual and reproductive needs, and desires of people with disabilities are rarely addressed.

The WHO (2012) estimates that there are over one billion people with disabilities worldwide, which equals 15% of the worlds' population. An estimated 20% of these one billion people are between the age of 10 to 24 years old (UNDEVSOC, 2016). The WHO Regional Office for Europe states that 6-10% of people in the region live with a disability. It is predicted that disability is on the rise, as the world population is aging and the prevalence of noncommunicable conditions is increasing (WHO Regional Office for Europe, 2019). Additionally, the global increase in chronic health conditions and mental health disorders, but also road traffic accidents, armed conflict and other forms of trauma contribute to this trend.

INTERNATIONAL FRAMEWORKS AND LEGISLATION

There are several international conventions and instruments that provide a framework for advancing SRHR for young people with disabilities. In this section, a brief overview of the most relevant ones is provided:

THE UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (CRPD)

The CRPD was adopted by the UN in 2006 and is signed and ratified by all countries in the EU. The framework was unique as it was the first time a convention was geared

towards people with disabilities and their rights, including seeing them as subjects of rights rather than objects of charity. Persons with disabilities are, with this framework, inherently entitled to all human rights and the convention stipulates that disability is a development issue. All countries that ratified the convention must ensure that international cooperation, including international development programmes, are inclusive and accessible. Several articles within the CRPD are of direct relevance of the enjoyment of SRHR for persons with disabilities:

1. Article 1: addresses the definition of disability.
2. Article 12: addresses the right to legal capacity, including reproductive rights and the right to give consent to intimate relationships and medical treatment.
3. Article 16: the right to live free from exploitation, violence and abuse.
4. Article 21: freedom of expression and access to information, which includes the use of adapted communication forms, barrier-free use of the internet and audio-visual media.
5. Article 22: ensures the respect for privacy.
6. Article 23: the respect for home and the family, which is inclusive of the right to marriage, the right to decide freely on number and spacing of children and the right to access to information, education and communication on reproduction and family planning.
7. Articole 24: the right to education without discrimination and on an equal basis with others, including sexuality education.
8. Article 25: the right to the enjoyment of the highest attainable standard of health, free from stigma and discrimination.

PROGRAMME OF ACTION (POA)

The PoA was adopted during the International Conference on Population and Development in 1994. It is remarkable in its recognition that reproductive health and rights, women's empowerment and gender equality are at the heart of population and development programmes (UNFPA, 2014). It directly addresses the needs of persons with disabilities (UNFPA, 2018).

SUSTAINABLE DEVELOPMENT GOALS

The seventeen SDGs were agreed in 2015 as a follow up on the Millennium Development Goals (MDGs). In contrast to the MDGs, which did mention SRHR but did not recognize the rights of persons with disabilities, there are five SDGs that explicitly mention persons with disabilities in their indicators.

SDGS THAT INCLUDE DISABILITY	SDGS RELATED TO SRHR
4. Quality Education	3. Good Health and Wellbeing
8. Decent Work and Economic Growth	4. Quality Education
10. Reduced Inequalities	5. Gender Equality
11. Sustainable Cities and Communities	6. Clean, Water and Sanitation
17. Parnetrship for the Goals	16. Peace, Justice, and Strong Institutions

Source: Sexual and Reproductive Health and Rights Position Paper, Liliane Fonds 2018

ACTION PLAN FOR SEXUAL AND REPRODUCTIVE HEALTH (SRH)

The Action Plan for SRH (WHO Europe, 2016) is a comprehensive framework to support countries to ensure that people are achieving their full potential for sexual and reproductive health and well-being. It includes objective 1.2 to establish and strengthen formal and informal CSE; this objective includes key action 27g, establishing mechanisms for the provision of CSE to disabled people and other less easily accessible groups.

THE GENERAL COMMENT NO. 22

The General Comment No. 22 (2016) on the rights to SRH (article 12 of the international covenant on economic, social and cultural rights) mentions that the right to SRH is an integral part of the right to health (UN Economic and Social Council, 2016). It explicitly mentions the right of people with disabilities to access SRH services and information.

SRHR FOR YOUNG PERSONS WITH DISABILITIES

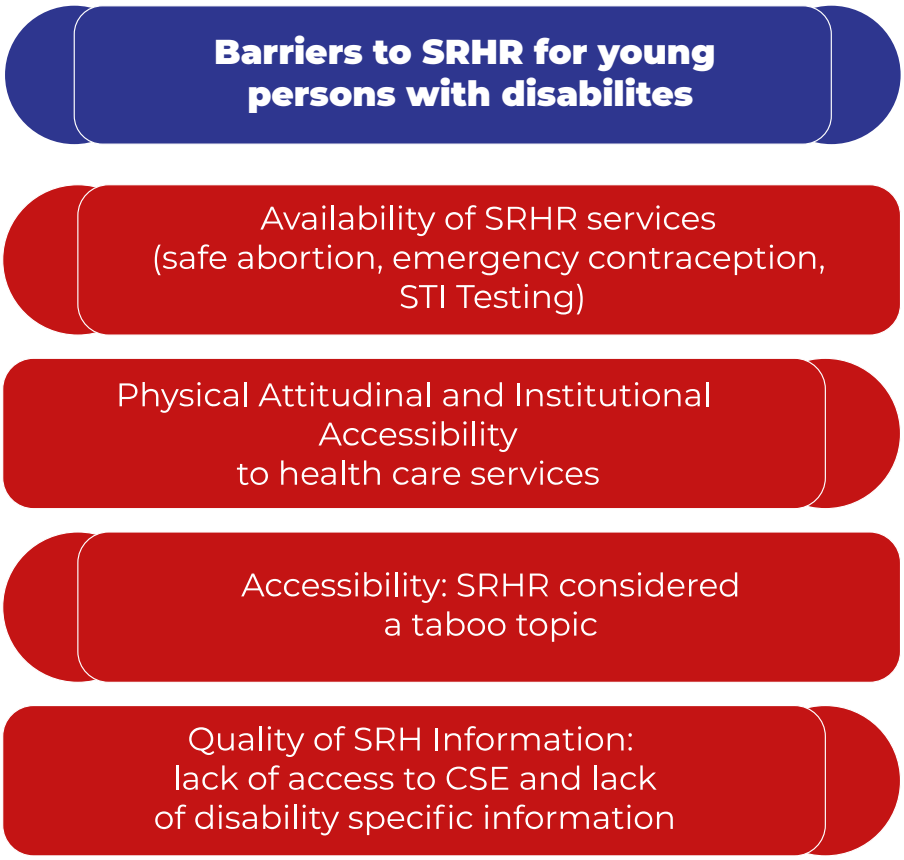
Although the perceptions of both SRHR as well as disability have changed over the past couple of decades towards a more rights-based approach, the person has become more important than the impairment. Therefore, it is acknowledged that persons with disabilities are sexual beings too. The increased acceptance of both concepts separately does not automatically lead to acceptance of both concepts combined. The SRHR for young persons with disabilities is rarely addressed. Sexuality as an expression of love is not recognised for people who have been stigmatised in society (Gianotten et al, 2008). Very often, sexuality education is reactive and used as a risk-reduction, there is little access to information, education and communication materials for both youth with a disability as well as parents, caregivers, and health workers resulting in them feeling untrained and anxious (Ballan, 2012). Lastly, there is a lack of an intersectional view. People with disabilities are found in all key populations that SRHR organisations are focusing on, and therefore cannot be seen as a separate target group. These key populations include people who identify as Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI), children out of school, women and girls, young people and migrants.

SEXUAL DEVELOPMENT OF CHILDREN AND YOUNG PERSONS WITH DISABILITIES

Like their non-disabled peers, children and young people with disabilities gradually develop into adulthood, including physical, psychosocial, mental and sexual development. They, however, might encounter difficulties (Maris, Vink, Oud, Deurloo, Kuyper, Lijster-Van Kampen, 2019). Although the onset of puberty roughly starts around the same age as young people without disabilities (De Graaf & Maris, 2014), having, or acquiring, a disability can affect the sexual development of young persons with a disability. ‘Congenital or birth impairments often affect all aspects of sexual development, and lack of privacy and independence in daily living means adolescents often miss out on normal sexual experiences’. ‘In contrast, an acquired disability may have different implications depending on when it happened. Impairments early in life often produce low social and sexual confidence, whereas patients who become disabled in adulthood are much more aware of what has actually been lost’ (Glass & Soni, 1999).

Multiple studies show that youth with disabilities are more at risk for a variety of reasons. For example, they are more vulnerable to acquire Sexually Transmitted Diseases (STDs) or HIV or unintended pregnancies. Additionally, they are up to six times more likely to become victims of sexual abuse (Michielsen et. al., 2018; UNFPA, 2018; De Graaf, et.al., 2014). Violence against people with disabilities is compounded by the fact that they are often physically and/or financially dependent on those who abuse them. Additionally, in some contexts violence against children with disabilities is tolerated and seen as an appropriate way of controlling and disciplining behavior.

Having a disability furthermore increases the risk of being trafficked for sexual or other forced labor, and of experiencing sexual abuse. To protect young women and girls from an unintended pregnancy, parents and service providers often pursue (forced) sterilisation (Jones et. al., 2018). However, in practice, sterilisation increases their vulnerability to sexual abuse as it makes the abuse more difficult to detect.



Dependency and autonomous decision-making

In comparison to their peers without a disability, young persons with disabilities are depending on the care of parents and professionals around them. This results in their

overall independence as being less developed (Gianotten et al., 2008). This can affect their autonomy and privacy. Additionally, research shows that children and young persons with disabilities have a smaller social network, resulting in less opportunities to experience sexuality and romantic relationships (De Graaf et.al., 2015; Kuyper et.al., 2012) and they may therefore not develop the same level of autonomous decision-making (UNFPA, 2018). Additionally, they tend to have less sexual experiences and their first sexual experience often takes place later in life (De Graaf, et.al., 2019; Baines, et.al., 2018).

KNOWLEDGE GAP

Overall, studies show that young people with disabilities tend to have lower levels of SRH knowledge (Burke et al., 2017). Partly because of all children out of school, worldwide on average 5 out of 10 have a disability. Those who are in school have a disadvantage in sexuality education (De Graaf, et.al., 2019; Maris, et.al., 2019) and may lack access to CSE, as their educators and peers hold negative beliefs about the need for sexuality education of children with disabilities. Additionally, they lack the skills and tools to make CSE accessible for people with diverse learning needs.

Although young people with disabilities do not necessarily need other information than their peers without a disability, there is a need for disability-specific information. For example, children with cerebral palsy need information on the influence of spasticity or tension on sexual intercourse. Or they need advice on suitable ways of showing intimacy, apart from intercourse. The absence of quality sexuality education for people with disabilities, combined with learning about sex solely from conversations with others, or through sexual intercourse, leads to sexuality that is cognitively focused on a perfect performance. It is therefore important to invest in a twin-track approach towards SRHR[15], with both qualitative and scientifically accurate information, combined with disability-specific approaches towards issues such as sexuality.

BARRIERS TO SRHR FOR YOUNG PERSONS WITH DISABILITIES

The right to health model, which views the right to health from the aspects of availability, accessibility, acceptability, and quality, is a great tool to show the barriers to the right to SRH for people with disabilities. The following barriers can be distinguished:

15 Applying a twin-track approach means ensuring people with all types of disabilities have full access to SRHR by removing barriers and facilitating access. At the same time, SRHR actors have to provide specific solutions and individualised, disability-specific support to persons with disabilities, always with the principle of informed consent, choice and autonomy of the person. Collaboration with and referral to disabled people's organisations and disability-specific organisations is essential (Twin track approach | CBM HHoT)

AVAILABILITY

In some contexts, certain SRH services are not available for anyone, such as safe abortion or emergency contraception. However, services that are widely available for the public, such as prenatal care or testing for sexually transmitted infections (STIs) are rarely available for people with a disability. Additionally, young persons with a disability often do not know where and when services are provided, and if they do know services are mostly not tailored to their needs (which will be discussed in greater detail in accessibility). There is a gap in available services in projects, as SRHR organisations often have a blind spot for people with a disability in their programmes or campaigns - or are not equipped to include them, and disabled people organisations have not often mainstreamed SRHR into their approaches. Luckily, over the recent years there has been more interaction between the two fields. There are also other factors that intersect with and influence the availability of SRH services for people with disabilities. For example, people with a disability are overrepresented among those affected by natural disasters and emergency situations, leaving them with weak access to SRH services in for example settlement camps.

ACCESSIBILITY

People with disabilities tend to have greater unmet health care needs and poorer levels of health than the general populations. Different levels of accessibility can be distinguished:

PHYSICAL ACCESSIBILITY

SRH services are often physically inaccessible to people with disabilities. This varies from lack of ramp, the fact that services are too far away, to the lack of adapted examination tables and lack of adapted communication materials for example in braille. Some services are only accessible when they are accompanied by someone else, which reduces confidentiality and violates the right to privacy.

ATTITUDINAL ACCESSIBILITY

Low uptake is also caused by negative attitudes and the lack of skills among health care providers to provide care based on the needs of people with disabilities. this is fostered by the belief that people with disabilities are asexual, hypersexual, or not capable of feeling love and sexual desire.

INSTITUTIONAL ACCESSIBILITY

This can be divided into legal accessibility (access to justice) and economic accessibility. Legal accessibility is related to restrictive laws and policies that are linked to SRHR in general, or lack of implementation of proper SRHR policies. Marital status is also often a key determinant of whether young women are sexually active and whether they receive information about family planning or sexuality education. Economic accessibility is another barrier caused by lack of funding, including a lack of health-care insurance, which makes health care unaffordable for people with disabilities. According to the World Report on Disability, just over half of people with disabilities cannot afford health care services, compared to nearly one-third of people without disabilities

ACCEPTABILITY

As touched upon earlier, SRHR is a topic that is often taboo for this target group and generally not accepted to be an integral part of their lives. People with disabilities have to deal with stigma and discrimination in all societies and are often considered by their communities to be weak, worthless or even sub-human. As mentioned earlier, perpetrators of violence see people with disabilities as easy targets. There are also specific myths that make the experience of SRHR for people with disabilities a taboo topic. SRHR service providers, but also parents and teachers, fail to provide information to children and young people with disabilities because of the stereotypical beliefs (Miller, n.d.) that people with disabilities are dependent and childlike, and thus need to be protected, that they are either asexual or oversexed and have uncontrollable urges, that disability breeds disability or that they cannot raise children and thus will be an extra burden for the parents. Parents and health care providers feel anxious and untrained to bring up the topic and have no confidence to discuss the topic with their children.

Contributing to the idea that people with disabilities are dependent, in need of production, as individuals that will never be able to marry, catch feelings or reproduce - which is obstructing a discussion of the combination of disability and SRHR - consequently young people with disabilities grow up with this idea, which is self-stigmatising. Feelings of love, intimacy and nurturing contact form the basis of children's sexual development and their feeling of safety in the world. Children with disabilities, however, have fewer opportunities to experience caring and nurturing behaviour such as cuddling and

caressing, or to explore their bodies, because parents are often ashamed of their child, feel guilty, or simply because most physical contact occurs because of health care needs. Consequently, children with disabilities are less able to form healthy and nurturing relationships with those close to them and may have the feeling that their bodies belong to other people. Social or sexuality education only occurs at an informal and reactive level, for example when a challenge occurs. As parents also lack knowledge or information, and the topic is ignored until it becomes a challenge, the challenge is handled in a negative manner. Instead of focusing on constructive learning, sexual activity is often approached by saying no, or treated as something unhealthy or disgusting. These negative messages about sexuality and people with disabilities fuel negative attitudes and misguided beliefs about their sexual potential and take their toll on self-esteem. This, when combined with physical limitations or diminished sensation, may have sex and sexual relationships seem pointless, reaffirm unexpressed beliefs of asexuality, and tend to lead to the conclusion of 'why bother'.

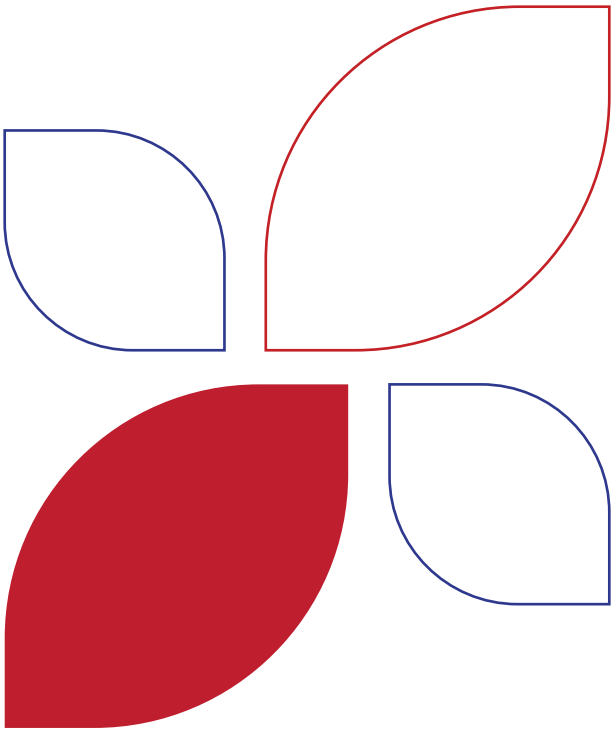
QUALITY

Too many young people receive information on SRH that is confusing and conflicting, which has consequences for their transition from childhood to adulthood. Additionally, the information that is available often focuses on how to avoid illness and the belief that sexuality is entirely tied to reproduction. The issue of sexual pleasure, autonomy and the full enjoyment of sexual well-being and health are controversial topics (Women Win, n.d.) and therefore rarely addressed in schools. When this information intersects with disability, it is even harder to receive good quality and scientifically accurate information, as it is assumed that people with disability are not sexually active at all, never get married or are 'oversexed' (Wood, 2004).

Evidence shows that young people with disabilities have a low level of SRH knowledge (Burke et. al., 2017). Not being able to express choices, wishes or desires in (sexual) relationships affects well-being and ultimately undermines political, social and economic empowerment (Alexander & Gomez, 2017). It is important to acknowledge that young people with disabilities are sexually active and engage in behavior that may put them at risk because they have little knowledge about sexual and reproductive health. Globally, five out of ten children that do not attend school are children with a disability (Liliane

Fonds, 2017). This means they are excluded from vital SRH education which is often provided in school settings. Those lucky enough to go to school, may lack access to CSE as their educators and peers hold negative beliefs about their needs or lack the skills and tools to accommodate youngsters with diverse learning needs (De Reus et. al., 2015).

Although young people with a disability do not necessarily need other information than their peers living without a disability, there is a need for disability-specific information. For example, children with cerebral palsy need information on the influence of spasticity or tension on sexual intercourse, or advice on suitable ways of showing intimacy, apart from intercourse. The absence of quality or a comprehensive approach towards sexuality education, and absence of disability specific information, in combination with learning about sex solely from informal conversations or intercourse, leads to sexuality that is focused on a perfect performance. Also in this regard, the twin-track approach could be helpful.



CHAPTER 4: DECOLONIZING SRHR

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DECOLONISING SRHR

OBJECTIVES OF THIS CHAPTER

- Understanding ways that make SRHR colonised.
- The concept of decolonisation.
- Have access to tools and information to support the decolonisation of SRHR.

UNDERSTANDING DECOLONISATION AND SRHR

"To decolonise is to acknowledge the often, harmful role that colonisation has played in distorting knowledge and restructuring our society; it asks how we may dismantle epistemologies derived through colonialism and instead centre the experiences of indigenous populations[16]."

SRHR are designed to protect people's human rights regarding sexuality and reproduction. Initially, the only modern time policies launched regarding reproduction were family-planning, which started in the West in the 1950's. However, for the past few decades there has since been a focus on reinforcing SRHR in the Global South which led to concerns about how they could reflect colonial power imbalances. Indeed, population control has always been one of the colonisers' weapons. Therefore, populations from the Global South and their allies have been growing increasingly wary of the overarching insistence on strengthening SRHR in the Global South under the pretext of reaching "SDGs". For instance, Africa's birth rate is singled out as being too overwhelming and eventually becoming a threat for the environment. Thus, under the pretense of wanting to save the planet the same pattern repeats itself: High-income countries determine how many children people from low-income countries should have. In this context, it can be tricky to formulate criticism against the widespread notion that "the South is overpopulated and therefore a threat to the world". However, when we dissect the history of sexual health, development, and international aid, it becomes clearer that SRHR still carries a colonialist ideology.

16 Smith, Linda Tuhiwai. Decolonizing methodologies: Research and indigenous peoples. Zed Books Ltd., 2013

SCIENCE

In the 17th century, science devised that women and men were characterized according to “temperaments”. Women were described as “cold and wet” while men were “dry and hot”. According to scientists of that time, these temperaments were particularly reflected in sexual behaviour, with women being thus dispossessed of their sexual desire. Temperaments were considered subject to alteration by several things, including climate. For example, in a hot and dry climate people’s temperaments were dry and warm. As a result, when the colonisation of Africa began, African women were very quickly perceived as having a warm temperament, i.e., subject to “uterine fury” (nymphomania). Exoticism, which fantasised the colonies as being “hot” in climate, quickly spread the belief that inhabitants of the colonies (now “Global South”) were savages prone to irrationality and in need of monitoring. This was carefully crafted de-humanisation under the guise of science which, very much like the sustainable development goals today, was a “rational” argumentation that could hardly be refuted.

Further down the line in history, the foundation of modern gynecology as we know it today was possible because of 19th century research led by the American J. Marion Sims (inventor of speculum - a surgical procedure to treat vesicovaginal fistula). All his research was made possible because of a racist society that allowed scientific research to be organised on black women’s bodies, without their consent nor the use of anesthesia. That was the case of Lucy, Anarcha and Betsey. Indeed, Sims was convinced that black people did not experience or feel pain as white people did.

While scientific racism has been officially debunked, racism is pervasive and racist theories will not disappear by themselves with the passing of time, they need to be properly analysed, explained, and refuted. Because gynecology and sexual health were created on racist grounds, racial and colonial stereotypes are infused in the way SRHR is thought and practiced. One of the most well-known and researched examples is “the Mediterranean syndrome”: people of colour are believed to have a higher pain tolerance, resulting in Black women being more likely to die in childbirth.

DEVELOPMENT

A prevalent argument when it comes to SRHR is that it is critical for development. Whilst it is undeniable that SRHR are determinant in one's ability to lead a fulfilling life, it is crucial to understand the underlying colonial roots of "development" and how that notion must be criticised and recontextualised. The concept of development as we know it emerged during the Enlightenment, an intellectual and philosophical movement that dominated the world of ideas in Europe during the 17th and 18th centuries. The Enlightenment era is characterised by its belief in a "rationality" that could improve the whole world. In 1796, Antoine Nicolas de Condorcet, a French enlightened philosopher and one of the most prominent figures of the era, wrote:

> *"Our hopes for the future condition of the human race can be subsumed under three important heads: the abolition of inequality between nations, the progress of equality within each nation, and the true perfection of mankind. Will all nations one day attain that state of civilization which the most enlightened, the freest and the least burdened by prejudices, such as the French and the Anglo-American [...] have attained already? Will the vast gulf that separates these peoples from the slavery of nations under the rule of monarchs, from the barbarism of African tribes, from the ignorance of savages, little by little disappear? These immense countries [...] to arrive at civilization, appear only to wait till we shall furnish them with the means; and, who, treated as brothers by Europeans, would instantly become their friends and disciples.""*

The quote, despite using a language that is considered racist nowadays, strikingly describes all the current goals of development. Both the human rights and development movement, of which SRHR are a part of, are led by the West, with a strong influence from the French and the Anglo-Americans due to their historic ties and current economic and political links with their ex-colonies. Human rights and development are global, however there is an overwhelming insistence on "developing" the "Global South". The North, which is considered developed, according to its own criteria for the best quality of human life, has decided that the Global South was underdeveloped in comparison and needed help in attaining the goals set by the North. Because those theories tied development to rationality, and rationality to humanity, any nation that is not developed is inferior and

ultimately dehumanised. This conclusion is not commonly stated, but it is implied when we analyse how international organisations and Non-governmental Organisations (NGOs) operate, how high-income countries' governments treat crises in the Global South, and even when we look at the imagery used when NGOs ask for donations for low-income countries during famine or wartime. Therefore, development as we practice it is extremely controversial, however it has not been criticised enough due to people's opinion that despite its shortcomings and problematic history, development can only improve lives in the end. This is false and that belief has had devastating consequences. Following the start of Donald Trump's mandate in 2017, the global political movement "SheDecides" was launched internationally to ensure that every woman and girl could enjoy their sexual and reproductive rights. The movement had to be hastily created in response to the effect of a policy called "The Global Gag Rule". The Mexico City Policy (aka Global Gag rule) was devised by the Reagan administration in 1984 and reinstated by every subsequent Republican president. The policy freezes United States (US) funding to any NGO that mentions abortion as a reproductive option. The Global Gag rule allows the funding of SRH services in developing countries to be determined by the political players in the US. When implemented, "the Global Gag" rule prevents charities that carry out abortion work from receiving US governmental funding, resulting in the defunding of reproductive health services in numerous low-income countries. If development was not so imbalanced to begin with, such a policy would not exist and even if it did, it would not have devastating consequences. In other words, the concentration of power at the hand of one or a handful of leading countries allows them to shape the world as they please, which is one of the main characteristics of western colonialism and imperialism.

NGOS AND INTERNATIONAL ORGANISATIONS

NGOs have a long history of being driven, by governments to exercise pressure on the Global South, which is called neocolonialism. In the past, NGOs did not exist therefore Western empires used religion and charitable organisations to subjugate the colonised and justify their crimes and racist rhetoric.

Before the rise of anticolonialism, colonial missionary societies and charitable organisations were legions in the South. They acted as religious agents for the enforcement of colonial rule. However, the decolonisation that occured from the 50's to 80's and the revendications brought forward for self-determination forced them to either shut down or rebrand themselves. In "The Missionary Position: NGOs and Development in Africa'', authors Firoze Manji and Carl O'Coill explain:

> *"The new discourse provided a solution of sorts. It offered an alternative language and set of practices that, at least on the surface, were free of racial signifiers. And it appeared to imply some connection with emancipation, the prospect of 'progress' that would benefit all. The missionary societies 'discovered' the appeal of expressing concerns about poverty, and they began to condemn the racial prejudice that had created this poverty with as much conviction as they had justified racial exclusion in the past. The exigencies of black resistance and international politics had forced them to reconstruct themselves as indigenous 'development NGO'".*

There is a strong history of colonial and post-colonial practices within different regions to control women's fertility while using NGOs and international organisations to advocate for medical aid and development. The creation of the Population Council in 1952 by the Rockefeller brothers was a key moment in history for the introduction of the concept of "overpopulation" as an international issue. It was taken up in 1962 by the UN, which declared it to be the "number one world problem". The creation in 1969 of the UNFPA, noticeably at a time when the Great Western colonial empires were collapsing, achieved to spread and normalise the fear of "overpopulation". This affects women of colour the most since women alone are considered to be responsible for reproduction in our patriarchal society.

The most cited example is the forced sterilisation of men and women. It is difficult to estimate how many women and men have been subjected to forced sterlisation, but

the practice has been extensively used as a means of population control in the colonies, including in Nazi Germany and targeting Aboriginal women in Canada and in Australia. Similarly, in the 60's, in France's ex colony Reunion Island, a significant number of women of colour and black women were forced to abort or be sterilised to reduce birth rates. Simultaneously, the French government was vehemently condemning abortion on its soil, forcing white French women to battle for the right to safe and legal abortions. This paradox further exposes the abortion practice in the Reunion Island as racist. The colonial history of regulating women of colour's sexuality by controlling their contraception has thus left generations feeling suspicious of contraception.

For instance, SRHR pioneers Margaret Sanger and Marie Stopes both had harmful connections to the eugenics movement. However, their beliefs have rarely been acknowledged or interrogated. It was only in 2020 that Planned Parenthood and Marie Stopes International made significant public commitments: in July 2020, the Planned Parenthood of Greater New York announced its plans to remove Margaret Sanger's name from the Manhattan Health Center. In November 2020, Marie Stopes International (MSI) changed its name to MSI Reproductive Choices in an attempt to break its association with Marie Stopes.

WHAT IS NEXT?

Although the full enjoyment of SRHR is an immutable human right, in order to respect everyone's identity, these rights must acknowledge and recognise the different cultures in which they are embedded where appropriate. It is important to learn from activists in low-income countries. Nowadays, many racist beliefs and practices are completely normalised and trivialised under the pretext that the intention is laudable. However, we have seen that the laudable intention of religious missionaries at the time of colonisation was to civilise "savages", which was then used to justify crimes against humanity. In short, intention is never a justification, it is the results that prevail.

Since SRHR are built on colonial and racist ideologies, it is always necessary to deconstruct them and to keep in mind that SRHR's core values are neither rational nor universal, but simply derivative of one of the many cultures existing in the world. They are not immutable or unquestionable in essence. Most people, even more so human rights advocates, want to picture themselves in a positive light, and they willfully either ignore

or underestimate power imbalances to avoid uncomfortable truths about their own participation in upholding colonialism. Nevertheless, when we do not confront these biases, they do not disappear, they only transform and adapt.

WHAT CAN WE DO

- Be mindful of the terminologies we use:

For instance, SRHR is often cited as being effective for "tackling poverty" and providing "empowerment" – but according to whose/which criteria? Why are they the rule of thumb?

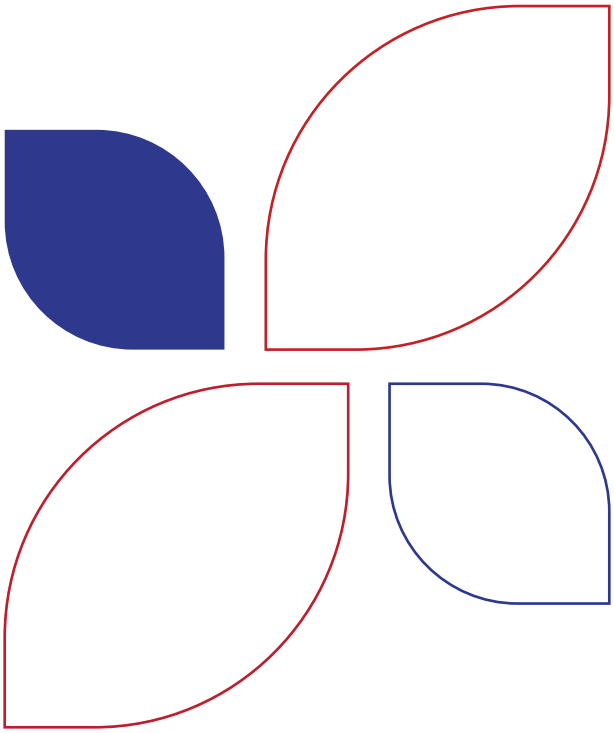
Instead of using words like "beneficiary, world's poorest, most vulnerable people, people left behind" use: " marginalised/excluded people, people who have been marginalised, under-represented groups/communities, people in need..."

Instead of: "Capacity building", use " sharing learning and knowledge", "community organizing and movement building", "community-led development"

2. Language is almost always a reflection of the mind therefore we also need to decolonise our minds. We need to acknowledge that those of us who have been educated in Western institutions face an insurmountable challenge: our epistemologies are grounded in colonial ideology. There should be some form of resource redistribution back into previously colonised countries who do not have enough resources to address sexual health concerns like the spread of HIV or access to safe and reliable contraception. Before and during any project development, we should always ask ourselves: How are we ensuring that we are working with people, not on them?

OUTCOMES OF THE CHAPTER

- Trainees have grasped the main concept of what "decolonisation" and "colonisation" means and what are the main connections between colonisation, racism, knowledge hierarchies, structural and systemic inequalities.
- Trainees have been presented with historical examples of colonisation within the healthcare system and SRHR.
- Trainees have been presented with current examples of colonial dynamics within SRHR, current challenges and struggles.
- Trainees have been given clues to recognise their own biases and how to start deconstructing their prejudices and beliefs.
- Trainees have been presented with key insights on how to actively support the decolonisation efforts of the SRHR sector as youth SRHR activists.



CHAPTER 5: HARMFUL PRACTICES

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HARMFUL PRACTICES

OBJECTIVES OF THIS CHAPTER

- Strengthening the understanding of harmful practices.
- Understanding of the strong connection between Harmful Practices and SRHR.
- Promoting an anti-racist and non-decolonial perspective of Harmful Practices.
- Promoting the non-use of the expression “traditional Harmful Practices”.
- Promoting an intersectional perspective to understanding and ending Harmful Practices.

UNDERSTANDING HARMFUL PRACTICES

Based on international organisations’ definitions[17], a definition of Harmful Practices in line with our values can be proposed:

Harmful Practices are violent, unsafe and/or unhealthy practices which are usually motivated by culture, values or traditions in a community. Harmful Practices can also have other motives such as discrimination or economic concerns (e.g: girl infanticide). They are practices negatively affecting the bodies and/or lives of a specific group within the population on which they are imposed as mandatory (usually women). Harmful Practices are a violation of human rights. Harmful Practices are most often Gender-Based and usually target women and girls, although some Harmful Practices concern men and boys.

This brochure will investigate 3 largely unexplored aspects of the topic; underrepresented forms of Harmful Practices and the relevance of SRHR to address the issue: Intersex Genital Mutilation, Virginity testing and so-called honour killings. Although it may be implicit, the goal behind most Harmful Practices is to control the bodies, sexualities and/or life-choices of the targeted group within the community, usually women and girls. This may be through the alteration or injury of body parts or through coercion and control surrounding marriage and pre-marital sexual relations etc. with a common non-

17 OHCHR https://www.ohchr.org/documents/publications/factsheet23en.pdf

IPPF https://www.ippf.org/sites/default/files/harmful_traditional_practices.pdf

WHO (see p.1) https://apps.who.int/iris/bitstream/handle/10665/41903/9241561866.pdf

existence of consent. Harmful Practices are in complete opposition to human rights, body integrity and safety, and the principles of SRHR which defend and protect freedom of choice and the access of knowledge and information around sexuality. Yet, Harmful Practices are often addressed from a Gender Equality perspective neglecting the SRHR approach. This opens an important reflection on how SRHR strategies can be used to tackle, prevent, and respond to these abuses.

Secondly, practices such as FGM or Early and Forced Marriage are thankfully more and more visible, even within the European population, yet many Harmful Practices remain unknown or thought as irrelevant in the European context. Therefore, it is crucial to raise awareness and foster understanding on some of the underrepresented Harmful Practices happening in Europe: honour killings, virginity testing and intersex genital mutilation.

DISCLAIMERS:

International organisations tend to use the phrase "traditional Harmful Practices"; however, the use of the term "traditional" can give the wrong idea that harmful practices only happen in non-Western traditional communities[18]. It can be misleading and stigmatising. Thus, this session uses "Harmful Practices." We recognise the double standard that exists for Western practices that are deemed acceptable and a question of freedom of choice.

Although it was designed with the utmost concern for the mental well-being of participants, the contents of this session, and chiefly the examples covered, may be triggering.

The examples chosen for this session are not an exhaustive list. Suggestions of additional resources will be provided to participants to learn more.

The violence and harm that is faced because of these practices cannot be measured and should never be compared.

18 EIGE Glossary https://eige.europa.eu/taxonomy/term/1410

INTERSEX GENITAL MUTILATION (IGM)

WHAT IS "INTERSEX GENITAL MUTILATION"?

Intersex individuals have been and are being subjected to recurrent SRHR violations across Europe and the rest of the world. Being individuals born with sex traits and characteristics that 'do not fit' binary medical and social norms for female and male bodies, their lives has been profoundly impacted by the "man" and "woman" dichotomy and by a structurally cisgender and heteronormative society. Despite not being very well known and understood, intersex genital mutilation is prevalent across Europe. In the whole European region, Malta and Portugal are the only two countries to prohibit intersex medical interventions before a child can give informed consent[19] . Throughout the decades, the fundamental human rights of intersex individuals have been repeatedly violated, as they have been subjected to coercive "normalising surgeries" and medical interventions since infancy, have endured everyday discrimination and have been stigmatised for not conforming to the established societal dichotomy (Carpenter, 2018)[20]

Intersex people are routinely subjected to unnecessary and non-consensual "normalising surgeries" which often led to irreversible consequences such as genital insensitivity, sterility, chronic pain, urinary infections and malfunctions, massive internal and external scarring, osteoporosis, life hormone replacement therapies and repeat surgeries, as well as trauma and depression (Cabral Grinspan, 2019[21]; Carpenter, 2018).

"Many of these procedures are done with the stated aim of making it easier for children to grow up "normal" and integrate more easily into society by helping them conform to a particular sex assignment. The results are often catastrophic, the supposed benefits are largely unproven, and there are generally no urgent health considerations at stake. Procedures that could be delayed until intersex children are old enough to decide whether they want them are instead performed on infants who then have to live with the consequences for a lifetime[22]."

19 Rainbow Europe, https://rainbow-europe.org/#0/8701/0.

20 Carpenter, M. 2018. Intersex Human Rights: clinical self-regulation has failed. http://www.srhm.org/news/intersex-human-rights-clinical-self-regulation-has-failed/

21 Cabral Grinspan, M. 2019. The Right to Truth and Intersex People. http://www.srhm.org/news/the-right-to-truth-and-intersex-people/

22 Human Rights Watch (2017) "I want to be like nature made me": Medically Unnecessary Surgeries on Intersex Children in the US, https://www.hrw.org/report/2017/07/25/i-want-be-nature-made-me/medically-unnecessary-surgeries-intersex-children-us.

Before the Covid-19 pandemic, intersex people were among the most vulnerable groups of the general population, due to a lack of access to health and healthcare, income, housing, and safety. The pandemic has now increased the risks for the intersex community and amplified their medical trauma acquired through unconsented, non-necessary medical interventions and treatment[23].

IGM AND LEGISLATION

"Most European societies recognise people as either male or female. However, this does not account for all variations in sex characteristics. As a result, intersex people experience fundamental rights violations ranging from discrimination to medical interventions without their consent".

- Many Member States legally require births to be certified and registered as either male or female.
- In at least 21 Member States, sex 'normalising' surgery is carried out on intersex children.
- In 8 Member States, a legal representative can consent to sex 'normalising' medical interventions independently of the child's ability to decide.
- 18 Member States require patient consent provided the child has the ability to decide[24].

Based, among others, on these findings legal and medical professionals should be better informed of the fundamental rights of intersex people, particularly children. Gender markers in identity documents and birth registries should be reviewed to better protect intersex people.

Intersex people, even as young children, should receive from doctors the full information about their bodies and medical interventions they are being offered. They need to be informed whether these medical interventions are urgent, the reasoning behind them, the risks and potential consequences connected to them[25]. If there is no urgent medical necessity, these medical interventions should be done only once the person is able to

23 OII Europe. Survey shows: intersex people are highly vulnerable during the Covid-19 pandemic. https://oiieurope.org/covid-19-survey-report/

24 European Union Agency for Fundamental Rights (2015) The fundamental rights situation of intersex people, https://fra.europa.eu/sites/default/files/fra_uploads/fra-2015-focus-04-intersex_en.pdf.

25 Intersex Russia. The Moscow Statement (Statement of The Russian Intersex Community). https://www.intersexrussia.org/statement-eng

give full informed consent on whether to proceed with the intervention[26].

EU Member States should avoid non-consensual 'sex-normalising' medical treatments on intersex people without their free and informed consent. This would help prevent violations of the fundamental rights of intersex people, especially through practices with irreversible consequences.

HONOUR KILLINGS

DEFINITION AND CONCEPT OF HONOUR

The concept of honour is closely tied to morality, and to the level of respect a community or society has toward an individual and their families/communities. Honour is seen as the quality of knowing and doing what is morally right. To vulgarise and simplify its understanding, we will be analysing it within the prism of binarity. The concept of honour and its impact can be summarized in one sentence: a man's honour is its own, a woman's honour is tied to her family. Morality and honour are strongly linked to one another. Morals can be defined as standards for good or bad character and behaviour and are used by family and community to approve or disapprove a woman's honour.

Societies are shaped within the scope of the patriarchy. They are centred and controlled by cis men who are overrepresented in roles of political leadership, and identify as the moral authority. The concepts of honour and morality are thus both heavily geared towards what men consider acceptable or unacceptable, and patriarchal ideals of masculinity and femininity.

Historically, in almost every civilisation and on all continents, women have been seen as men's possessions and their behavior and lives were strongly chaperoned by their families. It is seen as crucial to ensure that young girls and women will never be in situations where their honour could be questioned or a topic of rumors, since the entire family could suffer such a situation.

To this day honour, still shapes our societies and supports the survival of patriarchal structures.

Honour linked to purity, virginity and the existence of a hymen. We are aware of the lack of sexual education and access to information for all young people, and especially young

26 Intersex Russia. The Moscow Statement (Statement of The Russian Intersex Community). https://www.intersexrussia.org/statement-eng

girls and women. In certain communities, women and girls were not given a sexual education, nor did they have access to this information outside of marriage. Marriage was the key to accessing knowledge about sexuality and "grown-ups" information. Up until today, sexuality is weaponized against young girls and women who are taught that sexuality can destroy their lives if they become pregnant, or that they could bring shame to their families if they enjoy sex outside of marriage.

Honour reinforces the idea that women and girls' freedom is a threat to not only their families, but the entire society. It shapes the idea that women can be classified by society's perception of their behaviours. This ideal prescribes strict behavioural rules and these rules are enforced by both men, and women who have internalised them.

WHERE HONOUR KILLINGS ARE BEING PRACTICED?

Often, honour killings are perceived as being a "migrant" issue and are surrounded by several stereotypes and misconceptions. Indeed, attaching the word "honour" to the murders has been severely criticised by activists. Indeed, the use of the positive word "honour" in the expression can give the idea validating the motive of the crime. Femicide has been proposed as the best alternative, or shame killings. However, it is crucial to keep the notion of honour within the definition as the motive of the crime.

Femicide based on honour can be found in many different patriarchal societies, communities, and religions, where the actions of women and girls are closely monitored. A strong emphasis on virginity and sexual purity[27] should be made, as in many cases, those crimes are perpetrated if a woman/young girl falls in love with someone who does not match the family's expectations, such as religion, community or ethnic origin. As bearers of so-called honour, women and girls experience a lot of pressure on the way they behave, talk, dress, but more importantly on who they will be marrying as virgins.

Often, when families consider that the honour of the family has been shamed, destroyed, and / or put at risk their communities, men and leaders in the family will turn against women and girls. Punishing, repudiating, and killing them, are considered as the only ways to restore the honour of the family's name in the community and the society.

There are significant and important differences between honour killings and domestic violence / intimate partner violence. In the case of honour killing, abusing and / or the

27 Britannica (2009) Honour Killing, https://www.britannica.com/topic/honor-killing.

killing of the victim are performed as the "best way" to protect the family's honour in the eyes of the community, after they consider it tarnished by the victim's behaviour, whereas domestic violence is about controlling, coercing, threatening and / or coercing a partner or relative through violent and intimidating behaviour[28].

FEMICIDE BASED ON HONOUR AND LEGISLATION

For a long time, the issue of honour killings was not in the spotlight when it came to combatting violence against women in Europe. Honour killings were mostly considered to be an issue between low-income migrants, which led to them not being considered as a priority. Nevertheless, penal code articles focused on "defence of honour" crimes were prevented in European countries' legislations. For example, in Italy, up until 1981, the "honour crime" penal code article, stated that "whoever caused the death of the partner, daughter, or sister, after discovering an illegitimate carnal relationship in a state of rage due to the offence made to his honour or that of his family, is punishable by imprisonment from 3 to 7 years'.' The usual sentence for non-honour related homicides would be at least 21 years of imprisonment.

However, the growing interest for ending domestic violence progressively incorporated the fight against honour killings in international treaties. The 1979 Convention on the Elimination of All Forms of Discrimination against Women, which is the most prominent treaty regarding women's rights, has called for the removal of "the defence of honour" in countries' legislations. Other international treaties and covenants, such as The International Covenant on Civil and Political Rights and the Declaration on the Elimination of Violence Against Women also claim that women's rights must take precedent before traditions and "honour". Still, most of the international treaties focusing on women rights are either non-binding or selectively ratified by member states and end up having a limited impact.

At the European level, there are no official laws targeting honour killings specifically. They are commonly grouped with violence against women and classified as "homicides" in the law.

Women rights advocates are calling for the addition of "feminicide" in the legislation, as it would be an official recognition that women are murdered by men because of

28 Women's Aid, What is domestic abuse?, https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/

their gender. Unlike several countries in Latin America, no laws in Europe recognise that women can be killed because they are women and the term “feminicide” has no legal basis. The killing of Fadime Sahindal in 2002 in Sweden was the first case of honour killing to be recognised by the EU[29].

FEMICIDE BASED ON HONOUR IN EUROPE

The perpetuation of honour killings is largely undocumented in Europe as it is not considered as a “European issue”. However, this situation is due to the lack of knowledge of the existence of honour crimes and their recognition. Due to the cultural nature of honour killings and the taboo around them, there is truly little data. Indeed, many of the killings go unreported or they are miscategorised by authorities. This makes it difficult to track the full extent of this harmful practice throughout Europe[30] . However, the United Kingdom is believed to have the highest number of honour killings in Europe, with an estimate of 12 honour killings a year. The other European countries where this harmful practice is known to take place are:

- France
- Sweden
- Germany
- The Netherlands
- Italy

29 guardianweekly1 Guardian (2002) ‘Honour’ killing in Sweden silences courageous voice on ethnic integration, https://www.theguardian.com/theguardian/2002/jan/31/guardianweekly..

https://www.europarl.europa.eu/RegData/etudes/BRIE/2015/573877/EPRS_BRI(2015)573877_EN.pdf

30 European Parliament (2015) Combatting honour crimes in the EU, https://www.europarl.europa.eu/RegData/etudes/BRIE/2015/573877/EPRS_BRI(2015)573877_EN.pdf

VIRGINITY TESTING

The WHO definition of virginity testing is: "a gynaecological examination conducted under the belief that it determines whether a woman or girl has had vaginal intercourse."[31] It is carried out by inspecting the hymen for tears in the vagina and/or the size of the opening, by using the 'two-finger tests', which has been deemed to be an incredibly invasive procedure.

The emphasis on women's virginity is a form of sexual and gender discrimination and takes away the bodily and sexual autonomy of women and girls.

Within Europe, the countries where virginity testing is known to be conducted are:

- Spain
- The Netherlands
- Sweden
- Belgium
- The United Kingdom
- France

The French government is planning to introduce fines and prison sentences for doctors that carry out virginity testing (as of October 2020). Banning it is also contentious as it doesn't mean that people won't get the procedure but that they will have to go through even more dangerous, illegal means[32]. Virginity testing is often linked to conservative religious views - in France, it is often Muslim and Roma families that want proof of virginity before women marry, to ensure that there has been no sex out of wedlock.

Virginity testing is often linked to parallel practices performed on young girls to preserve their virginity. It is the case in the North African communities performing the "marbouta" a sort of witchcraft practice that aims at "closing" the young girls' vulva and her capacity to be sexually active[33]. Marbouta/R'bat[34] have important impacts on the mental health and sexual pleasure of young Muslim women. Vaginismus is the main consequence of

31 WHO (2018) United Nations agencies call for ban on virginity testing, https://www.who.int/news/item/17-10-2018-united-nations-agencies-call-for-ban-on-virginity-testing.
32 BBC News (2020), France plans punishment for 'virginity tests', https://www.bbc.co.uk/news/world-europe-54434080.
33 Dans Dialogue (2009) https://www.cairn.info/revue-dialogue-2009-3-page-91.htm.
34 Benboulerbah Isma (2020) There will be blood: honour, virginity and red drops. Migrant Women Network. www.migrantwomennetwork.org/wp-content/uploads/Isma-article-6-Feb-2020.pdf

such focus on virginity but also the taboo of sexual violence. Virginity, strongly linked to honour, prevents women and girls to report sexual violence fearing that their families will turn their back on them. This fear is a reality, as it has often been the case, that they would be repudiated and/or cast out of their community.

SRHR STRATEGIES TO TACKLE HARMFUL PRACTICES

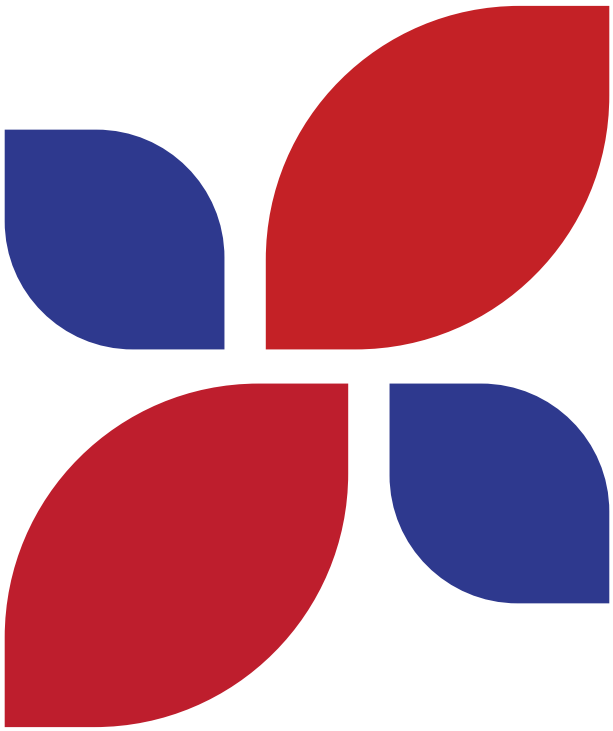
SRHR is about freedom of choice and harmful practices contradict this as it is about control. As a result of this, using SRHR strategies to tackle Harmful Practices helps to provide individuals with agency and autonomy. Using SRHR strategies allows us to focus on behaviour and attitude changes (through awareness and education) as these are more impactful than country laws against the practices. These strategies must also give priority to grassroots efforts and activist groups, as opposed to top-down approaches.

The below are some SRHR strategies that can be used to tackle Harmful Practices across Europe, whilst also recognising that this is not an exhaustive list and are context-specific.

- Education within a CSE curriculum around virginity, the hymen, gender norms, sexualities, intersex rights.
- Strengthening and amplifying the voices of affected communities and supporting community-led actions and movement building to end the practice.
- Collaborating with affected communities' leaders to alert and end practices like virginity testing.
- Educating health professionals on harmful practices and training them on how to sensitively address the harmful practice with at-risk populations.
- Training government and local authorities to identify cases of harmful practices (such as virginity testing, honour killings etc.)
- Supporting the development of anti-harmful practices advocacy messages.
- Strengthening data collection of harmful practices and ensuring that national governments are taking their responsibility in providing these numbers.
- Prioritisation of after-care access for Harmful Practices survivors.

OUTCOMES OF THE CHAPTER

- Readers have learned how to identify the links between Harmful Practices and the principles of SRHR.
- To have shared our definition of Harmful Practices along with an explanation of why we have not used traditional definitions to ensure that we have a decolonial perspective.
- Participants will have gained an understanding of how SRHR strategies can be used to tackle Harmful Practices, along with some of the motives behind Harmful Practices.
- To have created a safe space for participants to share their ideas about harmful practices within Europe.



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CONSENT AND RAPE CULTURE

SELECTED RESOURCES:

WEBSITES

RobotHugs- Building the consent castle - Consent in long-term relationships

SSAIC - Consent 201 - Having the consent conversation

PreventConnect- Exercises about consent

RAINN - What is consent

Healthline- Guide to consent

Teen Health Source- What is sex

VIDEOS

Planned Parenthood- Consent 101 series

Cynthia Kao- If a robbery report was treated like a rape report

James is dead - Regarding victim-blaming

Blue Seat Studio - Tea consent

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and Criminal Justice

Eurobarometer

Robot Hugs

DISABILITIES AND SRHR

SELECTED RESOURCES:

- Read sections on disability from Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission
  - Section 4: Populations in need of services: Paragraph: "Additional groups with specific disadvantages" (p 2671)
  - Section 7: Implications and recommendations: Provide additional support to groups often marginalized, disadvantaged, and subject to discrimination (p 2682-)
- DCCD (2017). Everybody matters. Good practices for inclusion of people with disability in SRHR programs.
- Handbook on disability mainstreaming 1 and 2
- UNFPA 2018; Women and young persons with disability https://www.unfpa.org/featured-publication/women-and-young-persons-disabilities

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HARMFUL PRACTICES

SELECTED RESOURCES:

FRA The fundamental rights situation of intersex people (Chapter on Intersex Rights, page 47)

How to Talk About FGM

Supporting your intersex Child

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