



AGENDA 2030

FOR LGBTI HEALTH AND WELL-BEING

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THE GLOBAL ADVOCACY
PLATFORM
TO FAST TRACK THE HIV AND
HUMAN RIGHTS RESPONSES
WITH GAY AND BISEXUAL MEN



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EXECUTIVE SUMMARY

This briefing paper illustrates how Sustainable Development Goal (SDG) 3, *Ensure Healthy Lives and Promote Well-Being for All at All Ages*, is relevant to the specific health needs of lesbian, gay, bisexual, transgender, and intersex (LGBTI) people. The paper highlights existing data pertinent to the health and well-being of LGBTI people across seven targets within this Goal, as well as relevant data gaps. The paper then makes a series of recommendations regarding what type of data and indicators Member States should report in order to effectively monitor progress on LGBTI health needs and ensure implementation of SDG 3 is truly universal and in line with the SDGs principle of “leave no one behind.”

Data regarding LGBTI health needs are inadequate and incomplete across the globe, but the data that is available suggest that LGBTI people’s health is consistently poorer than the general population. **Discrimination, violence, criminalization, and social exclusion are the social determinants for poor health outcomes.** While LGBTI people share common experiences of marginalization based on sexual orientation, gender identity and expression, and sex characteristics (SOGIESC), many also face intersecting forms of discrimination based on gender, age, race, ethnicity, ability, class, socioeconomic status, migration status, and other factors that drive exclusion.

Of particular concern is the disproportionate burden of HIV among gay and bisexual men and transwomen, and across LGBTI populations: poor mental health, higher prevalence of alcohol and substance abuse, lack of access to sexual and reproductive health services, and inadequate funding for effective interventions. In addition, health workers often lack technical capacity and sensitivity to effectively address the needs of LGBTI people, making access to needed services exceedingly difficult.

Collecting accurate and complete data disaggregated by SOGIESC will allow for the formation of evidence-based laws and policies that serve to promote and protect LGBTI people’s right to health. Community-based and LGBTI-led organizations are crucial in collecting these data. Community-based organizations are also best positioned to provide safe, non-judgmental health care to LGBTI people. Improving the health and well-being of LGBTI people must be grounded in human rights approaches that respect autonomy, bodily integrity, and self-determination. Laws, policies, and practices that directly or indirectly criminalize consensual same-sex behavior and self-determination of gender identity must be repealed to eliminate barriers to LGBTI people realizing their right to health.

Civil society, UN agencies, and Member States must work together to ensure accurate and comprehensive reporting on LGBTI health and well-being in development programming. This is necessary to fulfill State obligations to the principle of “leave no one behind” in Agenda 2030.

CROSS-CUTTING RECOMMENDATIONS

All Member States must:

- 1** Commit to ending stigma and discrimination based on sexual orientation, gender identity and expression, and sex characteristics (SOGIESC) in the provision of healthcare services, including prevention, promotion, and treatment.
- 2** Ensure that LGBTI people are actively and meaningfully participating in framing health policy that is responsive and respectful to the needs of LGBTI people, and promote the Greater Involvement of People living with HIV and AIDS (GIPA) principle.
- 3** Collect and disaggregate data by SOGIESC for all indicators where possible.
- 4** Repeal punitive laws, policies, and practices that criminalize consensual same-sex behavior and self-determination of gender identity.
- 5** Legally prohibit non-consensual medical procedures, including intersex genital mutilation, forced sterilization, and anal examinations.
- 6** Ensure that healthcare professionals are technically trained and supported to responsively address health needs of LGBTI people in a non-discriminatory manner.
- 7** Fund community-based and LGBTI-led organizations and service providers, which are typically better positioned to reach LGBTI people and gather data about their health.
- 8** Ensure that sexual and reproductive health programs are tailored to the specific needs of LGBTI people, including hormone therapy, routine sexual and reproductive health screenings, sexually transmitted infection testing and treatment, and family planning services responsive to diverse family forms.
- 9** Eliminate barriers to affordable medicines linked to essential services for LGBTI people by implementing Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibilities in accordance with the Doha Declaration, and other price containment mechanisms.

TARGET - SPECIFIC RECOMMENDATIONS

When reporting on targets in SDG 3, Member States should:

TARGET 3.3 HIV & AIDS

- For indicator 3.3.1, disaggregate HIV incidence by sexual orientation and gender identity and expression.
- Collect treatment coverage data disaggregated by sexual orientation and gender identity and expression.
- Measure stigma and discrimination in access to quality HIV services.

TARGET 3.4 Mental Health & Well-Being

- For indicator 3.4.2, disaggregate national suicide mortality rate by SOGIESC.
- Collect disaggregated data by SOGIESC on number and proportion of persons suffering from depression and anxiety.
- Collect the number of services that address preventative and mental health promotion for LGBTI people nationally.

TARGET 3.5 Drug & Alcohol Use

- For indicator 3.5.1, concurrently collect the coverage of treatment interventions that are tailored for LGBTI people.
- For indicator 3.5.2, disaggregate data by SOGIESC on the harmful use of alcohol.
- Collect the number of services that address the use of stimulant drugs among LGBTI people nationally.
- Fully disaggregate all data about drug use by LGBTI people.

TARGET 3.7 Sexual & Reproductive Health

- Collect the number of services that address the sexual and reproductive health (SRH) needs of LGBTI people nationally.
- Measure access to reproductive health commodities relevant to LGBTI SRH.
- Document inclusion of LGBTI topics in comprehensive sexuality education.
- Ensure SRH care providers commit to non-discrimination and respect for human rights in provision of SRH information and services.

TARGET 3.8
Universal
Health Coverage

- For indicator 3.8.1, disaggregate coverage of essential services by SOGIESC.
- Include gender affirmation and sex reassignment services as essential services.
- Provide viable options to alternative assisted reproductive technologies for LGBTI people with parenting intentions.
- Collect the number of people receiving services from LGBTI-led providers per 1000 population.
- Measure service denial, stigma, and delay experienced by LGBTI people while receiving treatment.

TARGET 3.B
Access to
Affordable
Medicines

- For indicator 3.B.1, disaggregate by SOGIESC the proportion of population with access to affordable medicines.
- Include anti-retroviral medicines, including anti-retroviral medicines used prophylactically, and hormone therapy medicines as essential medicines.

TARGET 3.C
Training of the
Health Workforce

- Collect the number of medical and nursing qualifications that include components on LGBTI health related needs and SOGIESC sensitive care.
- Measure the inclusiveness of standards of care and assess technical skills on a range of specific LGBTI health needs.

INTRODUCTION

LGBTI People and Agenda 2030

The Agenda 2030 for Sustainable Development was endorsed by the United Nations (UN) General Assembly in September 2015, encompassing 17 Sustainable Development Goals (SDGs) and 169 targets to build on the Millennium Development Goals (MDGs) and complete what they did not achieve. The SDGs establish intersectional approaches to overcoming barriers to accessing development interventions, and importantly, the SDGs emphasize a new approach to development which aspires to “leave no one behind.”

The consensus nature of negotiations on the Post-2015 Development Agenda Outcome Document meant that attempts to include lesbian, gay, bisexual, transgender, and intersex (LGBTI) peopleⁱ as a specific group facing barriers to the right to development were unsuccessful. However, advocates were able to ensure that inclusive terms in line with the “leave no one behind” principle and which embrace people marginalized because of their sexual orientation, gender identity and expression, and sex characteristics (SOGIESC) were inserted in commitments throughout SDG targets.¹ These terms have offered new entry points for promoting and protecting the rights of LGBTI people who have traditionally been overlooked within development initiatives.

Agenda 2030 is grounded in the Universal Declaration of Human Rights and international human rights treaties and seeks “to realize the human rights of all and to achieve gender equality and the empowerment of all women and girls.”² Furthermore, SDG targets 10.2 (By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status), 10.3 (Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard), and 10.4 (Adopt policies, especially fiscal, wage and social protection policies, and progressively achieve greater equality) are directly relevant to the rights of LGBTI people. Indeed, realizing the full spectrum of health and rights for LGBTI people requires progress across all development priorities. This briefing paper reaffirms that the protection and promotion of human rights of LGBTI people is crucial in development initiatives.

ⁱ This briefing paper is intended to be inclusive, and thus mostly refers to all populations in the LGBTI acronym. Sometimes the acronym LGBT is used when referencing a study, policy, or other document which cannot be considered to be inclusive of intersex people.

High-Level Political Forum on the Sustainable Development Goals and SDG 3

Convened under the auspices of the Economic and Social Council, the annual High-Level Political Forum (HLPF) is the UN central platform for follow-up and review of the 2030 Agenda and SDGs. A different thematic review of the SDGs is implemented each year at the HLPF, including discussion of SDGs relevant to the theme and Voluntary National Reviews (VNR) of progress on the SDGs by some Member States. Civil society is closely monitoring the HLPF to ensure that the SDGs are responsive to community needs and VNRs accurately depict progress and challenges in realizing the SDGs.

The July 2017 HLPF theme is Eradicating Poverty and Promoting Prosperity in a Changing World: Addressing Multi-Dimensions of Poverty and Inequalities, and the following SDGs will be discussed and reviewed: Goal 1 (End poverty in all its forms everywhere); 2 (End hunger, achieve food security and improved nutrition and promote sustainable agriculture); 3 (Ensure healthy lives and promote well-being for all at all ages); 5 (Achieve gender equality and empower all women and girls); 9 (Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation); 14 (Conserve and sustainably use the oceans, seas and marine resources for sustainable development); and, 17 (Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development), which will be reviewed at every HLPF.

“Improving the health and well-being of everyone requires focusing on populations that have been left behind and, in many contexts, are actively criminalized and persecuted.”

While many of the Goals under review at the 2017 HLPF are highly relevant to LGBTI people,ⁱⁱ this briefing paper focuses on SDG 3, Ensure Healthy Lives and Promote Well-Being for All at All Ages. The targets in SDG 3 are more ambitious and comprehensive than the health MDGs (4, 5 and 6). Improving the health and well-being of everyone requires focusing on populations that have been left behind and, in many contexts, are actively criminalized and persecuted. LGBTI people constitute such populations, and Member States must meet their obligations to ensure LGBTI people are not left behind.

ⁱⁱ Additionally, the following goals are highly relevant to LGBTI people: Goal 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all), 8 (Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all), 10 (Reduce inequality within and among countries), 11 (Make cities and human settlements inclusive, safe, resilient and sustainable), and 16 (Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels).

This briefing paper illustrates how Member States can and should achieve SDG 3 by addressing the marginalization of LGBTI people and promoting LGBTI inclusive development. The authors identified seven SDG 3 targets that Member States and civil society should utilize to measure progress on the health and well-being of LGBTI people, including:

- **Target 3.3:** By 2030, end the epidemic of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.
- **Target 3.4:** By 2030, reduce by one third premature and mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.
- **Target 3.5:** Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.
- **Target 3.7:** By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs.
- **Target 3.8:** Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
- **Target 3.B:** Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable and essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.
- **Target 3.C:** Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in the least developed countries and small island developing states.

For each of the above targets, this briefing paper briefly analyzes the evolution of the target; presents current data available regarding health and well-being of LGBTI people and health disparities with the general population; explores the causes of such health disparities; and proposes revisions to current SDG 3 target indicators and/or the addition of new indicators to track progress on LGBTI health and well-being.

Common Themes

While each section of the briefing paper delves in to specific data and data gaps related to topics captured in SDG 3 targets, common themes emerged across the review of LGBTI health and well-being in the context of development.

NEED FOR DISAGGREGATED DATA

There is limited data about the health of LGBTI people worldwide, but the data that is available suggest that LGBTI people's health is consistently poorer than the general population.^{3,4,5,6} An enhanced evidence base would help to secure support and resourcing of effective interventions to address LGBTI health disparities. The discrimination and exclusion that LGBTI people face in accessing basic services is largely invisible because of the lack of global and national data.

Recognizing these data gaps, the United Nations Development Programme (UNDP) has led a participatory process involving consultations with multisectoral experts and LGBTI civil society organizations, including virtual and in-person consultations convened by OutRight Action International and ILGA World, to complete the first phase of work to develop an LGBTI Inclusion Index. The LGBTI Inclusion Index proposes a framework for measuring how LGBTI people are included across five development dimensions: health; education; economic well-being; political and civic participation; and personal security and violence.⁷

These agencies also urge Member States to strive toward the disaggregation of national data collection by sexual orientation, gender identity and expression, and sex characteristics (SOGIESC). SOGIESC disaggregated data should be collected through routine health surveillance data in: HIV incidence; mental health; alcohol and drug use; reproductive health care; smoking; exercise and obesity. The scope and strength of available data often determines the financing that initiatives can attract. Nowhere is that truer than in the health field, where evidence-based health policy is meant to be based on epidemiological and clinical data. LGBTI people are well aware of the health disparities taking hold and stealing lives in their communities, but exclusion from data collection results in insufficient evidence to make a convincing case for health financing to address these needs.

This issue has been recognized by Member States, and in their Voluntary National Reviews at the 2016 HLPF on the SDGs, both the Philippines⁸ and Venezuela⁹ cited the need for data disaggregated by sexual orientation and gender identity. Furthermore, Vitit Muntarbhorn, the first Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity at the UN Office of the

“ LGBTI people are well aware of the health disparities taking hold and stealing lives in their communities, but exclusion from data collection results in insufficient evidence to make a convincing case for health financing to address these needs.

High Commissioner of Human Rights, stated in his first report that the SDGs “can allow Governments and other actors to generate data and information in a disaggregated manner so as to facilitate further planning and allocation of resources.”¹⁰ This briefing paper makes clear why Member States must systematically pursue data disaggregation by SOGIESC.

HUMAN RIGHTS, HEALTH, AND WELL-BEING

Improving the health and well-being of LGBTI people must be grounded in human rights that respect autonomy, bodily integrity, and self-determination. The human right to health was first asserted in the World Health Organization (WHO) Constitution.¹¹ The International Covenant on Economic, Social and Cultural Rights recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”¹² The right to health is also contained in several other international legal frameworks, including the Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, and the Convention on the Rights of the Child.

A human rights-based approach to achieving SDG 3 anchors implementation in State obligations established by international law. Realization of the right to health relies on the fulfilment of corresponding rights which address root causes of marginalization. At the time of this briefing paper’s publication, there are 72 countries where consensual same-sex behavior is criminalized, including 45 countries that apply such laws to women.¹³ Trans people are criminalized and prosecuted in 57 countries.¹⁴ **Criminalization remains one of the most acute barriers that LGBTI people face in realizing the right to health.**

The Yogyakarta Principles provide a strong analysis of what international human rights law obliges Member States to do in promoting and protecting the rights of people of diverse sexual orientation and gender identity.¹⁵ Principle 17 of the Yogyakarta Principles states, “Everyone has the right to the highest attainable standard of physical and mental health, without discrimination on the basis of sexual orientation or gender identity.” This Principle outlines States’ responsibilities to “take all necessary legislative, administrative and other measures to ensure enjoyment of the right to the highest attainable standard of health, without discrimination on the basis of sexual orientation or gender identity.”¹⁶

DIFFERENTIAL HEALTH OUTCOMES ACROSS LGBTI COMMUNITIES

LGBTI communities are not homogenous, and the health needs of lesbian, gay, bisexual, transgender, and intersex people are diverse. Moreover, while LGBTI people share common experiences of discrimination based on SOGIESC, many also face intersections of gender, age, race, ethnicity, ability, class, socioeconomic status, migration status, and other factors that drive exclusion. The amelioration of some health disparities faced by segments of LGBTI communities does not mean that the health concerns of all LGBTI people have been addressed.

Again, the exclusion of LGBTI people from many health data collection efforts results in less information on the health needs of most LGBTI people. While HIV-related public health programs and research have led to a focus on the HIV needs of gay and bisexual men, and to a lesser extent transwomen, **there has been much less attention to health research, service access, and financing to respond to the health needs beyond HIV for these groups or for any health needs of lesbian and bisexual women, transmen, and intersex people, particularly in low and middle-income countries.**

“ LGBTI-led community-based organizations play a crucial role in providing essential health services and information to LGBTI people across the globe, in addition to working with health services providers to improve access and quality of care for LGBTI people.

NECESSITY OF COMMUNITY ENGAGEMENT AND OWNERSHIP

Any initiative to address the health needs of LGBTI people must meaningfully engage LGBTI communities. From assessment and design to implementation and evaluation, all aspects of health and human rights programming must involve LGBTI-led community organizations to ensure interventions are tailored, appropriate, and effective. LGBTI-led community-based organizations play a crucial role in providing essential health services and information to LGBTI people across the globe, in addition to working with health services providers to improve access and quality of care for LGBTI people.

How to Use this Briefing Paper

For Member States: this report offers an overview of the ways that States should include LGBTI people in Voluntary National Reviews and data collection in health and development programs. Each target section assesses the indicators currently contained in targets of SDG 3, and offers additional insights for what type of data and evidence is necessary to help understand the health needs of LGBTI people and create effective and sustainable health policy.

For data generators and analysts, including civil society: this report offers entry points for tracking progress on the health needs of LGBTI people. It provides an oversight tool to monitor Member State reporting on LGBTI people in the context of SDG3, as well as inspiration for how to supplement State reporting. LGBTI civil society organizations working on health policy at the national level should reference data and data gaps outlined in this briefing paper to drive evidence-based policy advocacy.

About this Briefing Paper

In March 2017, the Global Advocacy Platform to Fast Track the HIV and Human Rights Responses with Gay and Bisexual Men (the Platform)ⁱⁱⁱ committed to produce this briefing paper in accord with its advocacy priority to hold Member States and UN agencies accountable for reporting on targets and commitments relevant to gay and bisexual men.

This briefing paper was written by Felicity Daly, DrPH, Global Research Coordinator at OutRight Action International, Stephen Leonelli, MPP, Senior Policy Advisor at the Global Forum on MSM & HIV, and Adam Bourne, PhD, Associate Professor of Public Health at the Australian Research Centre in Sex, Health & Society, La Trobe University.^{iv}

Subject specialists in each of the SDG 3 targets performed a scoping review of published academic and grey literature. Particular attention was paid to systematic reviews, Cochrane Colloquium reviews, data that has been published within the last 3 years, and data from UN Member States participating in Voluntary National Reviews at the 2017 HLPF.

This briefing paper was reviewed by members of the Platform, including Clifton Cortez, Sexual Orientation and Gender Identity Global Advisor at the World Bank, Edmund Settle, Policy Advisor at the United Nations Development Programme, Shaun Mellors, Director of Knowledge and Influence at the International HIV/AIDS Alliance, George Ayala, Executive Director at the Global Forum on MSM & HIV, Jessica Stern, Executive Director at OutRight Action International, and Niluka Perera, Regional Coordinator at Youth Voices Count.

Activists representing LGBTI constituencies and other researchers were contacted to provide suggested citations in certain areas. Keletso Makofane, Senior Research Advisor at the Global Forum on MSM & HIV, provided valuable feedback on this paper. OutRight Action International's team provided additional support: identification of relevant literature was undertaken by intern Matthew Steif, PhD; literature review was supported by HK Nekoroski, Executive Assistant; and Siri May, United Nations Program Coordinator, and intern Daniel Bradley provided inputs.

This briefing paper provides relevant highlights of key trends and patterns in LGBTI people's health and well-being as they relate to the framing of the SDG 3 targets and indicators. It is not meant to reflect an exhaustive account of the literature on LGBTI health.

ⁱⁱⁱ The Platform is composed of global and regional experts, researchers, and community members who provide ongoing strategic advice and guidance to UN agencies, global donors to the HIV response, and other stakeholders. See: <http://msmgf.org/msmgf-launches-global-platform-to-fast-track-the-hiv-and-human-rights-responses-among-gay-and-bisexual-men-and-other-men-who-have-sex-with-men/>

^{iv} The Australian Research Centre in Sex Health & Society (ARCSHS) at La Trobe University is an interdisciplinary center specializing in health research and policy development among LGBTI communities. For more information see www.latrobe.edu.au/arcs.

TARGET 3.3

By 2030, end the epidemic of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

Despite considerable progress on addressing HIV in the past 15 years, gay, bisexual and other men who have sex with men (MSM) and transwomen continue to bear disproportionate burden of HIV in all contexts worldwide. This disproportionate impact is due to entrenched structural barriers, including discrimination, violence, social, and criminalization. Member States must regularly collect data disaggregated by sexual orientation, gender identity and expression with respect to HIV incidence, treatment coverage, and stigma and discrimination in service provision.

Background

Goal 6 of the Millennium Development Goals (MDGs), Combat HIV/AIDS, Malaria, and Other Diseases, prompted coordinated action on halting and reversing the spread of HIV. However, no indicators in the MDGs explicitly mentioned key populations,^v which in part explains why considerable progress on MDG 6 resulted in major gaps for gay, bisexual and other men who have sex with men and transwomen.

In 2014, the Joint UN Programme on HIV and AIDS (UNAIDS) launched a “Fast Track Strategy” to end the AIDS epidemic by 2030, including the 90-90-90 treatment target by 2020: achieving 90% of people living with HIV knowing their HIV status, 90% of people who know their HIV status on treatment, and 90% of people on treatment with suppressed viral loads.¹⁷ The 90-90-90 target reflects global acknowledgement of the power of treatment in preventing illness and death, averting new infections, and ending AIDS. But the reality for key populations, and in particular transgender women and gay and bisexual men, is that services are out of reach: anti-LGBTI violence plays a major role

^v According to the 2015 UNAIDS Terminology Guidelines, key population groups “often suffer from punitive laws or stigmatizing policies, and they are among the most likely to be exposed to HIV.” Key populations include gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs, and prisoners and other incarcerated people. See more at http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf.

in stymying the HIV response,¹⁸ criminalization of self-determined gender identity and consensual same-sex behavior impedes access to services,¹⁹ and numerous surveys have indicated discriminatory treatment from medical practitioners to key populations and LGBTI people.²⁰ This means that gay and bisexual men and transwomen will nearly always be disproportionately represented in the “10%” not receiving treatment nor benefitting from treatment as prevention.^{vi}

In June 2016, the UN Political Declaration “On the Fast-Track to Accelerate the Fight Against HIV and to End the AIDS Epidemic by 2030” was adopted to reinvigorate the global HIV response. However, the Political Declaration failed to include key populations in a meaningful way, and further provided exclusions for States “based on national characteristics” – essentially allowing governments to overlook, deny, or ignore the disproportionate HIV disease burden among gay and bisexual men and transwomen.²¹ This means gay and bisexual men and transwomen are more likely to be left out of national programming for the HIV response.

“ Despite considerable progress on addressing HIV in the past 15 years, gay, bisexual and other men who have sex with men (MSM) and transwomen continue to bear disproportionate burden of HIV in all contexts worldwide.

Relevance for LGBTI Health: What We Know

Overall, the odds of having HIV infection are markedly and consistently higher among gay and bisexual men and other men who have sex with men and transwomen than among the general population in adults of reproductive age in every region and country in the world, including Asia, Africa, the Americas, and the Caribbean. The reasons for heightened vulnerability to HIV are multifactorial and driven by stigma, discrimination, and violence.^{22,23,24,25} In high-income countries, HIV is most prevalent among gay, bisexual men and other MSM.²⁶ In low- and middle-income countries, gay, bisexual men and other men who have sex with men are 19 times more likely to be living with HIV compared with people in the general population and represent an estimated 10% of all new infections each year.²⁷ The UNAIDS 2014 Gap Report estimated HIV prevalence among transgender women was 19%, and that transgender women are 49 times more likely to acquire HIV than cisgender adults of reproductive age.²⁸

Even where there have been recent and notable decreases in new HIV infections, prevalence and incidence is consistently higher and rising among men who have sex with men when compared with other men.^{29,30,31,32} In Kenya, the HIV prevalence among men who have sex with men is estimated to be as high as 43%, compared with 6.1% among other male adults. Similarly, in South Africa and Thailand, respectively, HIV prevalence among men who have sex with men is as high as 40% and 68% compared to general population prevalence of 17.9% and 1.1%.³³ Across China, Indonesia, Malaysia, Mongolia,

^{vi} The UNAIDS 2016-2021 Strategy sets other important targets: fewer than 500,000 new infections, fewer than 500,000 AIDS-related deaths, and zero discrimination by 2020. While the “Five Prevention Pillars” to ramp up the prevention response to meet these targets does name key populations, prevention services and commodities are constantly underfunded and not tailored to the needs of gay, bisexual men and transwomen.

Myanmar, Philippines, Thailand, and Vietnam, prevalence among gay men under 25 years of age is over 5%.³⁴ In Kyrgyzstan there is rapid growth in the number of new cases of HIV among men who have sex with men, and HIV prevalence in this group is currently estimated to be 6.3% compared to 0.3% in the general population.³⁵

Data on treatment coverage among gay and bisexual men and transwomen is almost non-existent because governments refuse or don't know how to safely and respectfully collect and report this data. The little data that is available comes from standalone studies, which suggest low treatment coverage. Thailand reported in its annual AIDS monitoring process that antiretroviral therapy coverage for men who have sex with men was 6.5% in 2015.³⁶ We expect that the numbers are even lower in other countries around the world.

Data about HIV prevalence and incidence among other vulnerable LGBTI populations is limited.^{vii} Lesbian, bisexual, and other women who have sex with women are often perceived to be at low risk for transmission. However, studies in several countries have found that some lesbian women engage in high risk behaviors that place them at risk for HIV transmission, such as using injection drugs and having sex with HIV-positive men. Additionally, lesbian and bisexual women face severe gender-based, ethnicity-based, and class-based violence and discrimination.³⁷ Indeed, gender-based violence and sexual violence driven by the perverse motivation to “correct” the sexual orientation of lesbian, bisexual, and other gender non-conforming women is a key factor in HIV risk. A survey of 591 women who in the preceding year had had sex with a woman in Botswana, Namibia, South Africa, and Zimbabwe found that forced sex was the most important risk factor for self-reported HIV infection.³⁸ Efforts to combat gender-based violence and sexual violence can and should be used as an entry point to raise issues relevant to women who have sex with women in national strategic plans to address HIV.³⁹

“ Exclusion of gay and bisexual men and transwomen, as well as vulnerable lesbian and bisexual women, from national AIDS planning processes has contributed to inadequately funded, inaccessible, and poorly targeted programs.

Understanding the Data: Social Determinants of HIV among LGBTI People

LGBTI people are less likely to have access to safe and competently delivered HIV services than the general population worldwide.⁴⁰ Exclusion of gay and bisexual men and transwomen, as well as vulnerable lesbian and bisexual women, from national AIDS planning processes has contributed to inadequately funded, inaccessible, and poorly targeted programs.⁴¹ National HIV prevention and treatment programs struggle to reach and respectfully serve gay, bisexual and other men who have sex with men,⁴² most likely due to substandard technical capacity and low political will to openly address the sexual and reproductive health needs of gay and bisexual men. This also creates an environment in which programs led by and intended for LGBTI communities are contested, defunded, or undermined.

^{vii} There is a dearth of data on HIV prevalence and incidence among transmen and intersex people. Transmen who have sex with men may face the same risk vulnerabilities as cisgender men who have sex with men.

“ Communities will require increased resources, capacity development, and expanded opportunities to strategize and lead in the HIV response.

Provision of safe spaces and social support, and promotion of community coherence, participation, and inclusion can help to reduce the spread of HIV among men who have sex with men.^{43,44,45} Community support, such as gay- and bisexual-specific health promotion, can have positive impacts such as encouraging condom use through education and sex-positive messaging.^{46,47} Service utilization may also be optimized when delivered by community-based organizations that are led by gay or bisexual men.⁴⁸ Communities will require increased resources, capacity development, and expanded opportunities to strategize and lead in the HIV response. **Laws, policies, and practices that criminalize same-sex behavior and self-determination of gender identity, and impose higher age of consent for consensual same-sex behavior, all obstruct the right to health and seriously threaten achieving the end of AIDS by 2030.**

What We Need from Member States

While SDG 3 explicitly names key populations in Indicator 3.3.1 (*Number of new HIV infections per 1000 uninfected population, by sex, age and key population*), this indicator is only one part of the picture relevant to ensure the health and well-being of LGBTI people with regard to the diseases covered in target 3.3. In order to holistically address LGBTI health concerns as it pertains to target 3.3, Member States must monitor the following three indicators:

Incidence disaggregated by sexual orientation, gender identity and expression. Incidence informs Health Ministries, donors, and civil society about new or recent HIV infections and the way an epidemic is concentrated and spreading. Many governments are reluctant to collect data about modes of transmission, sexual orientation, and gender identity and expression. Additionally, data regarding co-infections with Hepatitis and other communicable diseases will enable States to provide better preventative and comprehensive treatment services for the LGBTI community.

Treatment coverage disaggregated by key population, sexual orientation, and gender identity and expression. Treatment as prevention will fail and UNAIDS targets will not be met if key populations are not receiving adequate coverage, particularly in locations with criminalization and human rights barriers.

Stigma and discrimination must be monitored as these factors place barriers to the availability and accessibility of health care services, including HIV treatment among LGBTI people. Civil society, and in particular LGBTI community-based organizations, can play an important role in this monitoring work. Since 2008, the People Living with HIV Stigma Index has been implemented in 90 countries, reaching over 100,000 people living with HIV.⁴⁹ The Index offers a template for measuring stigma and discrimination experienced in each country context with regard to HIV services. These measures should be expanded to include stigma and discrimination experienced by vulnerable LGBTI people who may be trying to access HIV prevention and testing.

TARGET 3.4

By 2030, reduce by one third premature mortality from non-communicable diseases (NCDs) through prevention and treatment, and promote mental health and well-being

Social exclusion, violence, discrimination, and criminalization perpetuate mental health and non-communicable disease disparities among LGBTI people. Member States must disaggregate national suicide mortality rate by sexual orientation, gender identity and expression, and sex characteristics (SOGIESC) and track the number of preventative and promotion mental health services for LGBTI people.

Background

While this section focuses on the mental health disparities faced by LGBTI people, data has also suggested that poor mental health, alcohol consumption, tobacco and drug use elevate the risk of non-communicable diseases (NCDs) among sexual minorities.⁵⁰ Such risk behaviors reflect ways that sexual and gender minorities cope with stress. Minority stress theory suggests that sexual and gender minorities experience distinct, chronic stressors related to their stigmatized identities which disproportionately compromise their mental health and well-being.^{51,52}

Mental health was not addressed in the MDGs, and its inclusion as a priority within the SDGs is an opportunity to overcome the severe lack of resources for mental health services throughout the world. The World Health Assembly's adoption of WHO's Comprehensive Mental Health Action Plan in 2013 prepared the groundwork for mental health to be addressed within the international development framework. The WHO Plan acknowledges that LGBT people are vulnerable to significantly higher risk of experiencing mental health problems and asserts that, regardless of sexual orientation, all people should be able to access "essential health and social services that enable them to achieve recovery and the highest attainable standard of health."⁵³

What We Know: Data on LGBTI Mental Health and Well-Being

Poor mental health represents one of the leading causes of premature death and disability and is a common source of human misery. Numerous studies have established that a higher burden of poor mental health exists among LGBTI people compared to the general population. The mental health of transgender people is an acute concern. A U.S. national survey found 41% of transgender respondents reported ever attempting suicide compared to 4.6% of the general population.⁵⁵

A systematic review of general population studies conducted in Australia, Europe, and North America found that compared with heterosexual people, lesbian, gay, and bisexual people are at higher risk for mental disorders, including depression and anxiety, suicidal ideation and deliberate self-harm, and further that gay and bisexual men have suicidal ideation rates almost twice those of heterosexual individuals.⁵⁶

The review asserts that there is “no evidence that homosexuality is itself a disorder that is thereby subject to higher co-morbidity than is found in heterosexuals.”⁵⁷ Similarly, guidelines for the provision of mental health care with trans and gender nonconforming people establish that beyond mental health issues “relating to or resulting from”⁵⁸ their gender identity, trans people “experience the background rates of mood disorders and other psychiatric conditions seen in the general population.”⁵⁹

“ Studies have established a higher burden of poor mental health among LGBTI people compared to the general population... [which] is a reflection of the lived reality of discrimination, hatred, victimization, violence, and structural prejudice.

Mental health disparities among LGBTI people is a reflection of the lived reality of discrimination, hatred, victimization, violence, and structural prejudice.^{60,61} Resources available to help cope with mental health challenges may be unavailable to LGBTI people, including support from family or friends, and they may face discrimination when accessing health and social services.⁶² Incidence of mental health problems varies within LGBTI populations, and several studies have demonstrated that depression symptoms are more prevalent among trans people relative to cisgender LGB people.⁶³ Every mainstream medical and mental health organization has denounced so-called “conversion therapy,” which falsely claims to change a person’s sexual orientation, gender identity and/or expression. Despite this, the practice is still perpetrated on vulnerable LGBTI people, including young people, and can lead to health problems.⁶⁴ There is no inherent propensity for poor mental health among LGBTI people; mental health problems arise because of persistent stigma, discrimination, and violence based on SOGIESC.

Mental health disparities within LGBTI communities are also influenced by the intersection of age, race, ethnicity, socioeconomic status, gender, and other factors. Studies conducted in several countries have established that sexual minority women experience more depressive symptoms than heterosexual women, and that bisexual women, particularly younger women, have higher levels of depressive symptoms than lesbians.^{65,66,67,68} LGBT youth demonstrate higher rates of emotional distress, symptoms related to mood and anxiety disorders, self-harm, self-stigma, suicidal ideation, and suicidal behavior compared to heterosexual youth.^{69,70,71}

Studies conducted in Brazil, South Africa, and the U.S. found that sexual minority men from low socio-economic status and/or minority ethnic communities experience greater psychological stress due to the combination of discrimination based on sexuality and other forms of prejudice.^{72,74,74} A study in European countries considered the impact of heteronormative gender roles on sexual minority men and found many gay and bisexual men struggle with internalized sexual stigma, fueled by social stigma, which affects their well-being.⁷⁵

Understanding the Data: Social Determinants of LGBTI Mental Health

Data from the UK demonstrate that gay and bisexual men have “half the odds of depression, three quarters the odds of anxiety, a third the odds of suicide attempt and two fifths the odds of self-harm”⁷⁶ when they cohabitate. This suggests that greater social acceptance and recognition of same sex relationships could be an effective strategy for enhancing LGBTI well-being. **In countries where same-sex relations and gender non-conforming identities are criminalized, some data shows mental health is worsened by the impact of punitive laws.** A review of criminalization of same-sex conduct between women in 44 countries asserts that the effects on lesbian and bisexual women include mental health issues and suicide.⁷⁷

A study of men who have sex with men in Kenya found high levels of depression (16%), compounded by experiencing trauma or abuse, which is considerably higher than the national prevalence of depression (6%).⁷⁸ In a comparative study, gay men in Malaysia reported higher levels of internalized homonegativity (also referred to as internalized sexual stigma, an indicator of self-reflected social stigma) than Australian gay men.⁷⁹ A study of men who have sex with men in Russia found that depressive symptoms are associated with homosexual identity and experience of stigma and imprisonment, and these experiences have been exacerbated by the passing of anti-gay propaganda laws.⁸⁰ Prior to the 2014 Indian Supreme Court recognition of trans people as a “third gender,” data collected in 2011 and 2012 showed high prevalence of depression among transwomen in Delhi and the states of Maharashtra, Tamil Nadu, and West Bengal.⁸¹

What We Need from Member States

The indicator to monitor Member States’ progress on improving mental health and well-being is the *National Suicide Mortality Rate*. However, most countries don’t record any data about SOGIESC in coroner reports, which are the basis of suicide statistics. Given that available data demonstrates high rates of suicide and suicidal ideation within LGBTI communities around the world, this indicator will fail the LGBTI community if governments don’t collect SOGIESC data.

From a preventative standpoint, Member States that want to decrease suicide rates must endeavor to improve the mental health of LGBTI people in their country. A study among sexual minorities found lack of social support had the strongest association with suicide ideation, while greater self-acceptance and less self-stigma was a key protective factor against suicide ideation.⁸² In order to effectively address suicidal ideation among LGBTI people, Member States must provide services that enhance resilience, self-acceptance, and self-esteem among LGBTI people and advance the acceptance of same-sex relationships and gender diversity in society.

“ Member States must provide services that enhance resilience, self-acceptance, and self-esteem among LGBTI people and advance the acceptance of same-sex relationships and gender diversity in society.

Additional indicators relevant for inclusion of SOGIESC in this target are elaborated in WHO's Mental Health Action Plan 2013-2020,⁸³ which urges Member States to collect data on a core set of mental health indicators routinely collected and reported every two years, including:

- Number and proportion of persons, including LGBTI persons, with a severe mental disorder who received mental health care in the last year. Given that data demonstrate that LGBTI persons experience common mental health disorders including depression and anxiety at higher rates than the general public, there should be greater emphasis on assuring access to mental health care to alleviate acute symptoms and enhance well-being; and,
- Number of functioning programs of multisectoral mental health promotion and prevention in existence that reach vulnerable LGBTI people.

TARGET 3.5

Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

Social exclusion and discrimination drive substance and alcohol abuse among LGBTI people, and services are inadequate for those who seek help. Member States must collect coverage of treatment interventions that are tailored for LGBTI people, the number of services that address use of stimulant drugs among LGBTI people, and fully disaggregate all data about alcohol consumption and problematic^{vii} drug use by SOGIESC.

Background

There are no UN level strategies or work plans that specifically address the services need of LGBTI people with problematic drug and alcohol use and addiction. A recent review of stimulant use highlights the particularly high prevalence of crystal methamphetamine use among gay and bisexual men.⁸⁴ The UN Office on Drugs and Crime (UNODC) 2016 World Drug Report⁸⁵ makes no mention of lesbian or bisexual women, only one brief mention of transgender people (connected to gay men), and only makes passing mention of gay men in relation to higher stimulant use and concerns for HIV/STI transmission in sexualized drug contexts (commonly referred to as “chemsex”). This scenario perpetuates the invisibility of LGBTI people and their elevated need for targeted substance abuse and treatment services within the MDGs. UNODC normative guidance only makes mention of LGBTI people in the context of prison based needle and syringe exchange programs.

What We Know: Data on LGBTI Alcohol and Drug Use

While levels of documented opiate use have historically been low in most countries, a significant and growing body of literature has demonstrated that **the use of other substances (especially stimulants) is significantly higher among lesbian, gay, and bisexual people when compared to heterosexual people.**^{86,87} While prevalence of frequent or problematic alcohol use is relatively similar among gay, bisexual, and heterosexual men, higher levels of problematic alcohol use among lesbian and bisexual women compared to heterosexual women have been reported in numerous countries around the world.^{88,89}

^{vii}The UNODC 2016 World Drug Report defines problem drug users as “people who engage in the high-risk consumption of drugs, for example people who inject drugs, people who use drugs on a daily basis and/or people diagnosed with drug use disorders (harmful use or drug dependence), based on clinical criteria as contained in...the International Classification of Diseases (tenth revision) of the World Health Organization.”

In countries where drug use data is collected, drug use is found to be higher among lesbian, gay, and bisexual people when compared to their heterosexual counterparts. Most of this data is from high-income countries where national-level studies disaggregate data by sexual orientation. Findings from the UK indicate gay and bisexual men were three times more likely to have used drugs, not otherwise prescribed by a physician, within the previous 12 months than heterosexual men.⁹⁰ They were 7 times more likely to have used stimulant drugs and 15 more likely to have used crystal methamphetamine compared to heterosexual men. Crystal methamphetamine has been closely connected with HIV transmission risk behavior and with diminished adherence to HIV antiretroviral therapy.^{91,92} Among lesbian and bisexual women, the use of any non-prescribed drug was four times higher than among heterosexual identified women.

Data from Australia shows that use of any non-prescribed drug within the previous 12 months was three times higher among lesbian and bisexual women. Among gay men, use of cannabis, ecstasy, and methamphetamine were all at least 3 times higher than heterosexual men.⁹³ Similar patterns of elevated prevalence are documented in several other countries (including the U.S.⁹⁴), while higher rates of drug dependence have been documented in New Zealand⁹⁵ and the Netherlands.⁹⁶ However, most other countries do not disaggregate data from national health surveys by sexual orientation (and/or do not ask questions regarding gender identity).

Community surveys provide valuable insight into the profile of drug use among LGBT populations in other parts of the world. A survey of gay men in Kenya found that 45% of respondents reported problematic levels of alcohol use and 22% were deemed to have substantial or severe drug abuse issues.⁹⁷ The Asian MSM internet Survey (including Thailand, Malaysia and Indonesia) found that 4.0% of 10,826 respondents had used crystal methamphetamine, 8.1% had used ecstasy, and 5.3% had used ketamine within the previous six months.⁹⁸

There is significantly less research relating to substance use among transgender people, although data from Canada indicate they are significantly more likely to use cocaine and amphetamines compared to an age-matched reference population.⁹⁹ U.S. studies indicate that transmen and transwomen report high rates of marijuana, cocaine, crack, and amphetamine use, and that substance use differs by gender.¹⁰⁰ More than a quarter of participants in one U.S. study stated they had used drugs or alcohol specifically to cope with the impact of discrimination.¹⁰¹ The experiences of alcohol and drug use among intersex individuals has rarely been examined, although research from Australia reported that the use of drugs by some intersex individuals was closely intertwined with experiences of bullying or used to help cope following genital reconstruction surgeries.¹⁰²



Understanding the data: Social Determinants of LGBTI Alcohol and Drug Use

Examining the global body of literature relating to drug and alcohol use among LGBTI people, it is evident that these populations use drugs more commonly than their heterosexual or cisgender counterparts. As described in Section 3.4, stigma, discrimination, and violence (or the fear of it) engenders minority stress,^{103,104} while social exclusion and violence (or the fear of it) drive LGBTI people towards specific social spaces where alcohol is served and drugs are more accessible.¹⁰⁵ Both are significant contributing factors in the higher rates of problematic drug and alcohol use among LGBTI people. LGBTI people also experience a broad range of harms as a consequence of their drug use, including significantly high rates of overdose¹⁰⁶ and drug induced mental trauma.¹⁰⁷

Added to this, LGBTI people are systematically disadvantaged, or actively excluded, from supportive drug and alcohol services.¹⁰⁸ In focusing on opiate use, many traditional drug services do not have the capacity to address the specific drug treatment or support needs of LGBTI people, for whom stimulant use is more common. A comprehensive, global systematic review recently reported significant challenges faced by LGBTI people in accessing healthcare services in many countries due to heteronormative beliefs imposed by health professional and due to the impact of punitive health policies that disproportionately affect this population.¹⁰⁹

What We Need from Member States

The indicators for this target are 3.5.1 *Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders* and 3.5.2 *Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in liters of pure alcohol*. While indicator 3.5.1 can be seen as a useful measure at a general population level, the specific treatment interventions needed to support LGBTI populations are unlikely to be captured given that many people will instead seek more tailored support from LGBTI community organizations.¹¹⁰ Indicator 3.5.2 would be improved by greater attentiveness to the particular populations most affected by problematic drinking, including LGBTI populations.

In order to ensure appropriate inclusion of LGBTI people within this development target, Member States must consider the following revision to the existing indicators:

- **Coverage of services that address the use of stimulant drugs.** These are more commonly used, and are a significant source of harm, among a larger section of the LGBTI population than any other group.
- **Coverage of community-based LGBTI drug services.** Given the challenges in accessing traditional drug and alcohol services, data should be collected as to the number of clients seen by community based LGBTI organizations.
- **Disaggregation of alcohol consumption data.** To record and monitor problematic levels of alcohol use that are known to occur for at least some sections of the LGBTI population.

Member states must also consider:

- **Collection and disaggregation of non-prescription drug use data, specific to LGBTI people.** Where general population data is collected about the use of non-prescription drugs (such as national health surveys, household surveys), appropriately worded questions should establish the sexual orientation and gender identity and expression of respondents. Data should then be suitably disaggregated for reporting.

TARGET 3.7

By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs

Heteronormative framing of sexual and reproductive health continues to exclude men and LGBTI people, and the health care workforce is ill-prepared to address the sexual and reproductive health needs of LGBTI people. Member States should collect the number of services that address the sexual and reproductive health needs of LGBTI people nationally, measure access to reproductive health commodities relevant to LGBTI sexual and reproductive health, and document inclusion of LGBTI topics in comprehensive sexuality education.

Background

Sexual and reproductive health service provision for LGBTI communities should respect bodily integrity and physical autonomy, promote sexual pleasure and healthy relationships, and support family planning intentions.

Through MDG 5, Member States endeavored to improve maternal and reproductive health, but the selective nature of these interventions limited health benefits impact for certain populations. LGBTI inclusive implementation of SDG 3.7 can provide opportunities to enhance sexual and reproductive health and rights (SRHR) for all.

Since the International Conference on Population and Development (ICPD) in 1994, Member States have been encouraged to provide universal access to comprehensive sexual and reproductive health (SRH) services which include: prevention and treatment of infertility; abortion-related care; and prevention, detection and treatment of sexually transmitted infections (STIs).¹¹¹ SRHR advocates call on Member States to deliver high quality services which “provide access to full information, enable clients to make informed choices, and treat clients with dignity and respect.”¹¹² These points are crucial for ensuring LGBTI people’s access to SRH services.

Both ICPD and the Beijing Platform for Action in 1995 framed reproductive health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (and) therefore implies that people are able to have a satisfying and safe sex life.”¹¹³ This establishes sexual rights for all, including LGBTI people, and underscores that effective SRH service provision within LGBTI communities should enhance autonomy, pleasure, and healthy relationships.

What We Know: Data on LGBTI Sexual and Reproductive Health and Rights

Many countries have documented high incidence to common STIs among gay and bisexual men and transwomen.¹¹⁴ Yet in some countries, including Guatemala, fear of discrimination, cost, and lack of social support impede these communities from accessing SRH services.¹¹⁵ WHO asserts that effective STI interventions must incorporate services that address SOGIE-related violence and address stigma and discrimination in health services and the community.¹¹⁶ Inclusive SRH services also must consider the STI risks of transmen and transwomen in same sex relationships.^{117,118,119} As mentioned in the review of target 3.3, several countries, including India, are experiencing dual epidemics of STIs and sexual violence targeting lesbian, bisexual, and other gender non-conforming women.^{120,121}

“ LGBTI people have limited access to [sexual and reproductive health] information relevant to their sexual lives and to their ability to protect themselves and their partners from sexual health risks, particularly when they are young adults.

LGBTI people have limited access to SRH information relevant to their sexual lives and to their ability to protect themselves and their partners from sexual health risks, particularly when they are young adults. A U.S. study highlighted that same-sex sexual behaviors are excluded during in-school sex education, leaving gay, bisexual, and questioning young men to seek other resources.¹²² In Uganda, one in three young adults who have had same-sex sexual experiences reported unmet sexual health counselling needs in university health services.¹²³ Moreover, LGBTI people have limited access to essential reproductive health commodities for safer sex including condoms and lubricants, as well as other barrier methods to prevent STI transmission such as dental dams, latex gloves, and finger cots.

There are many challenges to accessing affordable, non-discriminatory and consensual reproductive health services for LGBTI people. **Violation of the bodily integrity, physical autonomy, and well-being of intersex people persists in SRH services.** There is global evidence of SRH care providers enacting violent approaches, including: “normalizing” genital surgeries; non-consensual sterilization; preimplantation genetic diagnosis; pre-natal screening/treatment and abortion of intersex fetuses; and infanticide of intersex infants.¹²⁴

In high-income countries, women in same-sex partnerships who wish to become pregnant are often directed to utilize assisted reproductive technology, such as fertility medication, available through costly private health care and unviable in resource poor settings.¹²⁵ Similarly, gay men in high-income countries have become parents through surrogacy, another assisted reproductive technology which is unavailable in many settings.¹²⁶ The fertility related needs of trans people have been understudied and are compromised in many countries where legal gender recognition requires irreversible surgical reassignment, resulting in sterilization.¹²⁷



Understanding the data: Social Determinants of Accessing LGBTI SRH Services

Quality, comprehensive, non-discriminatory SRH services remain out of reach for many LGBTI people. Draconian and discriminatory measures which seek to control sexual behaviors have not resulted in decreasing SRH problems.

Holistic responses to enhancing the SRH of LGBTI people have emerged as a need within HIV prevention programming that helps people achieve a sense of sexual well-being¹²⁸ and allows them to explore having “the best sex with the least harm.”¹²⁹ SOGIESC-inclusive SRH information is essential to navigate satisfying and safe sex, and implementation of comprehensive sexuality education brings health benefits to more young people and can enhance social acceptance of sexual and gender differences.

Given the interference of punitive laws, as well as freedom from expectations governing heteronormative relationships, LGBTI people’s partnerships and families take varied forms.¹³⁰ **Health workers need to be aware of different relationship forms and recognize the family planning intentions of LGBTI people.** Importantly, health workers in SRH care settings must de-pathologize their approach to the diversity of sex characteristics to expand SRH choices of LGBTI people and respect rights at all life stages.

What We Need from Member States

The indicators for target 3.7 focus on SRH service uptake among heterosexual women: 3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods; 3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group. The heteronormative framing of these indicators excludes men and the SRHR concerns of most LGBTI people.

In order for Member States to make access to SRH authentically universal, additional indicators should capture:

- LGBTI disaggregated data from SRH service points including reporting proportion of people with basic knowledge about SRHR.
- Data on SRH services targeted to LGBTI people.
- SOGIESC relevant SHR information including proportion of schools that provide comprehensive sexuality education includes SOGIESC topics.
- Essential reproductive health commodities relevant to LGBTI people’s SRH, including condoms, lubricants, dental dams, latex gloves and finger cots.
- Sexual and reproductive health care providers’ commitment to non-discrimination and respect for human rights in provision of SHR information and services.

TARGET 3.8

Achieve universal health coverage (UHC), including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

“ LGBTI people experience limited access to essential health care services, lack of competent and quality care from providers, and challenges in affording services necessary to realize the right to health.”

LGBTI people experience limited access to essential health care services, lack of competent and quality care from providers, and challenges in affording services necessary to realize the right to health. These realities threaten to undermine universal health coverage. Involvement of people living with HIV and LGBTI people in framing health policy, focus on preventative services, and tracking service uptake by community-led service providers is necessary to ensure UHC is truly inclusive and meeting the needs of LGBTI people.

Background

In the creation of Target 3.8, Member States recognized the need to transform how health services are funded, managed, and delivered so that services are centered around the needs of people and communities. By the time the MDGs were drafted, political will to work towards UHC had stalled somewhat since the 1978 Alma Alta Declaration which called for “health for all.” The health MDGs instead focused on access to services that are generally identified as priorities in countries with a UHC-oriented reform agenda.

In recent years, through the World Health Assembly, countries have adopted several resolutions related to health systems strengthening and UHC. In addition, the UN General Assembly adopted a resolution on UHC in 2012.¹³¹ UHC and other health financing schemes have become increasingly important as international donors withdraw funding from countries that are transitioning to middle-income status, with the expectation that strengthened health systems and UHC will continue to fund essential health services, including the HIV response. However, in countries where same-sex behavior and self-determination of gender identity is criminalized, political will is lacking to ensure that essential health services support LGBTI populations.



What We Know: LGBTI Access to Quality Health Services

UHC means all individuals, especially the poorest and most marginalized, receive the full spectrum of essential, quality health services from health promotion to prevention, treatment, rehabilitation, and palliative care without suffering financial hardship. LGBTI people face challenges in accessing essential health services due to barriers at the point of service. According to data from a 2014 global online survey, only half or fewer than 2,312 MSM from 154 countries perceived that condoms, lubricants, HIV testing, and HIV treatment were easily accessible, and younger men generally reported comparatively lower access to all services.¹³² Studies have similarly shown low access to HIV services among transmen.¹³³ Criminalization is a key determinant in health care access, wherein arrests and convictions under anti-LGBTI laws have a strong negative association with access to HIV prevention and care services.¹³⁴ Indeed, studies from Malawi, Namibia, and Botswana have demonstrated that fear of seeking health care because criminalized sexual behavior is a formidable barrier to seeking HIV services.¹³⁵

Studies have shown evidence of disparities in health care access wherein LGBTI people may opt out of further care and/or are lost during follow-up, which is particularly problematic to effective treatment and prevention of HIV. Lesbian and bisexual women may be more vulnerable to premature death from reproductive cancers as they are less likely than heterosexual women to access routine SRH checks, such as PAP tests, due in part to fear of discrimination.¹³⁶ Similarly low PAP test uptake among transmen are likely due in part to lack of access to providers with experience seeing transgender patients.¹³⁷

Numerous reports and studies have illuminated negative experiences that LGBTI people undergo in health care settings. In Brazil, the negative attitudes of health workers toward LGBTI service users have been documented in primary, secondary and tertiary health care.¹³⁸ A U.S. national survey found 28% of trans people had postponed health care, due to discrimination, and 28% reported being harassed by health workers when they did seek out care.¹³⁹ As discussed in previous sections, intersex people experience significant distress as a result of their treatment in health care settings, including surgeries in infancy, surgery and other interventions without informed consent, and lack of disclosure from parents and health care providers.¹⁴⁰

Multiple studies have shown that HIV outcomes are significantly improved when services are community-led, meaning that members of LGBTI communities are more likely to access services that are delivered by LGBTI people.¹⁴¹ Availability of community-led HIV services is dismally low in many contexts, particularly for transgender people. Progress toward UHC and building resilient and sustainable health systems should incorporate and safeguard the role of community-led service providers, including for LGBTI communities.

Every year 100 million people are pushed into poverty and 150 million people suffer financial catastrophe because of out-of-pocket expenditure on health services. Analysis of the impact of financial hardship caused by medical expenses among the LGBTI community is insufficient. However, research has shown that the experience of social marginalization based on SOGIESC may limit incomes, and thus make high out-of-pocket costs more burdensome.¹⁴²

Understanding the Data: Social Determinants of LGBTI Health Coverage

As outlined above, stigma, discrimination, and criminalization create major obstacles for the LGBTI community to access health care, and threaten to undermine the principles of universal health coverage. From lack of legal recognition for relationships that would grant coverage to same-gender partners, to criminalization of sexual orientation and self-determined gender identity, laws, policies, and practices have the potential to undermine health coverage for the LGBTI community.


The World Professional Association for Transgender Health (WPATH) released guidance on the medical necessity of treatment, including hormone therapy, sex reassignment, and gender affirmation for transgender people, and insurance coverage for these services.¹⁴³ In most countries, these essential services for the well-being of trans people are not covered by any social welfare schemes.

Income disparities between LGBTI people and heterosexual people, as well as rejection from family and lack of social safety nets, may put LGBTI people at risk for higher financial burden for paying for emergency or routine health services. As discussed in the section on target 3.7, lesbians and gay men intending to become parents often have limited options. In resource poor settings, few can afford or even access private health services offering assisted reproductive technologies.

What We Need from Member States

LGBTI people must be included in progress towards achieving universal health coverage. Target 3.8 includes indicator 3.8.1: *Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)*. All health services data collected should be disaggregated by sexual orientation, gender identity and expression, and sex characteristics. Gender affirmation and sex reassignment services must be considered essential services for trans people. Respect for the parenting intentions of lesbians and gay men should provide options other than costly assisted reproductive technologies.

Gender affirmation, hormone therapy, and sex reassignment services must be considered essential services for trans people.



Health promotion and prevention, such as public health campaigns, haven't been adequately incorporated into the concept of UHC. **The move toward promoting UHC must not undermine essential health promotion campaigns that need to reach LGBTI people to address drug and alcohol use, smoking, access to mental health counselling, and HIV prevention.** Additionally, the framing of UHC systems must respectfully and meaningfully involve LGBTI people, as well as include principles of greater involvement of people with living with HIV and AIDS (GIPA)¹⁴⁴ to ensure strong community ownership. Otherwise, access and quality of services will continue to lag behind for the LGBTI community.

Other indicators that States should consider:

- **Number of people receiving services from LGBTI-led providers per 1000 population.**
This would give governments an indication of the essential need for community-led services.
- **Measure service denial, stigma, and delay experienced by LGBTI people while receiving treatment.**

TARGET 3.B

Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable and essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all


“ Member States must prioritize access to affordable medicines that impact LGBTI health, including antiretroviral, pre- and post-exposure prophylaxis, and hormone therapy regimens.

Member States must prioritize access to affordable medicines that impact LGBTI health, including antiretroviral, pre- and post-exposure prophylaxis, and hormone therapy regimens. **Donors must particularly monitor changes in drug pricing while transitioning out of middle-income countries.**

Background

The 2001 Doha Declaration on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and Public Health stipulates that TRIPS “can and should be interpreted and implemented in a manner supportive of World Trade Organization (WTO) Members’ right to protect public health and, in particular, to promote access to medicines for all.” This is a reaffirmation of the right of WTO Members to use “flexibilities” to ensure that the interests of profit did not interfere with the maximal delivery of health care. These flexibilities include the right to: define standards of patentability; order government use of patented inventions; issue compulsory licenses to increase treatment access; and use parallel importing and competition law and policy to remedy abuses of IP rights.¹⁴⁵

TRIPS flexibilities have been utilized by HIV treatment activists in South Africa, Brazil, India, Thailand, and a variety of other countries to negotiate significant price reductions for life-saving antiretroviral (ARV) medications. Increasing the use of quality-assured generic medicines through competition is a key strategy for reducing prices and therefore improving the affordability and accessibility of medicines.¹⁴⁶ However, many attempts by low- and middle-income countries (LMICs) to use measures to promote access to affordable medicines have been fraught with difficulty and met with retaliation and opposition from some high-income countries and corporations. In addition, flexibilities have not been regularly incorporated into national IP laws.



As middle-income countries (MICs) and upper middle-income countries (UMICs) are currently being targeted with funding cuts, these countries are also facing higher medicine prices because of intellectual property barriers. High drug costs present a serious obstacle to sustainability and scale-up HIV services in MICs, where gay and bisexual men and transwomen are disproportionately affected, as outlined in section 3.3. ARVs tend to be patented more frequently in MICs than in LICs, and many MICs are excluded from pharmaceutical companies' voluntary licenses and other programs that can lower costs. As a result, drugs used for first-line antiretroviral therapy (ART) and pre-exposure prophylaxis (PrEP), are far more expensive in many MICs (such as Argentina and Ukraine) than elsewhere. Due to high costs of ARVs across the spectrum, such countries often have fewer alternative options (including second- and third-line drugs) than much poorer and higher prevalence places.

The already-evident equity gap in access to medicines will persist and almost certainly get larger as donors continue to transition away from MICs. Countries may no longer be able to afford some or many of the drugs currently available, meaning that the number of clients who can get ARV medications may be capped.

The Impact of TRIPS Flexibilities and Access to Medicines for LGBTI People

Not only should ARVs be considered an essential medicine for treatment, but as a preventative medicine ARVs used for PrEP, and post-exposure prophylaxis (PEP) should also be protected under TRIPS flexibilities. PrEP has been proven to be effective in HIV prevention for gay men and transwomen.

Medicines that compose hormone therapy regimes must also be considered essential medicines for the health and well-being of trans people. The goal of hormone therapy, in general, is to align the external appearance of the body with the experienced gender; for many transgender people, hormone therapy is part of the affirmation of their gender identity, so providing this service may assist them to realize their sexual and gender rights.¹⁴⁷ Cost-prohibitive hormone therapy, or other barriers to accessing hormone therapy medicines, can cause trans people to seek underground sources and self-administer, which may have detrimental health effects.¹⁴⁸ If a transgender person who was previously receiving hormone therapy is suddenly prevented from accessing it, the undesired regression could cause serious physical and emotional harm. Lastly, data has shown that integrating hormone therapy into HIV services may optimize antiretroviral adherence among trans people living with HIV,¹⁴⁹ but affordability and access to medicines is crucial.

Version 7 of the World Professional Association of Transgender Health (WPATH) Standards of Care¹⁵⁰ covers hormone therapy for transgender adults and adolescents, and the Endocrine Society Clinical Practice Guidelines of 2009¹⁵¹ offers additional comprehensive source for hormone therapy practice. These documents, and other guidelines from WPATH, are essential for outlining safe hormone regimes that are necessary for trans health.

What We Need from Member States

Indicator 3.B.1 *Proportion of population with access to affordable medicines and vaccines on a sustainable basis* must be disaggregated by sexual orientation, gender identity and expression to ensure that LGBTI people are accessing ARV, PEP, PrEP, and hormone therapy.

TRIPS flexibilities should be extended to MICS, and donor transition plans should give close and careful attention to changes in drug pricing for countries where international donor support is waning.

TARGET 3.C

Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small developing states

“ Community-based and LGBTI-led organizations are typically better positioned to reach LGBTI people and gather data about their health and thus require sufficient financial support.

Member States must ensure that domestic resource mobilization and effective absorption of aid to health results in allocation of sufficient funds for public health services. Community-based and LGBTI-led organizations are typically better positioned to reach LGBTI people and gather data about their health and thus require sufficient financial support. In order to enhance the standard of care for LGBTI people, Member States should report on the number of medical and nursing qualifications that include components on LGBTI health related needs and SOGIESC sensitive care, measure the inclusiveness of standards of care, and assess technical skills for all health workers on specific LGBTI health needs.

Background

Significant resources were leveraged toward the achievement of the health MDGs, reaching US\$ 8.9 billion in 2014.¹⁵² Nevertheless, expenditure consistently fell short of the amounts required to meet service coverage targets. To achieve MDGs 4 and 5, financing of maternal, new-born, and child health rose from US\$ 2.673 billion in 2003 to US\$8.345 billion in 2012.¹⁵³ Global financing for HIV and AIDS to meet targets of MDG 6 increased from around US\$5 billion in 2000 to a projected US\$ 21.7 billion in 2015.¹⁵⁴ Meanwhile, it is estimated that Official Development Assistance (ODA) directly benefitting LGBTI people, including addressing the vulnerability of MSM to HIV, totaled US\$ 429.5 million, only 0.02% of all ODA allocated from 2002 to 2013.¹⁵⁵

The health workforce was not explicitly addressed within the targets and indicators of the health MDGs. Agenda 2030 will need to mobilize all available resources including: ODA, national contributions, partnerships with the private sector; as well as with civil society organizations and private philanthropy. The focus of SDG 17 is to strengthen the implementation and revitalize the global partnership for sustainable development, including strengthening domestic resource mobilization. Resource estimates for SDG 3 are based, in-part, on projections that call for: annual investment of US\$57 billion a year from 2015 rising to US\$91 billion a year by 2035.¹⁵⁶ UNAIDS asserts that investment in HIV services need to increase by about one third from 2016 levels to reach US\$ 26.2 billion by 2020.¹⁵⁷

What We Know: Data Relevant to LGBTI Health Financing & Workforce Trainings

While Section 3.3 documents the impact of HIV on gay, bisexual men and other men who have sex with men and transwomen, in many countries it is challenging to build a comprehensive and robust picture of such disproportionate burden because national HIV epidemiological surveys do not adequately capture incidence and prevalence among these key populations. This may arise from structural level stigma and a reluctance to engage with these populations, but also because of other barriers to testing. This exclusion results in a lack of accurate data, which international donors and governments use to justify underinvestment.¹⁵⁸

There has been consistent underfunding of HIV programs serving gay, bisexual men and other men who have sex with men worldwide. For example, total global investment in HIV prevention programs for men who have sex with men is estimated to be just 2%.^{159,160} Data from countries that criminalize same-sex sexual behavior, including Ethiopia, India, and Nigeria, demonstrates that countries that criminalize same-sex sexuality spend fewer resources on HIV services that could reach men who have sex with men.¹⁶¹

As described in Section 3.8, health service providers are often ill-prepared to serve the needs of LGBTI people, and sometimes actively discriminate against LGBTI people. Pertinent lessons from the HIV response demonstrate that in-service training can challenge discriminatory attitudes and improve quality of care for LGBTI patients. In Kenya, an innovative sensitization training on men who have sex with men resulted in health workers improving their ability to provide service in a non-stigmatizing way and expressing comfort engaging men who have sex with men patients.¹⁶¹

Understanding the Data: Social Determinants of Health Financing & Workforce Trainings

While the vulnerability of gay and bisexual men and trans women to HIV has received insufficient finances, **there have been few, if any, resource estimates conducted for services that address other LGBTI health disparities.** An effective response to HIV must ensure that gay and bisexual men and trans women and the community-based organizations, including LGBTI organizations, that serve them are adequately resourced. It is important to acknowledge the role social enablers can play in improving the quality, acceptability, accessibility, and affordability of services for LGBTI people. Social enablers include: advocacy, political mobilization, law and policy reform, human rights, public communication and stigma reduction. UNAIDS argues that 6% of total HIV expenditure should be allocated to social enablers by 2020.¹⁶³

Health workers may feel unprepared to provide quality care to LGBTI patients due to a lack of knowledge and terminology; in-service training can challenge discriminatory attitudes and improve quality of care for LGBTI patients.

Even in contexts where there is growing social acceptance of LGBTI people, health workers may feel unprepared to provide quality care to LGBTI patients due to a lack of knowledge of health concerns particular to LGBTI people and SOGIESC terminology. In other contexts, discriminatory attitudes held by health care workers reflect homophobia and transphobia prevalent in the general population. Programs in Brazil, Canada, South Africa, and the U.S. have sought to include SOGIESC sensitive training in medical and nursing school curriculum.^{165,166,167,168}

What We Need from Member States

The single indicator for this target is *health worker density and distribution*. That data tells us nothing about whether health worker training and development can ensure quality of care and sensitivity in caring for patients who are harder to reach and retain. Member States must endeavor to include SOGIESC sensitive information in health worker training and development to ensure LGBTI patients can realize their right to health.

Additional indicators for this target should encourage Member States to:

- Record the number of medical and nursing qualifications that include components on LGBTI health related needs and SOGIESC sensitive care.
- Update nurses and doctors on latest standards of care, as set out by the World Health Organization and other UN agencies.
- Strengthen technical skills on a range of specific LGBTI health needs.
- Support health workers with managing “dual loyalty” situations,¹⁶⁹ whereby same-sex relations and/or self-determined gender identity is criminalized, the health worker ensures his/her principle ethical duty is to “do no harm” to patients.

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About OutRight

Every day around the world, LGBTIQ people's human rights and dignity are abused in ways that shock the conscience. The stories of their struggles and their resilience are astounding, yet remain unknown—or willfully ignored—by those with the power to make change. OutRight Action International, founded in 1990 as the International Gay and Lesbian Human Rights Commission, works alongside LGBTIQ people in the Global South, with offices in six countries, to help identify community-focused solutions to promote policy for lasting change. We vigilantly monitor and document human rights abuses to spur action when they occur. We train partners to expose abuses and advocate for themselves. Headquartered in New York City, OutRight is the only global LGBTIQ-specific organization with a permanent presence at the United Nations in New York that advocates for human rights progress for LGBTIQ people.

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About MSMGF

The Global Forum on MSM & HIV (MSMGF) was founded in 2006 at the Toronto International AIDS Conference by an international group of activists concerned about the disproportionate HIV disease burden being shouldered by men who have sex with men worldwide. Today, we are an expanding network of advocates and experts in sexual health, human rights, research, and policy, working to ensure an effective response to HIV among gay men and other men who have sex with men. MSMGF watchdogs public health policies and funding trends; strengthens local advocacy capacity through our programs initiatives; and supports more than 120 community-based organizations across 62 countries who are at the frontlines of the HIV response.

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About The Platform

The Platform works towards achieving UNAIDS 2020 and 2030 targets by advising UN agencies, the Global Fund, U.S. PEPFAR, bilateral donors, and international funders of the global HIV response. Convened by MSMGF and UNAIDS, the Platform, in partnership with grassroots advocates and their networks represented by the Consortium of MSM and Transgender Networks, takes an active role in elevating the sexual health and human rights concerns of gay, bisexual and other men who have sex with men in the context of the global HIV response.

NOTES



THE GLOBAL ADVOCACY
PLATFORM
TO FAST TRACK THE HIV AND
HUMAN RIGHTS RESPONSES
WITH GAY AND BISEXUAL MEN