FACT SHEET

Sexual health systems have been built around a narrow picture of whose body counts.

These ten themes explore what that means, and what needs to change.

worldsexualhealthday.org

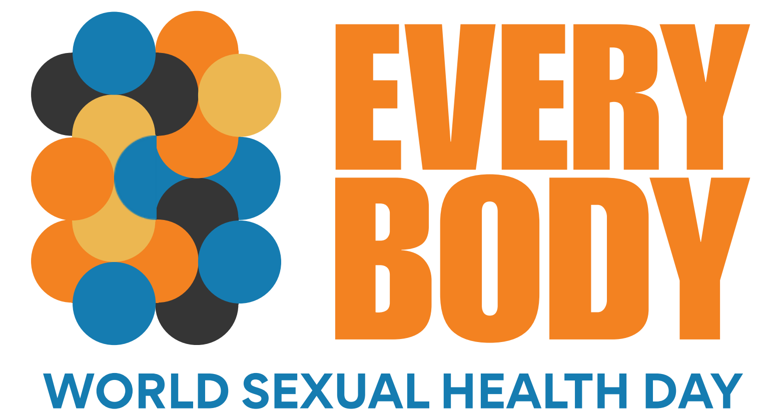
1

Young Bodies

Children have bodies. Those bodies deserve age-appropriate information, starting well before puberty.

Children who know the correct names for their body parts are more likely to report abuse, and more likely to be believed when they do.

Age-appropriate learning about bodies, boundaries, and consent is foundational to lifelong sexual health. But it is routinely withheld. Adult discomfort, not children's needs, drives that decision. Withholding information does not protect children. It leaves them more vulnerable.



1 Young Bodies

WHAT NEEDS TO CHANGE

- Comprehensive sexuality education must begin in early childhood, not at puberty.
- Accurate anatomical language and teaching on bodily autonomy should be standard, not contested.

WHAT YOU CAN DO

Parents and caregivers: Age-appropriate conversations about bodies and boundaries are protective. Start early and keep going.

Educators: Advocate for evidence-based content across all year groups, not just adolescence.

LEARN MORE

UNESCO International Technical Guidance on Sexuality Education (2018)

www.amaze.org - free videos for young people and families

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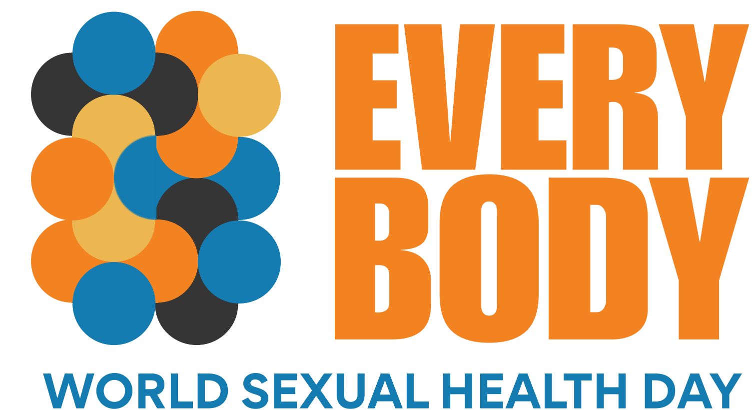
2

Aging Bodies

Sexuality doesn't end at a certain age. Healthcare systems act as though it does.

Around 40% of adults aged 65–80 are sexually active. STI rates among adults over 55 have more than doubled in a decade, in part because this group is almost absent from prevention messaging.

Older adults are routinely excluded from sexual health conversations, by providers, researchers, and prevention campaigns designed for younger people. The result: missed diagnoses, untreated conditions, and a false message that sexual health stops mattering with age.



2 Aging Bodies

WHAT NEEDS TO CHANGE

- Sexual health must be part of routine care at every age, not dropped as patients get older.
- Prevention campaigns must reflect the reality that people remain sexually active across the lifespan.

WHAT YOU CAN DO

Older adults: Your sexual health is legitimate. Raise it with your provider.

Health professionals: Ask. Don't assume age ends the conversation, the evidence says it doesn't.

LEARN MORE

Cameron, J. & Santos-Iglesias, P. (2024). Sexual Activity of Older Adults: A Systematic Review of the Literature. International Journal of Sexual Health, 36(2), 145–166.

www.tandfonline.com/doi/abs/10.1080/19317611.2024.2318388

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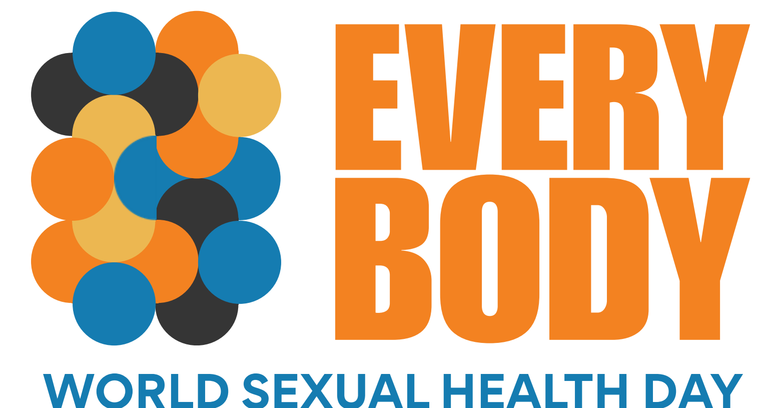
3

Disabled Bodies

People with disabilities have sexual lives, sexual health needs, and sexual rights. Systems have largely behaved as though they do not.

People with disabilities face elevated rates of sexual violence, in part because systems failed to give them the knowledge and language to identify and report it.

People with disabilities are significantly less likely to receive sexuality education, to be asked about sexual health by providers, or to find services designed with their access needs in mind. This includes neurodivergent people, or those living with scarring, whose experience of intimacy and relationships is rarely reflected in sexual health provision.



3 Disabled Bodies

WHAT NEEDS TO CHANGE

- Sexuality education must be inclusive and accessible from the outset, not adapted after the fact.
- Sexual health services must actively remove physical, communicative, and attitudinal barriers.

WHAT YOU CAN DO

People with disabilities: Your sexual health matters and you have the right to care designed for, not around, you.

Health professionals and educators: Examine whose bodies your practice was designed for.

LEARN MORE

Bussières et al. (2022). Sexual Violence Against Persons With Disabilities: A Meta-Analysis. Trauma, Violence, & Abuse, 23(4), 1330–1343.

www.pmc.ncbi.nlm.nih.gov/articles/PMC9425723/

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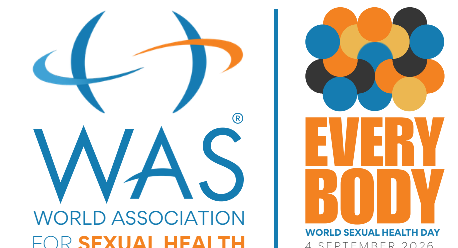


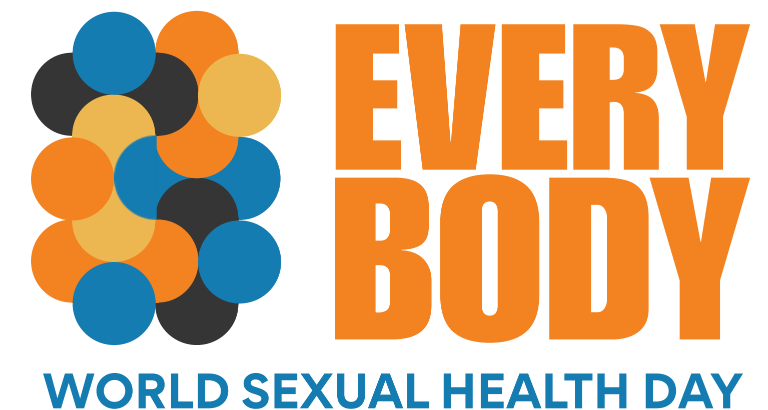
4

Intersex Bodies

Intersex people are born with natural variations in sex characteristics. Those variations are not disorders. They do not require correction.

Intersex people report significantly higher rates of trauma and depression, often as a direct result of non-consensual interventions performed in childhood.

Despite this, intersex people are routinely subjected to surgical and hormonal interventions in infancy and early childhood to make their bodies conform to binary expectations. These practices have been condemned by the United Nations and the World Health Organization. They continue in most countries.



4 Intersex Bodies

WHAT NEEDS TO CHANGE

- Non-consensual, medically unnecessary interventions on intersex infants and children must end.
- Intersex people must have access to full information about their own bodies and medical histories.

WHAT YOU CAN DO

Health professionals: Familiarize yourself with rights-based, affirming care. The evidence on harm from non-consensual interventions is substantial.

Advocates: Intersex people are often absent from sexual health conversations. That absence is its own form of harm.

LEARN MORE

Human Rights Watch & interACT (2017). "I Want to Be Like Nature Made Me": Medically Unnecessary Surgeries on Intersex Children in the US.

www.hrw.org/report/2017/07/25/i-want-be-nature-made-me/medically-unnecessary-surgeries-intersex-children-us

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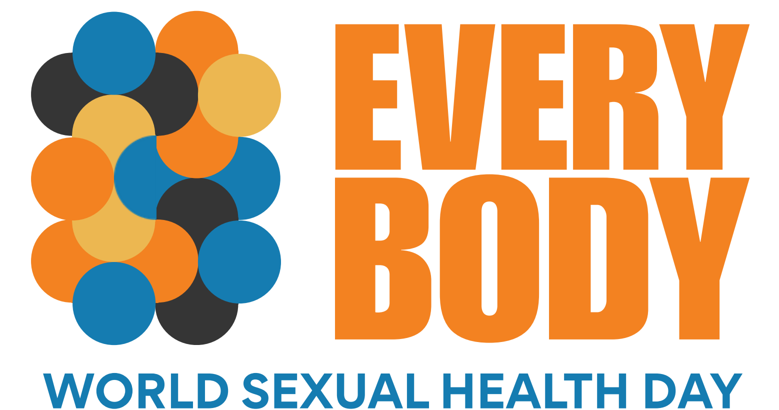
5

Racialized Bodies

Race shapes sexual and reproductive health outcomes. Not because of biology, because of systems.

Black women are two to three times more likely to die from pregnancy-related causes than white women in the United States. Similar disparities are documented across high-income countries.

Structural racism operates through healthcare, housing, employment, and education to produce persistent disparities in sexual and reproductive health outcomes. Inside clinical settings: unequal access, differences in how pain is assessed, and discrimination that causes people to avoid seeking care.



5 Racialized Bodies

WHAT NEEDS TO CHANGE

- Sexual and reproductive health systems must examine and address structural inequities, not just individual provider behavior.
- Racialized communities must be involved in designing the services meant to serve them.

WHAT YOU CAN DO

Health professionals: Examine your practice and the systems you work within. Disparities don't persist without cause.

Researchers and policymakers: Collect disaggregated data. Fund community-led research.

LEARN MORE

Hoyert (2025). Maternal Mortality Rates in the United States, 2023. NCHS Health E-Stats. CDC.

www.cdc.gov/nchs/data/hestat/maternal-mortality/2023/maternal-mortality-rates-2023.htm

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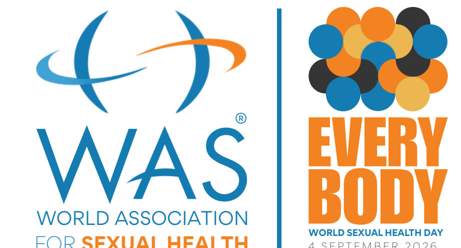


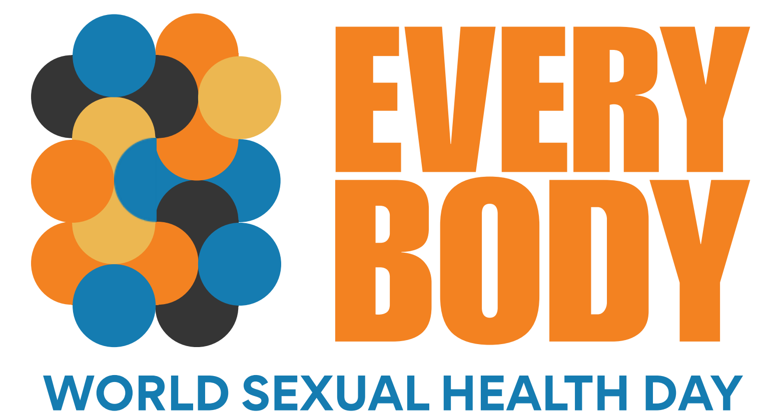
6

Bodies of Different Sizes

Weight stigma in healthcare is well-documented, widely experienced, and directly harmful.

People in larger bodies are more likely to avoid or delay medical care due to anticipated stigma, and when that stigma is experienced, it directly reinforces avoidance.

Research consistently identifies healthcare providers as a primary source of weight-based discrimination. That bias shapes what providers ask, what they screen for, and how they communicate. In sexual health, it means consultations that never happen, concerns that go unvoiced, and care that is simply not delivered.



6 Bodies of Different Sizes

WHAT NEEDS TO CHANGE

- Weight-neutral approaches to sexual and reproductive healthcare should become standard practice.
- Provider training must address weight bias explicitly, including how it shows up in sexual health consultations.

WHAT YOU CAN DO

People in larger bodies: You are entitled to sexual healthcare focused on your needs — not your weight.

Health professionals: Weight is not a precondition for quality care.

LEARN MORE

Puhl & Heuer (2009). The Stigma of Obesity: A Review and Update. Obesity, 17(5), 941–964.

www.pubmed.ncbi.nlm.nih.gov/19165161/

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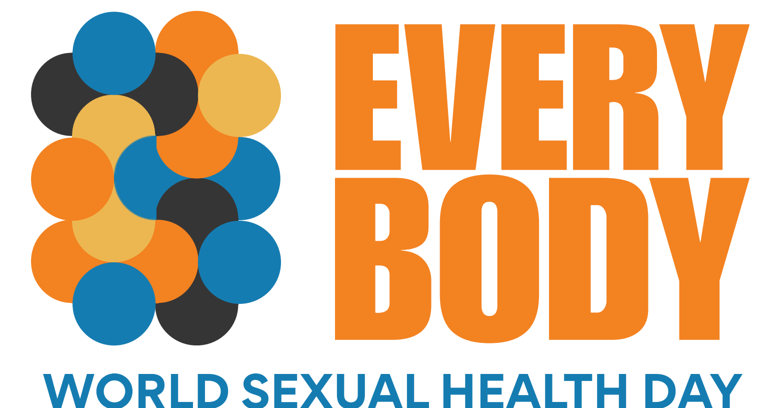
7

Trans and Gender-Diverse Bodies

Trans and gender-diverse people have the same right to sexual health as everyone else. Health systems have not consistently acted as though this is true.

Around 1 in 4 transgender adults avoids needed healthcare due to fear of discrimination. Around a third report at least one negative experience with a provider in the past year.

Provider knowledge gaps, cisnormative systems design, and institutional indifference have created a healthcare environment that trans people have learned — through experience — not to trust. That distrust is a rational response to documented, repeated mistreatment.



7 Trans and Gender-Diverse Bodies

WHAT NEEDS TO CHANGE

- Healthcare providers need mandatory, meaningful training in trans-affirming care.
- Health systems must review intake forms, protocols, and facilities to remove cisnormative assumptions.

WHAT YOU CAN DO

Trans and gender-diverse people: Your right to dignified, affirming care is real — even when systems fail.

Cisgender allies: Advocate within your institution. Change is harder to ignore when it comes from inside.

LEARN MORE

James, S.E. et al. (2016). The Report of the 2015 U.S. Transgender Survey. National Center for Transgender Equality.

www.transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

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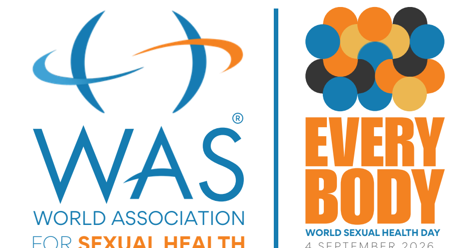


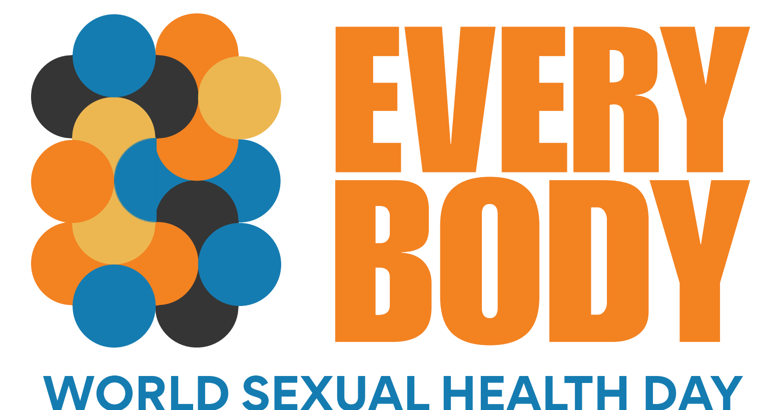
8

Chronically Ill and Dying Bodies

Chronic illness doesn't end a person's sexual life. It changes it. At the end of life, intimacy and closeness don't stop mattering.

In one palliative care study, 96% of patients had never been asked about intimacy before their consultation, yet almost all said the conversation, when it finally happened, was helpful.

For people living with long-term conditions, sexual wellbeing is rarely part of clinical care. Treatments that directly affect sexual function go undisclosed. At the end of life, the silence deepens, despite clear evidence that people who are dying still value closeness, connection, and intimacy.



8 Chronically Ill and Dying Bodies

WHAT NEEDS TO CHANGE

- Sexual wellbeing should be a routine part of care for people with chronic conditions.
- Palliative and end-of-life care must explicitly include intimacy as part of holistic care — not treat it as peripheral.

WHAT YOU CAN DO

People living with chronic illness: Your sexual wellbeing is a legitimate part of your healthcare. Raise it.

Health professionals: Ask. The evidence that patients want this conversation is unambiguous.

LEARN MORE

Kelemen, A., Cagle, J., & Groninger, H. (2016). Screening for intimacy concerns in a palliative care population: Findings from a pilot study. Journal of Palliative Medicine, 19(10), 1102–1105

www.doi.org/10.1089/jpm.2016.0092

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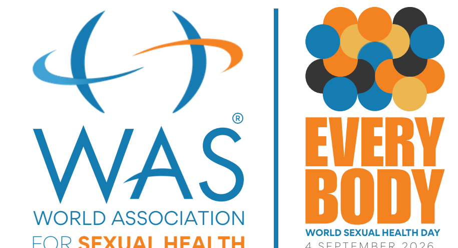


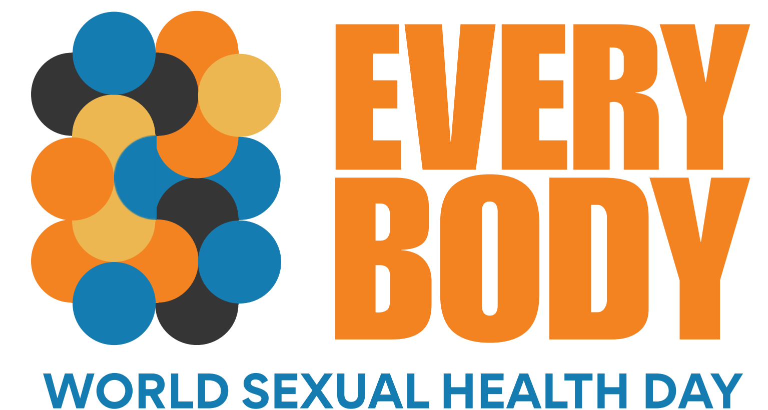
9

Pregnant and Postpartum Bodies

Pregnancy and the postpartum period bring significant changes to the body. The sexual health dimensions are almost entirely absent from routine care.

Postpartum people report high rates of sexual health concerns — pain during sex, changes in desire, body image difficulties — that go unaddressed because providers don't ask and people don't know they can raise them.

Routine antenatal and postnatal care focuses on fetal wellbeing and physical recovery, with little acknowledgment of how pregnancy and birth affect desire, comfort, body image, or intimate relationships. People are largely left to navigate these changes without information or support.



9 Pregnant and Postpartum Bodies

WHAT NEEDS TO CHANGE

- Sexual health should be included in routine antenatal and postnatal care.
- People should be informed about likely changes to their sexual wellbeing before birth — not left to discover them alone afterward.

WHAT YOU CAN DO

Pregnant or postpartum people: Your sexual wellbeing matters during this time. You are entitled to raise it.

Midwives, obstetricians, and GPs: Ask about sexual wellbeing — before and after birth.

LEARN MORE

O'Malley, Smith & Higgins (2022). Sexual health issues postpartum, a mixed methods study of women's help-seeking behavior after the birth of their first baby. Midwifery, 104, 103196

www.pubmed.ncbi.nlm.nih.gov/34767981/

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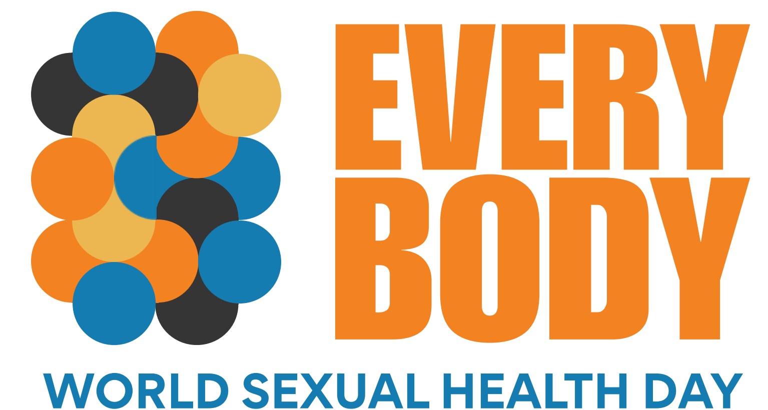
10

Menopausal and Perimenopausal Bodies

Menopause is a significant bodily transition with real implications for sexual health. The healthcare system has largely treated it as something to manage quietly, if at all.

Many people experiencing menopausal symptoms wait over a year before seeking help, citing embarrassment, normalization of symptoms, and the expectation of being dismissed.

Menopause and perimenopause can profoundly affect desire, comfort during sex, body image, and intimate relationships. Yet they remain among the most underaddressed areas in sexual healthcare. Ageism and stigma around female aging shape what gets researched, taught, and discussed.



10 Menopausal and Perimenopausal Bodies

WHAT NEEDS TO CHANGE

- Menopause education must be mandatory in clinical training — not an elective.
- People must be proactively offered information and options, including for sexual health.

WHAT YOU CAN DO

People experiencing menopause or perimenopause: Your sexual health deserves attention during this transition. Push to be taken seriously.

Health professionals: The menopause conversation is not optional.

LEARN MORE

Dintakurti et al. (2022). An online survey and interview of GPs in the UK for assessing their satisfaction regarding the medical training curriculum and NICE guidelines for the management of menopause. Women's Health, 18.

www.ncbi.nlm.nih.gov/pmc/articles/PMC9500171/

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