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Agenda item 3

**Promotion and protection of all human rights, civil,**

**political, economic, social and cultural rights,**

**including the right to development**

 The right to the enjoyment of the highest attainable standard of physical and mental health of persons, communities and populations affected by discrimination and violence based on sexual orientation and gender identity in relation to the Sustainable Development Goals

 Report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity[[1]](#footnote-2)\*, [[2]](#footnote-3)\*\*

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|  *Summary* |
|  In this report, the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity, Victor Madrigal-Borloz, examines discriminatory and often violent barriers faced by lesbian, gay, and bisexual persons, trans and other gender diverse persons, and intersex persons, impeding full and equal enjoyment of the right to the highest attainable standard of physical and mental health. The report identifies structural drivers of exclusion and gives an overview of health-related violence and discrimination. It then brings a sexual orientation and gender identity lens to the health-related commitments of the Sustainable Development Goals, with a particular focus on SDG3, identifying obstacles and challenges to implementation, as well as good practices. As the mid-point of SDG implementation draws near, the report outlines six fundamental steps, based on the mandate’s ASPIRE guidelines, aimed at making the SDGs’ pledge to “leave no one behind” a reality for all.Activities carried out in the period 1 May 2021 – 30 April 2022 are included as Annex 1. |
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 I. Note on methodology and terminology

1. Inputs to the report included 81 responses to a January 2022 questionnaire from States, United Nations entities, national human rights institutions, civil society organisations (CSOs), academic institutions, and other stakeholders. Collectively, they reflect the views of 119 State and non-State entities in relation to 143 Member States in all world regions. Other inputs include desk reviews facilitated by the IE’s academic home at the Human Rights Program of the Harvard Law School and an online consultation on 14 April 2022. The mandate’s stock of knowledge, built through previous thematic and country visit reports, communication procedures and dialogues, has also been drawn upon. The Independent Expert (IE) is indebted to all stakeholders for their contributions.

2. While many persons affected by discrimination and violence self-identify under the identities lesbian, gay, bisexual, and trans, these terms and the acronym LGBT do not exhaust the multitude of identities and orientations under which persons self-identify around the world. When data at the source expressly refers to lesbian, gay, bisexual, trans and/or gender diverse persons, the correlative acronyms are used; names of organisations, projects or publications cite denominations are as they appear in the source.

3. Intersex persons are among those born with sex characteristics that do not fit typical definitions for male or female, including sexual anatomy, reproductive organs, hormonal patterns, and/or chromosome patterns.[[3]](#footnote-4) Human rights violations are perpetrated against them based on *inter alia* dominant societal sex and gender norms and regulation of bodily autonomy. Those are commonalities at the base of joint activism between human rights defenders working on SOGI issues and on intersex issues; a SOGI framework alone, however, does not adequately address all human rights concerns of intersex persons, for which rights of the child, disability rights and freedom from torture frameworks are also essential. Consequently, it is the policy of the mandate not to extrapolate data and policy frameworks on LGBT persons to the intersex population without clear evidence and reasoning for supporting that inclusion.

 II. Introduction

4. The right to “the highest attainable standard of physical and mental health,”[[4]](#footnote-5) first articulated in the Constitution of the World Health Organisation (WHO), was incorporated into a legally binding State obligation in the International Covenant on Economic, Social and Cultural Rights (ICESCR; art. 12). The right has subsequently been included in another five core international human rights treaties[[5]](#footnote-6) and in several regional treaties, conventions, and charters.[[6]](#footnote-7) It is also enshrined in at least 115 national constitutions.[[7]](#footnote-8)

5. As the Committee on Economic, Social and Cultural Rights (CESCR) has affirmed, the right to health must be ensured to all without discrimination, based on any prohibited grounds, which has the intention or effect of nullifying or impairing its equal enjoyment or exercise.[[8]](#footnote-9) It is well established that sexual orientation and gender identity are prohibited grounds of discrimination under international human rights law.[[9]](#footnote-10) The right to health includes freedom to control one’s health and body, including sexual and reproductive freedom, and freedom from non-consensual medical treatment and interference, as well as entitlements, including “the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health [and] a variety of facilities, goods, services and conditions.”[[10]](#footnote-11)

6. The principles of equality, non-discrimination, and equity[[11]](#footnote-12) in health, and the practices of exclusion that flout them, are also a central concern of the 2030 Agenda for Sustainable Development agreed under UN auspices in 2015. Anchored in international human rights standards, the Agenda includes interrelated global goals and time-bound targets aimed at spurring equitable and universal access to health for all (SDG3), achieving gender equality, including by ensuring universal access to sexual and reproductive health and rights (SDG5), and eliminating discrimination, reducing inequalities and promoting the social, economic and political inclusion of all (SDG10 and SDG16). The cornerstone of the Agenda is the pledge to “leave no one behind” and to ​​see the goals and targets met “for all segments of society”, reaching “the furthest behind first.”[[12]](#footnote-13)

7. As the mid-point of Agenda 2030’s implementation draws near, this report uses SDG commitments as an entry point for analysing progress and obstacles in combating health-related discrimination and violence based on sexual orientation and gender identity (DV/SOGI). It begins with an overview of the discriminatory, often violent barriers, and the structural drivers of exclusion faced by LGBT, as well as intersex persons, impeding their full and equal enjoyment of the right to health. The report then brings a SOGI lens to health-related SDG commitments, with a particular focus on SDG3, identifying obstacles and challenges to implementation, as well as good practices by States and CSOs. It concludes by outlining six steps, based on the mandate’s ASPIRE guidelines, aimed at making the SDGs’ pledge to “leave no one behind” a reality for those facing DV/SOGI, an imperative if Agenda 2030 is to achieve its overarching aim of “realising the human rights of all.”

 III. Structural drivers of health inequality

*“To talk about health and the right to health is to talk about politics, about resistance, about the right to a decent life, and about the social context.”[[13]](#footnote-14)*

8. A substantial body of work in social epidemiology describes stigma as the co-occurrence of processes of labelling, stereotyping, othering, devaluing and excluding in the context of power exercised by hegemonic groups.[[14]](#footnote-15) According to consistent findings by the mandate, these processes have the objective of instrumentalising LGBT lives to galvanise political constituencies, instil a fake sense of moral panic, and perpetuate patriarchal, binary and hetero/cisnormative social models. The work to dismantle DV/SOGI requires continued analysis of structural drivers of exclusion and, in this report, their relationship with health inequality.

 Criminalisation

9. Direct or indirect criminalisation of same-sex intimacy and gender identity is a form of State-sponsored discrimination. In 69 countries, discriminatory laws criminalize private, consensual same-sex intimacy, exposing millions to the risk of arrest, prosecution, and imprisonment—and, in at least five countries, the death penalty.[[15]](#footnote-16) Criminal laws also discriminate explicitly or implicitly based on gender identity or expression: for example, in 10 countries of Asia, trans persons are criminalized using so-called “cross-dressing”, “impersonation” and “disguise” laws.[[16]](#footnote-17). Criminal laws on abortion, sex-work and HIV transmission/non-disclosure also have discriminatory effects on women and LGBT people.

10. Such laws are contrary to international human rights obligations of all States and undermine health outcomes. Where they exist, services which should be tailored to these communities are suppressed,[[17]](#footnote-18) and LGBT persons are deterred from seeking generally available health services out of fear of being arrested and prosecuted.[[18]](#footnote-19) Laws criminalizing same-sex intimacy deter LGBT persons from participating in HIV prevention programs: during his country visit to Tunisia, the IE was informed that over half of lesbian, gay and bisexual persons, and three-quarters of trans persons, don’t go to the doctor or undergo medical tests for fear of mockery, abuse by medical staff, or legal action.[[19]](#footnote-20)

11. Sixty percent of countries report administering laws, regulations, or policies that present obstacles to effective HIV prevention, treatment, care, and support for people in key populations and high-risk groups.[[20]](#footnote-21) Criminal laws impact particularly HIV prevention for persons living at the intersection of different identities or with increased exposure to risk of violence, such as LGBT persons in detention.[[21]](#footnote-22)

 Pathologisation

12. Homosexuality was removed from the International Classification of Diseases in 1990 and trans identities from the chapter on mental disorders in May 2019. Yet some countries continue to classify homosexuality as an illness and in almost all countries trans persons are treated as if they were sick or disordered. As the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (SRH) has concluded, “mental health diagnoses have been misused to pathologise identities and other diversities” and “the pathologisation of lesbian, gay, bisexual, transgender and intersex persons reduces their identities to diseases, which compounds stigma and discrimination.”[[22]](#footnote-23) The IE considers this to be the case for intersex persons as well,[[23]](#footnote-24) and has called on States to address the deep grooves carved by pathologisation in all cases. Since 2019, the IE and the SRH have called on States to review their medical classifications and adopt proactive measures, including education and sensitization campaigns, to eliminate associated stigma.[[24]](#footnote-25)

13. Some States are considering measures that entrench pathologisation. In 2021 the mandate conveyed its concerns to Guatemala about proposed legislation that sought to protect children from the “disorder” and “trauma” of trans gender identity,[[25]](#footnote-26) to Ghana about draft legislation that promotes practices of so-called “conversion therapy” by offering incentives to trans persons who “recant,”[[26]](#footnote-27) and to Poland, about the Polish Episcopal Conference’s call for the creation of so-called “clinics” purportedly offering services for people who want to “regain” their so-called “natural” sexual orientation.[[27]](#footnote-28)

14. In 2020,[[28]](#footnote-29) the mandate made a global call for a world free of practices of so-called “conversion therapy” after concluding that they are cruel, inhuman, and degrading treatment or punishment under international human rights law. The IE welcomes the 2021 medical ban in Chile, directives issued by the Madras High Court in India to prohibit them, as well as the issuance of laws seeking to end them in Germany in 2020, Canada and France in 2021, and New Zealand in 2022; similar legislation is currently under review in several other States. Practices of conversion have also been banned at the local level in Mexico, Spain, the United States, and Australia.

 Stigmatisation and negation

15. Negation is the position - still voiced with alarming frequency in intergovernmental debates on international human rights and sustainable development - that DV/SOGI does not exist because there is no lesbian, gay, bisexual, trans or gender diverse persons in a given context. Stigmatisation and negation are deeply enmeshed with the criminalization and pathologisation of SOGI diversity, as well as the lack of related research, data, and public health policy resources. These drivers not only fuel DV/SOGI, but are used to condone it, perpetuating the impunity and invisibility surrounding it.

16. Seeking to consign LGBTI persons to invisibility by writing them out of international agreements makes a mockery of the principles of equality and non-discrimination that are their cornerstone. It is also a form of gross negligence in relation to health: valuing the lives and inherent dignity of all persons is key to effective and equitable health strategies and responses.

17. Drivers of DV/SOGI also include stigmatization entrenched in the patriarchal and cisnormative sociocultural construction of same-sex intimacy, gender non-conformity and sexual pleasure as morally transgressive. Sexuality and gender identity are deeply rooted aspects of human personality that go to the core of every person’s rights to bodily and mental integrity, and to the highest attainable standard of physical and mental health.[[29]](#footnote-30) Stigmatisation of LGBT persons leads to their dehumanisation, legitimises DV/SOGI and compounds the social and economic marginalisation and exclusion of persons affected by it.

 IV. Health-related discrimination and violence based on SOGI

*“[N]o person, no community, and no country are exempt from the interaction of the social, economic, and political factors that determine health and healthcare.”[[30]](#footnote-31)*

18. The evidence overwhelmingly suggests that SOGI-based discrimination has far-reaching detrimental effects on the mental and physical health of LGBT persons.[[31]](#footnote-32) The harms it inflicts include rape and other sexual and gender-based violence, forced sterilization, so-called “conversion therapies” and surgery without obtaining consent, increased risk of HIV/AIDS and sexually transmitted infections, and stress/trauma-related depression and anxiety, leading to increased risk of suicide, drug and substance abuse, body dysmorphia and disordered eating, among others.

19. Preventing these grave harms is part of States’ human rights due diligence. They must be addressed through an intersectional lens that recognizes how factors such as race, class, gender, age, and disability compound SOGI discrimination in shaping health outcomes and inequalities. Some of the key manifestations of health-related discrimination and violence are outlined below.

 Discrimination by health providers and systems

20. States have a duty to ensure that health systems and services are available in sufficient quantity, accessible to all without discrimination, culturally acceptable including for minority communities, and of good quality.[[32]](#footnote-33) Submissions received from across the globe indicate that most States are falling woefully short on these obligations because of widespread health inequities stemming from pervasive and longstanding DV/SOGI.

21. Reported instances of direct discrimination and ill treatment by medical providers include refusal to make clinic appointments or treat patients, treatment of patients with gross disrespect or inferior care, violation of medical privacy, private shaming and public disparagement.[[33]](#footnote-34) UNAIDS observes that the percentage of transgender people who avoid seeking HIV testing due to stigma and discrimination ranges from 47% to 73%,[[34]](#footnote-35) and surveys in sub-Saharan Africa found that between 10% and 40% of men who have sex with men delay or avoid health care due to fear of stigma.[[35]](#footnote-36)

22. The attitudes of health care providers make many LGBT persons reluctant to share personal and medical information:[[36]](#footnote-37) in a survey in Peru, 59% of respondents reported that the mental health providers were not properly trained to deal with LGBTI persons;[[37]](#footnote-38) and in a 2017 survey at a highly ranked hospital in Changsha, China, 87% of medical staff respondents said they were opposed to same-sex sexual behaviours.[[38]](#footnote-39)

23. A submission referred to reports in Mexico more than 18% of over a thousand cases of violence and discrimination in healthcare settings were against bisexual persons.[[39]](#footnote-40) Studies have documented therapists reacting to patients coming out to them as bisexual by telling them they were “confused” and “had unresolved issues with [their] sexuality.”[[40]](#footnote-41) Data collection has not been adequately resourced but research suggests that lesbian and bisexual women are less likely to have regular cervical and breast cancer screenings and more likely to develop breast cancer as compared with heterosexual women.[[41]](#footnote-42) A similar situation may affect trans men.

 Sexual and gender-based violence

24. Of all the manifestations of DV/SOGI, gender-based violence is perhaps the most devastating in its impacts on physical and mental integrity and health. In some settings, lesbian women are subjected to killing, rape and other forms of torture and cruel, inhuman, and degrading practices.[[42]](#footnote-43) In a South African study conducted among 591 women who have sex with women, one-third reported having experienced sexual violence.[[43]](#footnote-44) Research has revealed an association between high levels of violence against women and increased HIV infection risk, risks of unwanted pregnancies, and underage pregnancies.[[44]](#footnote-45) Rights to sexual and reproductive health for many adolescent lesbian or bisexual girls are also compromised in other ways, including rape, coercion into unwanted sex or marriage, and unequal power relations that make it difficult for them to refuse sex or insist on safe sex practices.[[45]](#footnote-46) Healthcare needs of lesbian and bisexual women and trans men, such as screening for cervical cancer, termination of pregnancy, and contraception, are often refused by service providers,[[46]](#footnote-47) as are other measures of gynaecological[[47]](#footnote-48) or andrological care, fertility treatment, medical procreation techniques and transition-related medical services.[[48]](#footnote-49)

25. While a lack of disaggregated records by national authorities makes it difficult to determine the extent of DV/SOGI against trans people on a country-by-country basis, the Trans Murder Monitoring project has documented 4,042 murders in 66 countries between 2008 and 2021.[[49]](#footnote-50)

26. Intersex infants, children and adolescents are often subjected to surgeries aimed at modifying the appearance of their genitals[[50]](#footnote-51) in interventions which amount, in the view of the mandate to gender-based violence and torture or cruel, inhuman and degrading treatment.[[51]](#footnote-52) The well-documented consequences of these interventions[[52]](#footnote-53) include permanent infertility/sterilisation, incontinence, loss of sexual function and sensation, and interventions tantamount to rape.[[53]](#footnote-54) The UN Committee on the Rights of the Child,[[54]](#footnote-55) the Committee against Torture and the Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment (SRT) have expressed concern over these surgeries,[[55]](#footnote-56) qualified by the SRH as genital mutilation.[[56]](#footnote-57) The mandate concurs with the SRH and concludes that States must ban all medically unnecessary surgeries on intersex infants and children.[[57]](#footnote-58) Malta, Portugal, and Germany have already passed bans,[[58]](#footnote-59) as well as India’s Tamil Nadu state government,[[59]](#footnote-60) after an Indian court ruled that “[t]he consent of the parent cannot be considered as the consent of the child.”[[60]](#footnote-61) The European Parliament has strongly condemned such surgery and encouraged Member States to adopt legislation protecting the bodily integrity of intersex people “as soon as possible.”[[61]](#footnote-62)

 Denial of legal recognition of gender identity and of gender-affirming health care

27. People’s lived experience of their gender often defies stereotypical gender norms and imposed binaries, and evidence shows that acquiring gender characteristics congruent with the self-identified gender identity generally improves health, well-being, and quality of life. Conversely, not being able to live according to one’s self-identified gender identity is likely to exacerbate other forms of ill health and erode dignity. Yet gender diversity continues to be repressed in the name of culture, religion, and tradition.

28. One of the key forms this takes is that the vast majority of trans and gender-diverse persons around the world do not have access to legal recognition of their gender identity.[[62]](#footnote-63) As mentioned in one submission, “[e]very aspect of a trans and gender diverse person’s social life […] depends on the ability to show a valid identity card or documentation that aligns with gender identity and expression.”[[63]](#footnote-64)

29. Gender-based violence and discrimination impacts trans and gender diverse persons who face cruel, inhuman and degrading treatment, and possibly torture, in the form of requirements for gender recognition that include genital and other forms of mutilation. In his 2018 country visit to Georgia, the IE observed that a majority of the trans men he interviewed were missing their middle finger and was subsequently shocked to learn that a medical authority entitled to certify a person as being a “true” trans person had demanded that the finger be amputated to create a prosthetic penis as part of the requirements for legal recognition. A survey in the United States found that, among nearly 5,000 respondents, “transgender or gender non-conforming respondents reported experiencing the highest rates of discrimination and barriers to care”.[[64]](#footnote-65)

30. Other barriers to healthcare arise from financial limitations. Gender-affirming surgeries, reparative surgeries and ongoing treatment for trans people and people with intersex variations may be unaffordable for those who seek them; for example, health insurance providers have denied reimbursement for surgical placement of breast implants for trans women.[[65]](#footnote-66) Gender-affirming healthcare services for trans persons are often expensive and unsubsidized, meaning that trans people may be forced to obtain hormones of dubious quality through the black market or resort to crude methods without proper supervision, leading to serious health problems.[[66]](#footnote-67) The CEDAW has called on States to ensure that the costs for gender affirming interventions are reimbursed.[[67]](#footnote-68)

 Restrictions on SOGI human rights defenders and health advocacy organisations

31. The mandate is concerned by legal and political obstacles for human rights defenders and CSOs working to realise the right to health of LGBTI people and communities.[[68]](#footnote-69) In at least 41 States, laws and regulations limit the ability of SOGI-related CSOs to legally register.[[69]](#footnote-70) Harassment, intimidation, persecution and violence are also perpetrated against human rights defenders and health rights advocates in other ways, and the mandate engages States from all regions with concerns about allegations of harassment and persecution: in 2021 alone, concerns were conveyed to Belarus,[[70]](#footnote-71) Tunisia,[[71]](#footnote-72) Poland,[[72]](#footnote-73) Honduras,[[73]](#footnote-74) Kazakhstan,[[74]](#footnote-75) Kyrgyzstan,[[75]](#footnote-76) Uzbekistan,[[76]](#footnote-77) Ghana,[[77]](#footnote-78) Nicaragua,[[78]](#footnote-79) Saudi Arabia,[[79]](#footnote-80) and Pakistan.[[80]](#footnote-81)

32. In at least 31 countries so-called “propaganda laws” restrict open discussion about LGBT health-related and other topics.[[81]](#footnote-82) In a study in Russia—where those who disseminate LGBT health information among minors are fined under “gay propaganda” legislation—72% of LGBT survey respondents reported experiencing discrimination after coming out to a doctor, including total refusal of essential care, medical personnel refusing to touch them, the use of excessive precautions, and being blamed for an HIV positive status and a “sinful lifestyle”. Over half agreed that health care providers’ attitudes had worsened since the “propaganda” legislation had been passed; 42% said they would likely no longer use medical services.[[82]](#footnote-83)

 Lack of appropriate and non-discriminatory health information and education

33. While many submissions referred to legislation creating obstacles for comprehensive sexual health and gender education,[[83]](#footnote-84) others provided evidence of bias and discrimination in educational curricula or sexual health information programs. For example, in a youth survey in the United States, 83% of respondents reported not having received comprehensive sexuality education at their current or previous academic institutions.[[84]](#footnote-85) To this must be added censorship of online content on SOGI issues, websites, and community groups; and obstacles to access to information on safe sex and other health issues.

34. The adoption of comprehensive and SOGI-inclusive sexuality education can significantly reduce physical and psychological health risks for LGBT and gender-diverse youth, including with regard to sexual and reproductive health, and in addition help them avoid secondary effects such as substance abuse, mistrust of health services and self-medication.[[85]](#footnote-86) As the UN Secretary-General has noted “[u]nequal access to education, including comprehensive sexuality and HIV education also increas[es] women’s vulnerability to HIV transmission”.[[86]](#footnote-87)

 V. Sexual orientation and gender identity and SDGs

 *“There are 17 sustainable development goals all based on a single, guiding principle: to leave no one behind. We will only realize this vision if we reach all people regardless of their sexual orientation or gender identity.”*[[87]](#footnote-88)

35. The 2030 Agenda for Sustainable Development has galvanised action by the international community to further equitable access to the right to health. The SDGs include comprehensive, time-bound, and universally applicable commitments, anchored in international human rights obligations, to be met by 2030. The 17 goals are closely interrelated and to be pursued in tandem.

36. SDG3 seeks to ensure healthy lives and promote well-being for all at all ages. Other goals include complementary commitments to tackle health inequalities and the discrimination underpinning them. SDG5 on achieving gender equality pledges to ensure universal access to sexual and reproductive health and reproductive rights, and to end all forms of discrimination and violence against women and girls. Under SDG10, States commit to reduce inequalities of outcome, including by eliminating discriminatory laws, policies, and practices. SDG16 on just and inclusive societies also pledges to promote and enforce non-discrimination through laws and policies, and to ensure legal identity and equal access to justice for all. SDG17, on means of implementation, seeks to enable monitoring and accountability through a significant increase in the availability of disaggregated data.

37. The pledge to “leave no one behind,” which lies at the foundation of the SDGs, must be operationalized in line with human rights principles of substantive equality and non-discrimination, and demands clear understanding of the lived experience of persons, communities and populations historically subjected to discrimination and violence, including based on SOGI. The following paragraphs illustrate several health-related SDG commitments which are of salience.

 Infectious diseases

39. SDG3 Target 3.3 aims to end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases. An indicator associated with this target is number of new HIV infections per 1,000 uninfected population, by sex, age, and key populations.

40. While substantial progress has been made in reducing HIV infections and AIDS related deaths overall,[[88]](#footnote-89) it is estimated that annual infections have increased by 25% for men who have sex with men since 2010, accounting in 2020 for 23% of new infections globally.[[89]](#footnote-90) HIV also continues to have a disproportionate impact upon women and girls, who in 2019 accounted for 48% of new infections worldwide and 59% in sub-Saharan Africa. In 2020 AIDS-related illnesses remained the leading cause of death among women of reproductive age globally.[[90]](#footnote-91) Trans women accounted for 2% of new infections globally and research in countries such as South Africa suggests that HIV prevalence among women who have sex with women is also disproportionately high.[[91]](#footnote-92) Submissions noted that in some contexts a very high proportion of new infections occur among young people from key populations.[[92]](#footnote-93)

 Mental health

41. SDG3 target 3.4 aims, by 2030, to promote mental health and well-being, and sets an indicator of the number of deaths attributed annually to suicide, per 100,000.[[93]](#footnote-94) The pervasive discrimination and violence LGBTI people face, whether from family and community members or public officials, has a profoundly detrimental impact on their mental health and well-being. States have a duty to “create and sustain enabling environments that incorporate a rights-based approach to mental health, promoting a life of dignity and well-being for all people, including LGBTI people, throughout their lifetimes.”[[94]](#footnote-95)

42. Reports from West Africa, Europe and the Asia-Pacific all conclude that LGBT persons evidence a higher risk for suicide, often correlated with having survived physical or sexual violence.[[95]](#footnote-96) Similar findings from Latin America indicate that a quarter of young LGBTI persons report having attempted suicide at some stage. A study in Chile documented that the adolescent suicide rate is five times higher within that population, while a survey of young LGBT persons in Mexico during the pandemic found that a quarter had had suicidal thoughts and 8% had attempted suicide.[[96]](#footnote-97) Studies in Europe and the United States have found high rates of attempted suicide among intersex people, linked to the particular mental health challenges they face as a result of discrimination, often compounded by racism and ableism.[[97]](#footnote-98)

43. Reports received by the IE covered a broader range of mental health issues beyond suicide. For example, findings suggest that older adults affected by DV/SOGI face higher levels of psychological distress compared to older adults in general, compounded by multiple barriers to accessing equitable, culturally appropriate mental health and ageing services,[[98]](#footnote-99) as well as a lack of emotional support from family or community members.[[99]](#footnote-100) Similarly, a survey of trans men and non-binary people in Argentina found that almost half of respondents reported serious mental health issues including depression, anxiety, and post-traumatic stress disorder.[[100]](#footnote-101)

 Substance abuse

44. SDG3 Target 3.5 aims to strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. An indicator associated with this target is coverage of treatment interventions for substance use disorders.

45. Evidence suggests that persons who identify as LGBT or otherwise suffer from DV/SOGI are at increased risk for substance use, linked to the mental health pressures resulting from societal discrimination.[[101]](#footnote-102) For example, a survey in Australia showed that lesbian, gay and bisexual persons are 1.5 times more likely to exceed lifetime risk guidelines on drinking alcohol than heterosexual persons,[[102]](#footnote-103) and in the United States, studies suggest that bisexual and lesbian women experience higher rates of smoking, cocaine use, and alcohol abuse.[[103]](#footnote-104)

 Sexual and reproductive health

46. SDG3 Target 3.7 aims to 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. It is complemented by SDG5 target 5.6 which clarifies that such access should be ensured in accordance with the 1994 International Conference on Population and Development (ICPD) Programme of Action, the 1995 Beijing Platform for Action, and the outcome documents of their review conferences. These instruments assert the right of women to have control over and decide freely on matters of sexuality and reproduction free of discrimination, coercion and violence, and the need for state policies and programmes to recognize the diversity of family compositions and structures.[[104]](#footnote-105)

47. Indicators for tracking progress on SDG3 and 5 include the adolescent birth rate; the proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care; and the number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information, and education.

48. The IE has gathered abundant evidence of the many ways in which lesbian, bisexual, trans and gender non-confirming women are deprived of their sexual and reproductive rights due to discrimination and violence. These include targeted rape motivated by their real or perceived sexual orientation, gender identity or expression; denial of access to sexual and reproductive health services and facilities due to the requirement that they be accompanied by a male partner or relative; and exclusion from sexual and reproductive health strategies targeted solely at heterosexual, cisgender women and aimed, in some cases, at deliberately stigmatizing other sexual orientations or gender identities.[[105]](#footnote-106)

49. A number of submissions highlighted recent struggles around access to abortion in different national contexts and their implications for the rights of women and all those facing DV/SOGI.[[106]](#footnote-107) In line with the long-standing commitments of the ICPD and Beijing processes and the jurisprudence of numerous human rights bodies, the IE considers that the ability to freely decide on termination of pregnancy, and to access abortion-related services which are safe, legally available and accessible to all without discrimination, are a fundamental element of sexual and reproductive health and rights, without which the SDG goals on health and gender equality cannot be achieved.

50. Forced sterilisation is another pervasive denial of reproductive rights and has been used worldwide as a form of punishment and regulation against indigenous and other marginalized women. Sterilisation also remains a requirement to legal gender recognition in many countries, imposing on trans and gender diverse persons the choice between the legal recognition of their gender or preserving their capacity to have children.[[107]](#footnote-108) Although UN and regional human rights bodies have affirmed that States must abolish compulsory sterilisation or surgery for those seeking legal gender recognition,[[108]](#footnote-109) submissions made reference to sterilisation requirements in Japan,[[109]](#footnote-110) Singapore,[[110]](#footnote-111) and 13 Member States of the Council of Europe.[[111]](#footnote-112) Intersex persons are also subjected to sterilization. Several international UN human rights bodies and agencies have noted that reproductive organ surgeries and procedures commonly conducted on intersex persons, often without their consent, may result in the termination of all or some of their reproductive capacity.[[112]](#footnote-113)

51. LGBT people are increasingly considering their fertility options as reproductive techniques grow. Laws governing sperm donation, egg donation, and surrogacy vary. Some countries ban surrogacy altogether while others have moved to restrict it.[[113]](#footnote-114) Access to reproductive health technologies such as in-vitro fertilisation, where available to LGBT prospective parents, can be prohibitively expensive.[[114]](#footnote-115) Protection of the family cannot be premised on an understanding that values some families less than others or continues to deny the diversity of family forms celebrated in the ICPD almost three decades ago.[[115]](#footnote-116) As stated by the High Commissioner, “the consensus regarding the role of families in sustainable development is grounded in a number of common elements, including the need to recognize the diverse and changing forms of the family institution, in accordance with the different social, cultural and economic characteristics of every society'”.[[116]](#footnote-117)

52. As outlined earlier, many submissions to the IE referred to the widespread lack of sexuality-related information and education that is inclusive of and tailored to the needs and rights of LGBT persons, including young people. Others, however, highlighted good practices at the national and international levels. For example, in Sweden, school curricula integrate “sexuality, consent and relationships” as core components of good quality comprehensive sexuality education.[[117]](#footnote-118) UN Women and UNESCO have issued the International Technical Guidance on Sexuality Education, a tool developed to assist education, health and other relevant authorities in the design and implementation of school-based and out-of-school comprehensive sexuality education programmes and materials, inclusive of LGBTIQ+ people.[[118]](#footnote-119)

 Universal Health Coverage

53. SDG3 target 3.8 on achieving universal health coverage (UHC) by 2030 is perhaps the most overarching and potentially transformative health-related commitment of the SDGs. UHC means that all people and communities have access to the full spectrum of quality health services across the life course - from promotion to prevention, treatment, rehabilitation, and palliative care – without being exposed to financial hardship.[[119]](#footnote-120) The inclusion of UHC in the SDGs is an opportunity to advance a comprehensive, inclusive, and rights-centred approach to health, focusing on strengthening health systems and tackling the structural factors that undermine them. Such factors include a widespread decline in health spending because of austerity measures worldwide, and growing deregulation, privatization, and commodification of health care as a result of the dominant neoliberal economic policy trends of recent decades.[[120]](#footnote-121)

54. The trends have contributed to the social and economic exclusion of LGBTI people, fueling inequality and discrimination in their access to the highest attainable standard of health, as well as to other economic, social and cultural rights.[[121]](#footnote-122) The COVID-19 pandemic has exacerbated health inequalities and other forms of socio-economic exclusion faced by persons on grounds of SOGI.[[122]](#footnote-123) It has also galvanised awareness of the need to invest in robust, comprehensive and equitable public health systems as a global public health imperative, making quality health care and services available, accessible and acceptable to all, as human rights standards require. The SDG commitment to universal health coverage is a vehicle for turning this awareness into action. UHC has now become a major goal for health reform in many countries, and a key focus of international cooperation and assistance efforts. However, making health coverage truly universal will demand a resolute fiscal commitment to ensuring the maximum available resources to progressively realise the right to health for all, as well as a clear political commitment to dismantling the economic, social, cultural, and environmental barriers to the full inclusion of LGBTI persons in health systems and strategies.

 Gender equality

55. Discrimination and violence based on SOGI cannot be effectively tackled without eradicating gender inequality. SDG5 seeks to address the structural inequalities women face in the legal, political, social, and economic spheres, and that manifests in myriad ways, including limits to women’s political participation and leadership, pervasive gender-based violence, child, early and forced marriage, unpaid labour and disproportionate care burdens, education disparities and unequal access to economic resources such as land, property and inheritance. Research on gender-based frameworks conducted by specialised UN bodies and the mandate has shown that these contextual realities shape the ability of lesbian, bisexual, trans and other gender non-conforming women to fully exercise their right to health and to decide freely on issues related to sexuality, gender expression and bodily autonomy.[[123]](#footnote-124) This will continue to be a cross-cutting concern for the thematic agenda of the IE.

 Discriminatory laws and non-discrimination guarantees

56. Under SDG10, States committed to reduce inequalities of outcome, including by eliminating discriminatory laws, policies, and practices. Under SDG16, they pledged to “promote and enforce non-discriminatory laws and policies for sustainable development” as a step towards more just and inclusive societies. These commitments are of potentially huge significance for combating DV/SOGI.

57. The IE is concerned about the widespread persistence of criminal laws which overtly discriminate against people on grounds of SOGI, rendering their very identities illegal. In 2021, the IE along with nine other special procedures voiced concern to the Ghanaian authorities at draft legislation criminalizing a sweeping range of so-called “LGBTQI activities” including consensual sex, marriage, and public expressions of affection, as well as forming associations, producing educational materials or carrying out advocacy. The draft legislation also promotes conversion therapy and unnecessary medical interventions on intersex children. Such measures of state-sponsored discrimination and violence are not only in breach of international human rights law, they run counter to the worldwide trend towards the adoption of laws and policies aimed at ensuring protection from SOGI discrimination and violence. A notable recent example at the international level is the Global Strategy on HIV, Hepatitis and STIs for 2022 - 2030 adopted by the World Health Assembly of the WHO.[[124]](#footnote-125)

58. Constitutional guarantees against SOGI discrimination - such as those adopted in South Africa, Fiji, Bolivia, Ecuador, and Malta - are a fundamental part of the toolbox available to States to address DV/SOGI at the national level. Other countries, such as Thailand and Australia, have issued general laws on non-discrimination covering SOGI, while many, including Australia, Colombia, Costa Rica, Georgia, Mexico, and Portugal have included prohibition of SOGI discrimination in health or other sectoral strategies.

59. Legal recognition of gender identity based on self-identification is of fundamental importance, and some Member States, including Argentina, Denmark, Malta, and Ireland, have implemented it through specific legislation. In Argentina, a study found that after the law was introduced, the percentage of survey participants who reported experiencing discrimination based on gender identity dropped from 80% to 30%.[[125]](#footnote-126)

 VI. Progress and challenges in tackling DV/SOGI through the SDGs

*“At the core of LGBTI advocacy is the capability to define and express one’s own identity. In the development framework, this capability is not just an individual freedom, it is a powerful step to creating a future where all LGBTI people can live a life of their choosing.”[[126]](#footnote-127)*

60. Issues of DV/SOGI were brought to the attention of member states during the Agenda 2030 civil society consultation process, and referenced in key preparatory documents.[[127]](#footnote-128) Although no explicit references to SOGI nor LGBTI were made in the final Agenda 2030 outcome document nor included in the indicators or metrics for monitoring SDG progress, the mandate believes that the goals cannot be achieved if those experiencing discrimination and violence based on SOGI continue to be left behind.

61. The IE therefore welcomes increasing efforts by States to include DV/SOGI in their national implementation plans, as well as the steadfast work of CSOs bringing a SOGI lens to SDG monitoring and implementation at the national, regional, and global levels. Nevertheless, the mandate has observed three key challenges that need to be overcome if Agenda 2030 is to live up to its inclusive promise.

 Inadequate coverage of SOGI issues in SDG implementation & tracking

62. A review of Voluntary National Reviews (VNR) synthesis reports from 2016–2021 indicates increasing albeit uneven attention to issues of DV/SOGI in national reports and plans. In 2017 and 2018, Chile and Australia made specific reference to LGBTI persons in their VNRs: the former explaining difficulties faced in data collection and disaggregation; the later informing of LGBTIQ-oriented programmes. Canada reported that it had designated an official to work with the LGBTQ community and address discrimination against them. Ireland reported that it had developed a LGBTI+ National Youth Strategy. The 2020 and 2021 VNR synthesis reports include sections dedicated to progress in relation to LGTB persons, with examples of CSO-established community-based drop-in centers (Malawi, 2020) and the role of LGBT civil society groups (Estonia and Seychelles, 2020). Bhutan, Denmark, Dominican Republic, Norway, Sweden and Thailand also provided specific information on SOGI in their VNRs in 2021.

63. Nevertheless, many submissions noted that strategies designed to implement the SDGs at national level lack references to SOGI,and national entities in charge of monitoring SDG-related progress usually do not include information about LGBTI persons, a shortcoming that is then reflected in VNRs. Moreover, LGBT human rights defenders and organisations encounter significant barriers to participation in SDG monitoring processes, often encountering little support if not active persecution from their governments.

 Restrictions on LGBT rights defenders and barriers to participation in SDG processes

64. As the IE and the Special Rapporteur on Human Rights Defenders have jointly affirmed, human rights defenders working on SOGI issues and defenders of sexual and reproductive rights are among the most widely targeted in many parts of the world.[[128]](#footnote-129) As outlined above, the threats they face - from prosecution under “propaganda laws” or laws criminalising their identities, to hate speech and physical attacks - often have a crushing effect on LGBTI people’s access to the health information and services they need. They also impede the participation of LGBT communities and organizations in the monitoring and implementation of the SDG agenda. SDG16 includes commitments aimed at creating an enabling environment for human rights defenders to carry out their work. In fulfilling their commitments, States must not only refrain from such attacks, but create a conducive legal and institutional environment in which LGBT and intersex rights defenders and their organizations can carry out their work without fear or arbitrary restriction.

65. Enabling the central role of CSOs (including LGBTI-serving and LGBTI-led health providers) in supplementing State action in the field of health requires resources. Yet LGBT organisations cannot always rely on domestic State funding or philanthropy, and in some environments are impeded from doing so. International health cooperation and assistance can be critical in supporting LGBT organisations and communities. Both donor and recipient states should refrain from imposing arbitrary conditions or limitations on international funding. During his country visit to Mozambique, the IE found that several organizations had to close LGBT-serving facilities due to the United States’ policy known as “global gag rule,” which cut funding to organisations offering abortion-related services and information.

66. Meaningful participation of LGBT communities and organisations in the process through which the sustainable development agenda is monitored and implemented was a constant demand made by most submissions received by the IE. Involvement must be meaningful and effective: some submissions referred to purely performative consultation processes that did not open real spaces for incidence. Policymakers must also adopt measures that build trust between LGBT communities and State agents to overcome the distrust created by historical State-sponsored or acquiesced violence.

67. Some positive developments regarding LGBT representation and participation are noted at international level. For example, in 2019 a coalition of CSOs working to advance the rights of LGBTI people was formalised as a Stakeholder Group under the UN-convened structure for civil society and other stakeholder engagement in the monitoring and review of Agenda 2030, the recommendations of which are invaluable. International NGOs working against DV/SOGI have played a leading role in facilitating participation by LGBT organisations in SDG implementation and review processes. Several have authored guides on LGBT Inclusion in the SDGs, highlighting the specific challenges LGBTI people face and encouraging LGBTI civil society activists to submit their own “spotlight reports” alongside States’ VNRs at the High-Level Political Forum.[[129]](#footnote-130) Nevertheless, submissions indicated that national SDG-related consultations with LGBT-led organisations and individuals in some contexts are rare or non-existent. They also noted that opportunities for participation in global and national consultative processes are often skewed by asymmetries of power within LGBT communities.

68. Inter-governmental actors have made notable efforts to facilitate inclusion in SDG processes. For example, UNDP partnered with the World Bank and civil society partners to develop an LGBTI Inclusion Index to measure development outcomes for LGBTI people, aligned with the SDG global indicator framework.[[130]](#footnote-131) Similarly, the Global AIDS Strategy 2021-2026 was developed through a process that prioritised the participation of some 10,000 persons from 160 countries, including LGBTI individuals and other key populations, as a result of which it contains strong targets in relation to community-led and key population-led responses.[[131]](#footnote-132)

 Data and research gaps

69. Improving health outcomes for LGBTI persons and monitoring progress on the SDG commitments to “leave no one behind” will require a radical transformation in how data and evidence of DV/SOGI is gathered, analysed, and acted on. As noted by the mandate,there is a dearth of accurate data regarding the scale, prevalence, and nature of DV/SOGI worldwide. The systematic collection, disaggregation and analysis of data allowing a comparison of population groups is a key step towards meeting States’ duty to exercise due diligence to protect those at risk of violence and discrimination and to take measures to tackle its causes.

70. The mandate notes with great interest the implementation of some important initiatives in this realm. For example, in the United States, the National LGBTQ+ Women’s Community Survey collects data from the experiences of women who partner with other women;[[132]](#footnote-133) in Mexico, the 2021 National Survey on Sexual and Gender Diversity includes specific data on access to health by LGBT persons;[[133]](#footnote-134) in Australia, the National Drug Strategy Household Survey disaggregates data on the use of alcohol and other drugs by sexuality for people aged 14 and over.[[134]](#footnote-135) Some countries are promoting research that can allow public health decision-makers and administrators to better serve LGBTI populations and further equity and inclusion. In Cuba, for example, the National Centre of Sexual Education was created by the Ministry of Public Health to carry out LGBT-inclusive research, training, capacity building and social communication. Some good practice research efforts can also be found at the regional and global level.[[135]](#footnote-136) The European Commission, for example, committed to support health research of relevance to LGBTI persons in its LGBTIQ Equality Strategy 2020-2025.[[136]](#footnote-137) Furthermore, the Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination aims to increase coordinated technical assistance and support to country efforts to end stigma and discrimination across six settings: healthcare, justice, education, workplace, humanitarian and community.[[137]](#footnote-138)

71. The IE is nevertheless aware of serious gaps in the evidence-base regarding health-related DV/SOGI. For example, very little contemporary literature exists that addresses the health and well‐being of older lesbian women. Similarly, there is a dearth of research on the right to health of trans men. A submission noted that the lack of discussion on trans pregnancy services leads to stigma and prejudice for trans men who get pregnant, and a hearing before the Inter-American Commission on Human Rights (IACHR) revealed that severe violence in the health sector is among the most common types of violence suffered by trans men.

72. The SDGs have spurred a globally concerted effort to improve national and global level statistical gathering in areas related to health, inequality, and exclusion. Such efforts must be made more responsive to the huge statistical blind spots rendering DV/SOGI largely invisible and therefore largely unaddressed. In contexts of criminalization and stigmatisation, these efforts should also guard against any data being misused for surveillance, harassment, entrapment, arrest, and persecution of LGBT people.

 VII. Conclusions and recommendations

73. As any framework agreed by consensus, the SDGs result from a process in which political considerations shaped the content of the goals and the choice of metrics to monitor them. The evidence collected for this report strongly suggests that neglecting to address the challenges created by DV/SOGI could significantly compromise achievement of the goals, creating risk that a significant segment of society will continue to be left behind. The contributions also highlight the considerable efforts made around the globe by LGBTI and women’s rights defenders, CSOs, intergovernmental agencies, national human rights institutions, and numerous member states to address this gap and to ensure that the implementation of the SDG Agenda fulfils its inclusive promise.

74. While underlining the need to remedy the consequences of negation, at the current juncture the SDG framework creates significant opportunities to address the consequences of DV/SOGI in the realm of health, as well as in other areas of exclusion. Compliance with the obligations stemming from the right to the highest attainable standard of health, buttressed by four cross-cutting principles: non-discrimination, participation, representation, and accountability,[[138]](#footnote-139) is in essence the human rights-based approach that the mandate recommends. With due attention to the plethora of challenges existing in different contexts, this approach must also be implemented with due regard to *Do No Harm*, intersectional approaches, self-identification, privacy and transparency, and legality.[[139]](#footnote-140)

75. The need to advance an inclusive, rights-based approach to health is all the more urgent in the wake of the COVID-19 pandemic, which has highlighted the discriminatory and inequitable impacts of regressive health and socioeconomic policies that do not meet the standards and principles outlined above.[[140]](#footnote-141) The ASPIRE guidelines, issued by the IE SOGI in June 2020 to guide the design, implementation and evaluation of rights-based and non-discriminatory pandemic response and recovery measures, contain six steps that can frame a plan of action to fulfil the SDG pledge to “leave no one behind” and to “ensure healthy lives and promote well-being for all at all ages”, regardless of sexual orientation or gender identity.[[141]](#footnote-142) This universal pledge made by UN member states and endorsed by an unprecedented range of intergovernmental and non-governmental stakeholders, is an unmissable opportunity to put the ASPIRE guidelines into practice as a tool for queering the SDGs and fulfilling their promise of “realising the human rights of all”.

76. In dynamizing efforts to fulfil their SDG commitments, the mandate therefore recommends that States adopt the following measures:

 Acknowledgement

1. Acknowledge that ensuring healthy lives and promoting well-being for all, leaving no one behind, will only be achieved if discrimination and violence based on sexual orientation and gender identity, as well as on sex characteristics, are addressed through actions conducive to their eradication;
2. Explicitly recognize lesbian, gay, bisexual, trans and other gender diverse persons, and intersex persons, as subjects of rights and agents of sustainable development in all global, regional and national SDG implementation plans in the future;
3. Acknowledge and act on the evidence that COVID-19 has had disproportionate impact on populations historically subjected to discrimination, including LGBT persons and their communities, as detailed in the report of the mandate on the matter (A/75/258);
4. Address issues concerning violence and discrimination based on sexual orientation and gender identity, as well as sex characteristics, under relevant items of the agenda of the High-Level Political Forum in 2022, including in the thematic review of SDG5, as well as in the agenda of future review fora and monitoring processes at global, regional, and national level.

 Support

1. Refrain from attacks on LGBT-led and serving, as well as intersex-led and serving CSOs, and immediately rescind any laws and policies placing arbitrary and discriminatory restrictions to their work. These organisations must be enabled to operate in a conducive legal, institutional and social environment, without fear or arbitrary restriction;
2. Recognize advocates working on sexual orientation and gender identity issues as human rights defenders, guaranteeing them and their organisations the full range of protections outlined in the Declaration on Human Rights Defenders;
3. States in a position to do so should prioritise support for LGBTI human rights defenders and organisations when providing international cooperation and assistance in the areas of health and human rights, and affirm the value of their role and expertise through all relevant means. Both donor and recipient states should avoid the imposition of arbitrary restrictions or limitations on such assistance;
4. Recognise the impact of the COVID-19 pandemic on such organisations and ensure, within the scope of the State’s functions, the adoption of all relevant measures to address the resulting consequences.

 Protection

1. Adopt all measures necessary for the consideration of constitutional or legal protection from violence and discrimination based on sexual orientation and gender identity, as well as sex characteristics, as detailed in the mandate’s report on the matter (A/HRC/35/36);
2. Repeal all legislation enabling, promoting or acquiescing to the human rights violations perpetrated against lesbian, gay and bisexual persons, trans and other gender diverse persons, and intersex persons, as detailed in this report;
3. Repeal legislative, administrative and other measures enabling, promoting or acquiescing to pathologising views of sexual orientation and gender identity, in line with the recommendations set out in the previous reports of the mandate (A/73/152 and A/HRC/44/53);
4. Provide recognition of gender identity based on self-identification through all relevant means, as detailed in the mandate’s report on the matter (A/73/152);
5. Address violence and discrimination based on sexual orientation and gender identity, as well as on sex characteristics, in access to health through political, strategic and programmatic action;
6. Provide training and sensitisation for public officials, including as a priority those working in the health, security, justice and education sectors, in relation to violence and discrimination based on sexual orientation and gender identity, as well as on sex characteristics;

 Indirect Discrimination

1. In furtherance of the principle of prevention, include adequate mechanisms in process design and implementation of legislative, administrative or any other State measure impacting access to health, so that all available expertise about possible indirect discriminatory impact is part of the process and is given timely, serious and consequential consideration;
2. In furtherance of the principle of reparation, ensure the availability of adequate mechanisms so that actual indirect discriminatory impact of legislative, administrative or any other State measure can be identified and addressed in an efficient and efficacious manner, and that it includes all relevant considerations of non-repetition.

 Representation

1. Proactively take action to include civil society organisations working to address violence and discrimination based on sexual orientation and gender identity, as well as sex characteristics, in SDG monitoring and review processes at the national, regional and global levels;
2. Recognise the legitimacy and indispensable nature of including LGBT-led and serving, as well as intersex-led and serving CSOs and the communities they serve in the implementation and monitoring of all SDGs, particularly in relation to the specific matters addressed in this report;

 Evidence-based action

1. Explicitly adopt and follow a human rights-based approach in all evidence and data-gathering processes in relation to health inequalities and the SDGs. The overriding human rights principle of “do no harm” should always be respected through necessary safeguards to prevent the misuse of such data; all activities must take into consideration the principles of self-determination, privacy and confidentiality, lawful use, participation, right to information, transparency, accountability and impartiality in the terms expressed in the mandate’s report on data (A/HRC/41/41) and other relevant human rights sources;
2. Design and implement comprehensive data collection procedures to uniformly and accurately assess the type, prevalence, trends and patterns of violence and discrimination against lesbian, gay, bisexual, trans and gender-diverse persons, and intersex persons, in general and in relation to the particular findings of this report, regarding their access to the highest available standard of physical and mental health;
3. Adopt data processes that enable disaggregation according to populations, communities, and persons affected by discrimination and violence based on sexual orientation and gender identity, as well as by other relevant factors such as race, ethnicity, religion or belief, health status, age, class, caste and migration or economic status;
4. Use all available data to inform the policies and legislative actions of States with a view to prevent further acts of violence and discrimination and to address gaps in investigation, prosecution, remedies provided and sociocultural and economic inclusion;
5. Include data and analysis relevant to violence and discrimination based on sexual orientation and gender identity in Voluntary National Reviews and relevant regional and global progress reports;
6. Promote and support research activities to address the significant gaps in the evidence-base regarding health-related discrimination and violence based on sexual orientation and gender identity, with due regard to communities, populations and persons underrepresented in research.

Annex I

 Activities 2021 - 2022

1. Violence and discrimination based on sexual orientation and gender identity are never justified and must be prevented, prosecuted and punished and, if relevant, be at the base of measures of reparation.

2. Since his last report to the Human Rights Council in 2021, and given the continued challenges created by the ongoing COVID-19 pandemic, which affects populations and communities around the world very differently, the Independent Expert made efforts to maintain his virtual presence while steadily retaking in-person activities. Many events and activities were organized under hybrid formats, allowing for the engagement of a wider range of stakeholders.

3. The Independent Expert organized seven virtual events in English or Spanish, including some with French or Portuguese interpretation, to increase the visibility of all areas of his work. Some of the events addressed topics in focus during the year, namely the Reports on Gender, while many others continued threads of work initiated previously, such as the impact of the COVID-19 pandemic on LGBT persons, practices of “conversion therapy”, and social inclusion. These events brought together thousands of participants from all regions of the world. One of the new initiatives was the campaign “Diversity in Adversity”, in partnership with the Mandate of the Special Rapporteur on the situation of human rights defenders. The launch of the initiative had a record attendance of more than 300 simultaneous live viewers.

4. In June and October 2021, the Independent Expert participated in hybrid interactive dialogues with the Human Rights Council and the General Assembly. Throughout the year, he also maintained virtual contact with representatives of UN entities, international organisations, CSOs, and business leaders. At the regional level, activities were carried out with the OAS and its LGBTI Core Group, the IACHR, and the Council of Europe and European institutions. Dozens of bilateral exchanges with representatives of Member States were also held.

5. The gradual return of in-person activities allowed for the Independent Expert to resume the work programme contingent on travels. During the period, he undertook a country visit to Tunisia as well as promotional and advisory visits to Copenhagen, Honduras, El Salvador and Guatemala

6. The work on practices of “conversion therapy” continued to provide an example of the manner in which the mandate hopes to add value to ongoing efforts at the domestic level. Since the publication of the mandate’s report on the issue, several countries have introduced legislation to ban practices of conversion. The mandate was engaged with parliamentary commissions working on the issue in Canada and France, which have both concluded the process of adopting prohibitive legislation. Since May 2021, other countries have introduced administrative or professional directives against the practice, such as Chile and India, while New Zealand has criminalized attempts to change sexual orientation or gender identity of anyone under 18. Several other countries are still actively working on introducing bans, such as Ireland, Norway, Denmark and Finland.

7. Since May 2021, the Independent Expert attended official hearings with public agents from multiple States’ legislative and executive branches to advise on legislation and policy in topics related to sexual orientation and gender identity. Some of the entities that were in dialogue with the Expert were the Parliament of Ghana, the House of Commons of the United Kingdom, the Ministry of Interior of Uruguay, the Ministry of Foreign Affairs of Costa Rica, and the Committee on Equality and Non-Discrimination of the Parliamentary Assembly of the Council of Europe; among others.

8. At the invitation of UN leadership, the OHCHR, the United Nations High Commissioner for Refugees (UNHCR), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Development Programme (UNDP), the World Bank and other multilateral development banks, and the Commonwealth Secretariat (often in partnership with Governments, Parliaments, academia, and civil society partners), the Independent Expert took part in 12 meetings and events covering key issues related to sexual orientation and gender identity.

9. Between 1 May 2021 and 30 April 2022, at the invitation of Member States, government representatives, academia, and CSOs, the Independent Expert participated in 41 panels and presentations during which he engaged with hundreds of stakeholders from all corners of the world.

10. During the reporting period, the Independent Expert gave more than 40 in-depth interviews for television, radio and print media. He also issued essays, video messages, and op-eds, and developed an active social media presence. Available data shows that the mandate has built an audience across different regions of the world. He also issued 16 individual or joint official press releases and media statements, including on the situation of forcibly displaced LGBT persons and one thematic statement on the connections between right to freedom of religion and belief and right to live free from violence and discrimination based on sexual orientation and gender identity, on the occasion of the 2021 International Day against Homophobia, Transphobia and Biphobia, which was joined by a group of over 100 United Nations and regional independent experts.

11. The Independent Expert sent 21 communications in which allegations of human rights violations in relation to sexual orientation and gender identity were raised with other Special Procedures and/or by which he sought to provide technical advice on legislation and policies.

1. \* The report was submitted after the deadline to allow consideration of the large number of submissions received. [↑](#footnote-ref-2)
2. \*\* The annex to the report is circulated as received, in the language of submission only. [↑](#footnote-ref-3)
3. <https://www.ohchr.org/sites/default/files/Documents/Issues/Discrimination/LGBT/B>
ackgroundNoteHumanRightsViolationsagainstIntersexPeople.pdf. [↑](#footnote-ref-4)
4. WHO, Constitution of the World Health Organisation (1948). [↑](#footnote-ref-5)
5. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW; art. 12), International Convention on Protection of the Rights of All Migrant Workers and Members of Their Families (arts. 28, 43, and 45), International Convention on the Elimination of Racial Discrimination (ICERD; art. 5), Convention on the Rights of the Child (CRC; art. 24), and Convention on the Rights of Persons with Disabilities (CRPD, art. 25). [↑](#footnote-ref-6)
6. African Charter on Human and Peoples’ Rights (1981), 1988 Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador), European Social Charter (1961, revised in 1996), American Declaration on the Rights and Duties of Man (1969), and European Convention for the Promotion of Human Rights and Fundamental Freedoms (1950). [↑](#footnote-ref-7)
7. <https://www.ohchr.org/Documents/Publications/Factsheet31.pdf>. [↑](#footnote-ref-8)
8. CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health, para. 18. [↑](#footnote-ref-9)
9. A/HRC/47/27, paras. 12-35. [↑](#footnote-ref-10)
10. CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health, para. 8, 9. [↑](#footnote-ref-11)
11. “Equity is the absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g., sex, gender, ethnicity, disability, or sexual orientation), and health equity is achieved when everyone can attain their full potential for health and well-being.” WHO, *Health Equity*, <https://www.who.int/health-topics/health-equity#tab=tab_1>. [↑](#footnote-ref-12)
12. Transforming our World: The 2030 Agenda for Sustainable Development (United Nations, 2015), paras. 4, 7,14, 26. [↑](#footnote-ref-13)
13. Caribe Afirmativo, submission p. 3. [↑](#footnote-ref-14)
14. Global Health Justice Partnership of the Yale Law School and the School of Public Health, submission p. 3. [↑](#footnote-ref-15)
15. A/HRC/35/36, para. 52. [↑](#footnote-ref-16)
16. APCOM, submission p. 3. [↑](#footnote-ref-17)
17. A/HRC/14/20, para. 18. [↑](#footnote-ref-18)
18. A/HRC/32/44, para. 58. [↑](#footnote-ref-19)
19. <https://www.ohchr.org/en/press-releases/2021/06/preliminary-observations-visit-tunisia-independent-expert-protection-against?LangID=E&NewsID=27174>. [↑](#footnote-ref-20)
20. A/69/856, para. 52. [↑](#footnote-ref-21)
21. <https://www.ohchr.org/en/press-releases/2021/06/preliminary-observations-visit-tunisia-independent-expert-protection-against?LangID=E&NewsID=27174>. [↑](#footnote-ref-22)
22. A/HRC/35/21, para. 48. [↑](#footnote-ref-23)
23. <https://pubmed.ncbi.nlm.nih.gov/30568414/>. [↑](#footnote-ref-24)
24. A/HRC/35/21, paras. 48, 58. [↑](#footnote-ref-25)
25. OL GTM 10/2021. [↑](#footnote-ref-26)
26. OL GHA 3/2021. [↑](#footnote-ref-27)
27. OL OTH 89/2020; OL OTH 88/2020. [↑](#footnote-ref-28)
28. A/HRC/44/53. [↑](#footnote-ref-29)
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