Frequently asked questions on sexual and gender diversity, health and human rights - an introduction to key concepts

Second edition

World Health Organization

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Contents

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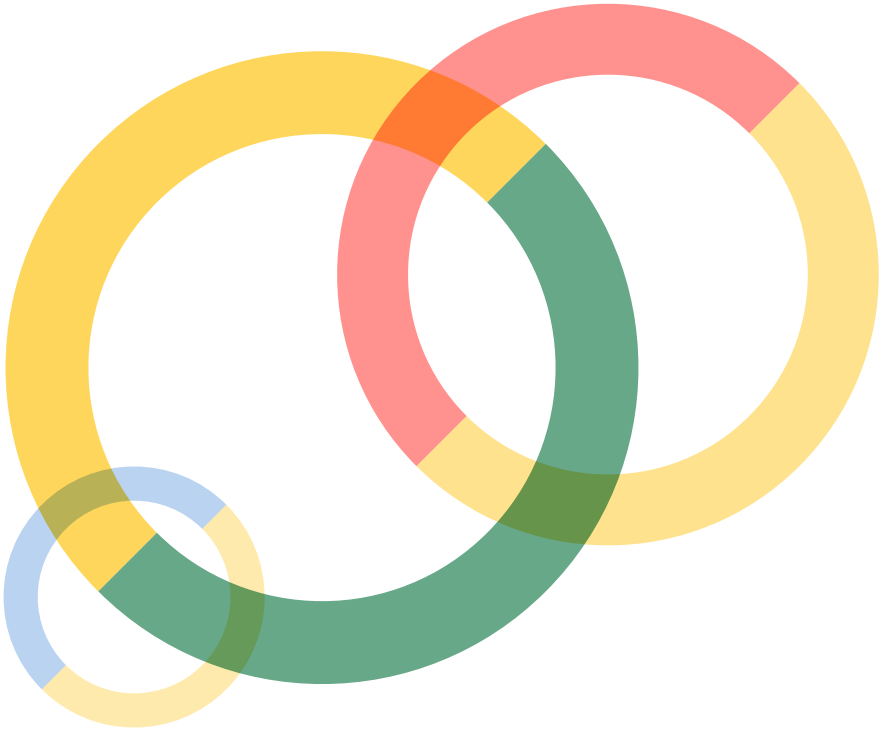
Abbreviations

FAQ	Frequently Asked Questions
GRE	Gender Equality, Human Rights and Health Equity
ICD	International Statistical Classification of Diseases and Related Health Problems
ILGA	International Lesbian, Gay, Bisexual, Trans and Intersex Association
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex and queer/questioning people.
MSM	Men who have sex with men
OHCHR	Office of the High Commissioner for Human Rights
PrEP	Pre-exposure prophylaxis
SOGIESC	Sexual orientation, gender identity and expression and sex characteristics
STI	Sexually transmitted infection
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization
WSW	Women who have sex with women

Methodology

The development and review process for this publication began with preliminary research of the terms and concepts from the original 2016 FAQ, updated with additional public-health data and reports from UN human rights mechanisms related to sexual orientation, gender identity and expression and sex characteristics (SOGIESC). An updated draft of the FAQ was then reviewed by WHO and external experts during a consultation in July 2019. That update of the FAQ was then reviewed during 2021 and 2022 by the WHO interdepartmental working group on SOGIESC, which included technical experts from the Department of Sexual and Reproductive Health, the Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes, the Department of Health Governance and Financing, the Health Workforce Department, the Department of Neglected Tropical Diseases, the Division of UHC/Healthier Populations, the Director-General's Office, as well as gender, equity and human rights focal points and advisors in WHO regional offices. Additional terms and definitions were added or revised to ensure alignment with relevant WHO normative statements, working definitions and guidance, UN human rights treaty body General Comments and Concluding Observations, and OHCHR and Human Rights Council Special Procedures reports and recommendations.



1. About this FAQ

This publication defines key concepts and terminology in health, gender identity and sexual diversity, and clarifies their meaning in WHO guidance, tools and other resources. It also explains how these concepts and terminology – along with public-health evidence – relate to rights: the right to health, rights to the underlying determinants of health, and other rights guaranteed under international human rights treaties which are relevant in the context of health. It is intended for policymakers, researchers, educators, health and care workers, and health and human rights advocates.

While some definitions in this FAQ are well established, such as those of human rights standards and principles, others are working definitions. These working definitions are based on the current understanding, as reflected in public-health data and normative statements issued by WHO and other UN entities, and as reflected in human rights standards and principles – consolidated in publications of the Office of the High Commissioner for Human Rights (OHCHR) – and established by international human rights treaty bodies, by Human Rights Council resolutions and by Special Procedures mandate-holders.

Many of these working definitions are dynamic and expected to evolve over time, and the connotations of usage in different contexts can be shifted by linguistic variations and historical and socio-cultural factors. This publication will be updated to reflect the continuing evolution in terminology, public-health evidence and medical knowledge. For the next update of this FAQ, invitations for comments will be circulated.

This publication was developed by an internal WHO cross-programme working group, led by the Department of Gender Equality, Human Rights and Health Equity (GRE), and updating *Frequently asked questions on health and sexual diversity: an introduction to key concepts*, published in 2016.

2. What is SOGIESC?

SOGIESC stands for sexual orientation, gender identity, gender expression and sex characteristics.

Sexual orientation is a person's physical, romantic, and/or sexual attraction (or lack of it) to other people. It includes three elements: sexual attraction, sexual behaviour, and sexual identity *(1, 2, 3)*. For some, sexual orientation is fluid and changes over time. For others, it is experienced as deeply innate and does not change over time. Sexual orientation and gender identity are distinct, and one cannot be inferred from the other.

Gender identity is a person's deeply felt internal and individual experience of gender,[1] which may or may not correspond with the sex assigned at birth *(3)*. It includes the personal sense of the body, which may involve – if freely chosen – modification of bodily appearance or function by medical, surgical or other means. Gender identity exists on a spectrum, so it is not necessarily linked to a single gender. And it can be fluid, evolving over the course of a person's life.

Gender expression is the way in which a person outwardly presents their gender identity. It is typically manifested through name and pronouns – for example, in Anglophone contexts, 'she/her' and 'he/him', as well as 'they/them', which some gender-fluid or non-binary people prefer. It is also manifested in the way a person chooses to dress, speak or conduct themselves socially. A person's gender expression is distinct from, and not necessarily linked to, their sex assigned at birth, gender identity or sexual orientation *(3)*.

Sex characteristics are physical or biological features. Primary sex characteristics are present at birth, and include gonads (testes or ovaries), genitalia (such as the penis and vagina) and hormones (such as oestrogen and testosterone). Secondary sex characteristics are those that usually emerge during the prepubescent to postpubescent phases of development, and include breast enlargement and menstruation in females, and body-hair growth and vocal changes in males *(3)*.

1. Gender refers to the socially constructed norms that impose and determine power, roles and relationships between women, men, boys, girls and trans and gender-diverse people, including people with non-binary gender identities. Gender norms, roles and relations vary from society to society and evolve over time. For more information, see WHO's **Q&A: Gender and Health**, at: https://www.who.int/news-room/q-a-detail/gender-and-health.

3. What are the terms used to describe diversity in SOGIESC?

Diversity in SOGIESC spans cultures around the world and includes many different terms. It is important to respect people's choice of the terms they use for themselves, as well as the names and pronouns they choose *(4)*.

Sexual orientation, gender identity and expression and sex characteristics are defined as prohibited grounds of discrimination under international human rights law *(5, 6, 7, 8, 9)*, and are included in guidance on human rights and the Sustainable Development Goals *(10)*.

Cisgender means having a gender identity that corresponds to the sex assigned at birth *(3)*.

Heterosexual or **straight** describes people who are physically, romantically and/or sexually attracted to people of the opposite sex and/or gender identity *(3)*.

Homosexual describes same-sex attraction and behaviour, including sexual behaviour or acts between women and sexual behaviour or acts between men. WHO removed "homosexuality" as a diagnostic category from its *International Statistical Classification of Diseases and Related Health Problems* (ICD) in 1990, reflecting the lack of empirical evidence to support pathologizing variations in sexual orientation *(11)*. Because of its historical roots as a pathologizing diagnostic classification, this term is not used by many civil-society and non-governmental organizations that advocate for equality and non-discrimination based on sexual orientation *(12)*.

Lesbian describes women who are physically, romantically and/or sexually attracted to the same sex and/or gender identity, and who identify as being lesbian *(3)*.

Gay is a term used to describe people who are physically, romantically, and/or sexually attracted to people of the same sex and/or gender identity as themselves, and who identify as being gay *(3)*.

Gay men and lesbians are often referred to as **homosexual** by certain sectors and institutions.

Bisexual describes people who are physically, romantically, and/or sexually attracted to people of the same sex and/or gender identity as well as to a different sex and/or gender identity *(3)*.

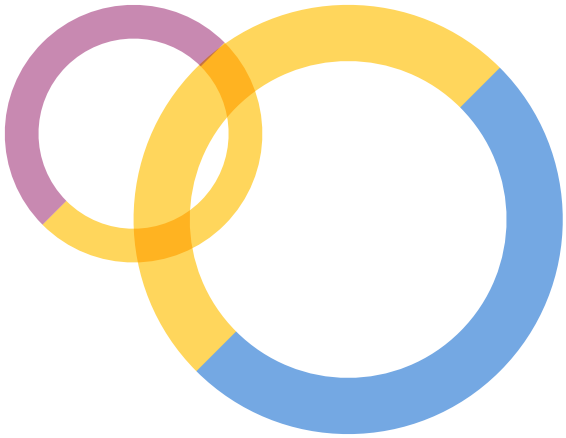
Transgender (often shortened to **trans**) and **gender-diverse** are umbrella terms for people whose gender identity, gender roles or gender expression do not conform to the norms and expectations traditionally associated with the sex assigned to them at birth *(3)*. It includes people who are transsexual or otherwise gender-diverse. Transgender people may identify as transgender, female, male, trans woman or trans man, transsexual, or using other terms. **Gender-diverse** includes people who identify as **gender-fluid** or **gender non-binary**. Trans and gender-diverse people may express their genders in a variety of masculine, feminine and/or androgynous ways. This is irrespective of whether they have undergone gender transition, such as hormonal or surgical interventions, to align their physiology with their gender identity. While these terms are increasing in familiarity in many countries, in a number of cultures other terms may be used.[2]

2. Specific indigenous terms include "hijra" (India), "meti" (Nepal), "skesana" (South Africa), "motsoalle" (Lesotho), "kuchu" (Uganda), "waria" (Indonesia), "kawein" (Malaysia), "muxé" (Mexico), "fa'afafine" (Samoa), "fakaleiti" (Tonga), "tarajens" (Iran) and "two-spirit" (some North American indigenous peoples).

Intersex people are born with physical or biological sex characteristics (such as genitalia, gonads, hormonal patterns and chromosomal patterns) that do not fit typical binary notions of male or female bodies, but which occur regularly in human biology *(3)*. These characteristics may be apparent at birth, emerge later in life (often at puberty) or not be physically apparent. Intersex people are sometimes subjected to gender-assignment interventions at birth or in early life, with or without their consent or that of their parents. The practice of non-consensual, medically unnecessary treatment and surgery has been condemned as a human rights violation by intersex communities, the UN (including WHO), and human rights experts *(4, 13, 14, 15, 16)*.

Queer is an umbrella term which encompasses lesbian, gay, bisexual, transgender and people with diverse sexual orientation and/or gender identity and expression, including gender non-binary people. "Queer", historically a negative term in English, has been reclaimed by some people and is considered inclusive of a wide range of diverse sexual orientations, gender identities and expressions. "Queer" is used by many people who feel – based on their sexual orientation, gender identity or gender expression – that they do not conform to the norms of a given society, whether those are gender, economic, social, cultural or political norms.

LGBTIQ+ is an acronym for lesbian, gay, bisexual, transgender, intersex and queer/questioning people. The **plus sign** represents people of diverse sexual orientation, gender identity, gender expression and sex characteristics who identify with other terms. This acronym, adopted from a Western (predominantly Anglophone) context, has become a term of convenience in the realm of public health and health research, including for some normative statements on human rights by WHO and other UN entities *(17)*. While the acronym LGBTIQ+ (or a derivation of it, such as LGB or LGBT) is widely used globally and in UN publications, it does not encompass the full diversity of terms used to describe SOGIESC *(3)*.



Men who have sex with men (MSM) are males who engage in sexual activity with other males, irrespective of their sexual identity *(3)*. It is a term used in public health and social science, including in surveillance, for the purposes of identifying sexual risk practices and sexual transmission of infections, including HIV. **Women who have sex with women (WSW)** is also a term used in public health and social science.

Sexual and gender minorities are individuals whose sexual orientation is not exclusively heterosexual and whose gender identity and/or gender expression is different than the sex assigned at birth *(3)*. Sexual and gender minorities may or may not identify with a particular identity or term, such as LGBTIQ+.

Sexuality: Sexuality can be described as "a central aspect of being human, and throughout life it encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the intersection of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors *(1, 9)*." Understandings of sexuality change over time and vary throughout societies and cultures.

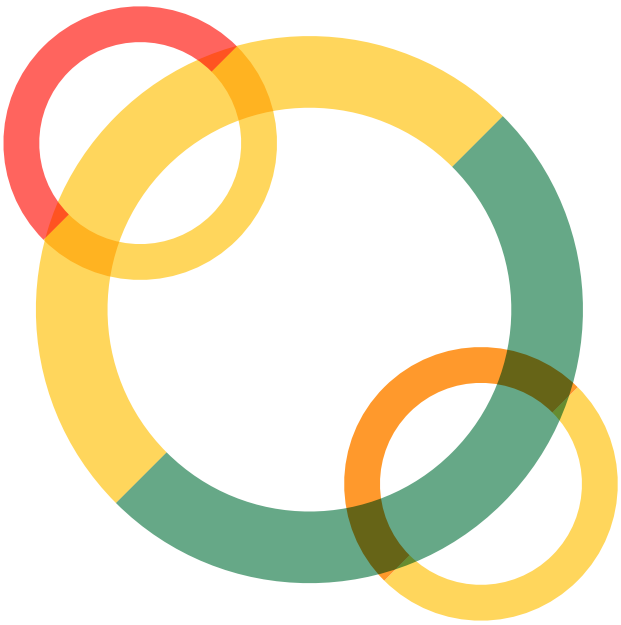
Sexual health: Sexual health can be described as "a state of physical, emotional, mental and social well-being in relation to sexuality across the life course; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences and relationships, free from coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all people must be respected, protected and fulfilled *(9, 18)*."

Sexual rights: The term sexual rights describes the application of existing human rights standards to sexuality and sexual health. Sexual rights thus protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination.

The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents, other consensus documents and national laws.

Rights critical to the realization of sexual health include:

- the rights to equality and non-discrimination;
- the right to be free from torture and cruel, inhumane or degrading treatment or punishment;
- the right to privacy;
- the right to the highest attainable standard of health (including sexual health);
- the rights to marry and found a family (with the free and full consent of the intending spouses), and to equal rights as to marriage – during marriage and at its dissolution;
- the right to decide the number and spacing of one's children;
- the rights to information and education;
- the rights to freedom of opinion and expression; and
- the right to an effective remedy for violations of fundamental rights *(19, 20, 21, 22)*.



4. What forms of stigma and discrimination do sexual and gender minorities experience?

The Universal Declaration of Human Rights (UDHR) states that all human beings are born free and equal in dignity and rights *(19)*. All people have an equal right to live free from violence, persecution and discrimination. However, sexual and gender minorities continue to be victims of serious human rights violations across the globe, experiencing higher levels of stigma, discrimination and violence based on their SOGIESC *(23, 24)*. This section describes the various forms of this stigma and discrimination.

Heteronormativity is the presumption that everyone is or should be heterosexual, that heterosexuality is the norm, and that society should be organized around the needs of heterosexual people *(3)*. Among individuals and within and beyond institutions, this can lead to invisibility and systemic stigmatization towards sexual and gender minorities. Often included in this concept is some degree of gender normativity and bias towards traditional gender roles: the assumption that people should identify as either men or women, that men should assume traditional masculine roles and women traditional feminine roles.

Homophobia is prejudice, stigmatization and discriminatory treatment based on a person's same-sex sexual orientation *(3)*. Homophobia can take many different forms, including negative attitudes and beliefs about, aversion to, or prejudice against people who are attracted to other people of the same sex and/or gender identity, including lesbian, gay and bisexual people.

Biphobia is prejudice, stigma and discriminatory treatment directed at bisexual people. Biphobia occurs both within and outside LGBTIQ+ communities *(3)*. In addition to experiencing biphobia from heterosexual people, bisexual people have often been excluded from or rendered invisible in LGBTIQ+ spaces and in conversations about LGBTIQ+ issues.

Transphobia is prejudice, stigma and discriminatory treatment directed at people who do not conform in presentation and/or identity to conventional conceptions of gender, and/or at people who do not identify with or express their assigned sex *(3)*. That includes gender-diverse populations who identify as gender non-binary, gender-fluid and other terms. As with biphobia, trans and gender-diverse people have often been excluded from, or rendered invisible in, LGBTIQ+ spaces as well as conversations about LGBTIQ+ issues.

Transphobia, biphobia and homophobia are closely linked because they are reactions to people who challenge dominant social norms regarding sexuality and gender identity. As with any form of discrimination, these can be individual or systemic, intentional or unintentional, and they can take the form of direct or indirect discrimination, as well as violence and other human rights violations.

5. What human rights protections exist for people of diverse SOGIESC?

UN Member States have committed to upholding the fundamental values enshrined in the UDHR and in ratified international human rights treaties, including the obligation to respect, protect and fulfil the human rights of all people *(7, 19, 25, 26, 27, 28, 29).* The principle of non-discrimination is a core element of all international human rights treaties. The WHO Constitution, which entered into force in the same year the UDHR was adopted, incorporates the enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic or social condition *(20).*

Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity, regardless of their race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (such as people living with HIV), sexual orientation, gender identity or other social status *(30, 31, 32).*

Member States have committed to upholding the fundamental values enshrined in the UDHR and human rights treaties and have obligations under international law to protect the human rights of all persons *(7, 18).* They have a duty to review and reform national legislation and policies in line with international human rights standards and their respective treaty obligations, with the support of UN entities if necessary. Furthermore, putting in place supportive legislative and regulatory frameworks and removing unnecessary restrictions from policies and regulations is likely to contribute significantly to improved access to health and other social services. (Box 1)

Under the leadership of the Office of the High Commissioner for Human Rights (OHCHR), the United Nations launched Free and Equal, an ongoing campaign that advocates for LGBTIQ+ equality and non-discrimination in the enjoyment of all civil, political, economic, social and cultural rights *(33, 34).* Further information on human rights protections for people of diverse SOGIESC is available on the website of the OHCHR *(35).*

Box 1: The report of the Independent Expert on sexual orientation and gender identity

The UN Human Rights Council appointed an Independent Expert on protection against violence and discrimination based on sexual orientation, gender identity and gender expression. The Independent Expert has reported on the significant negative effects of discrimination in health and social policy. Discriminatory policies and lack of social protection were found in various sectors, including education, employment, housing and health *(36).*

The Independent Expert also gives positive examples, where states are designing and implementing policies, strategies and frameworks to promote the social inclusion of LGBTIQ+ people. For instance, the Independent Expert noted that Botswana's Employment Amendment Act (2010) explicitly prohibits discrimination in the workplace based on sexual orientation, while Cabo Verde's Labour Code prohibits employers from requesting information about an employee's sex life and imposes sanctions on those who discriminate based on sexual orientation *(37).*

6. How does gender and sexual diversity relate to health?

Gender and sexual diversity interact with many areas of health, including sexuality, sexual health and sexual behaviours, as well as health services' availability, accessibility, acceptability and quality (Box 2). Recognition and respect for the diversity of sexual behaviour and expression contributes to people's overall sense of well-being and health *(1, 9)*. There are risks and vulnerabilities associated with the way sexual behaviour and expression are perceived in society. Understanding these is key for understanding the barriers to health, and how to address them.

For instance, a man can be categorized MSM regardless of whether he also has sex with women, and whether he identifies as heterosexual, gay, bisexual, or even as MSM *(4)*. Understanding sexual behaviour is imperative in developing, implementing and evaluating health-care interventions that aim to prevent disease and improve sexual health *(41)*.

Sexual and gender minorities disproportionately experience a significant disease burden throughout the world. A review of systematic reviews of disease burden among sexual and gender minorities found a significantly higher burden of HIV, sexually transmitted infections (STIs), STI-related cancers, mental health and substance use, in addition to these people facing higher rates of physical and sexual violence compared with the general population *(42)*. Compared with the general population, sexual and gender minorities face unique challenges – as well as similar ones – in accessing health-care services and in ensuring their health needs are met (Box 3).

Box 2: Cervical cancer screening among lesbian and bisexual women

Studies have found that lesbian and bisexual women are less likely to access cervical-cancer screening because of heteronormative assumptions – among both patients and health-care providers – that only heterosexual women require this screening *(38, 39, 40)*.

Box 3: Research on health outcomes among sexual and gender minorities

A global review of public-health studies found poor health outcomes among sexual and gender minorities, occurring because of a complex interaction of factors – social, cultural, legal and political. This includes heterosexism, as well as individual and systemic discrimination, both direct and indirect *(45)*.

There are significant inequalities in mental health, with LGBTI people being two to three times more likely to report enduring psychological or emotional problems, compared with the general population. Suicide attempts, suicidal ideation, depression and anxiety disorders were 1.5 times higher for LGB people compared with their heterosexual peers. In addition, intersex people showed a higher incidence of suicide attempts, at 19%; and 60% had considered suicide, compared with 3% in mainstream populations *(45)*.

They are also more likely to experience human rights violations, including violence, torture, murder (by both state and non-state actors), criminalization, forced sterilization (frequent in the case of intersex and transgender people), discrimination and stigma *(43, 44)*.

Research and evidence – gathered by UN entities, academics, and civil-society organizations – highlights the impact of stigma, discrimination and violence on sexual and gender minorities, including high rates of physical and mental health issues and reduced access to medical and social services *(46)* (Box 4).

Incidents of physical and psychological violence and torture in health-care settings have also been documented. A systematic review of sexual and gender minorities' experiences in health care settings found stigmatizing beliefs among health care workers, as well as denial of medical treatment and discrimination. Fear of stigma and discrimination in these settings had an impact on health-seeking behaviours and use of health services *(47)*.

In addition, health care settings are the site of medically unnecessary and unethical procedures. These include anal or genital exams (for the criminal prosecution of suspected "homosexual activities"), as well as so-called "sex-normalizing" surgery and "conversion therapy", also known as "SOGIESC-change practices" *(48)*. Some of these procedures can cause serious injury, scarring, pain, incontinence, loss of sexual sensation, and a range of negative mental health sequelae. These practices have been characterized as unscientific, harmful and contributing to ongoing stigma and discrimination *(49, 50)*.

Box 4: The Independent Expert's policy frameworks and action plans

The Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity has issued a report which outlines several policy frameworks and action plans to tackle discrimination and promote equality for LGBTIQ+ people, from an intersectional perspective. For instance, the Independent Expert noted that in Australia the government funded a programme to help health care settings become more culturally responsive to the Indigenous LGBTIQ+ community. The government also supported specialist services for LGBTIQ+ young people – and their families – who are homeless or at risk of homelessness *(51)*.

7. What health barriers do sexual and gender minorities face?

There are inequities in physical and mental health outcomes between sexual and gender minorities and the general population. These stem from a range of factors, including stigma and discrimination within several sectors, including health, where it affects the availability, accessibility, acceptability and quality of services *(52)*. Studies have demonstrated that poorer health outcomes in many areas are contributed to by stigma, discrimination and criminalization directed at consensual same-sex behaviour and at people whose gender identity and expression is different from the sex assigned them at birth. These poorer health outcomes are seen in areas including substance-use disorders, mental health, sexual health, sexually transmitted infections, cardiovascular health (Box 5), intimate-partner violence and abuse, as well as preventative care and screening *(24, 53, 54, 55, 56, 57)*.

Box 5: Cardiovascular disease risk among sexual minorities

A study published in the American Journal of Public Health found that social conditions, including marginalization and discrimination, appear to exert a negative effect on cardiovascular disease risk among sexual minorities. Compared with heterosexual women, lesbian and bisexual women had greater cardiovascular disease risk related to tobacco use, alcohol consumption, illicit drug use, poor mental health and body mass index. Similarly, compared with heterosexual men, gay and bisexual men had excess risk related to tobacco use, illicit drug use and poor mental health *(58)*.

Furthermore, stigma and discrimination are major obstacles that prevent sexual and gender minorities from accessing and engaging with health care services. Many Member States prohibit discrimination in health care settings in their general anti-discrimination policies and laws, but may not specifically prohibit discrimination based on sexual orientation, gender identity or gender expression. A lack of legislation specifically affirming the human rights of sexual and gender minorities, including anti-discrimination protections, can act as a major barrier to their enjoyment of the highest attainable standard of health *(59)*. This can be compounded by health workers' attitudes towards sexual and gender minorities, as well as health systems' lack of readiness to respond to their specific health needs *(60, 61)*.

Although further research is needed, studies suggest that this discrimination intersects with other forms of social advantage and disadvantage, such as socio-economic status, race, ability, geography, health status, migration status and age *(62)*. These intersecting barriers to health care and social services result in drastic health inequities between those who have access to these essential services and those who do not *(63)*. International human rights law prohibits discrimination, including discrimination based on sexual orientation or gender identity. Discrimination can negatively affect individuals, communities and societies and can also contribute to syndemics, also known as synergistic epidemics: the aggregation of two or more concurrent or sequential epidemics or disease clusters in a population with biological interactions, which exacerbate the prognosis and burden of disease *(64)*.

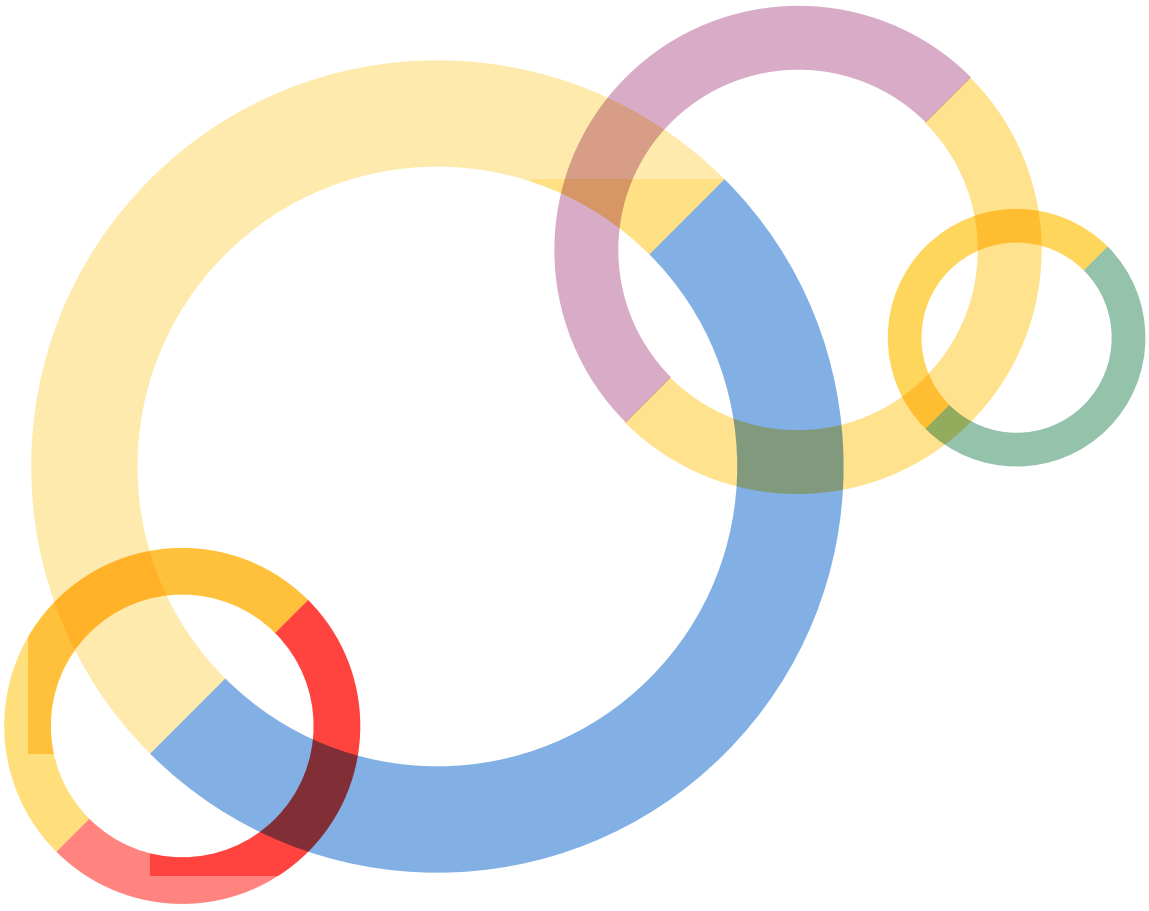
8. What does the ICD-11 say about transgender health?

The 11th revision of the WHO International Classification of Diseases and Related Health Problems (ICD-11) reconceptualised categories based on additional empirical data and advances in medical and scientific knowledge about sex and gender. The categories "transsexualism" and "gender identity disorder of children," which appeared in ICD-10, are now "gender incongruence of adolescence and adulthood" and "gender incongruence of childhood", respectively. Gender incongruence has been moved out of the "Mental and behavioural disorders" chapter and into the new "Conditions related to sexual health" chapter. This reflects current evidence that transgender and gender-diverse identities are not behavioural, hormonal or mental health conditions (*65, 66*).

The revised ICD-11 codes are expected to impact health financing and provision of care, reflecting contemporary knowledge of gender identity and sexual health. Including gender incongruence in the ICD aims at facilitating transgender people's access to gender-affirming health care, as well as to adequate financial coverage for these services.

9. What is gender-affirming health care?

Gender-affirming health care can include any social, psychological, behavioural or medical intervention designed to support and affirm an individual's gender identity – or a combination of them *(67)*. It could range from gender-affirming psychotherapy, to hormonal treatment, to transition-related surgeries *(68)*. Non-medical interventions can include facial-hair removal, modification of speech and communication, and behavioural adaptations such as genital tucking or packing, or chest binding. Gender-affirming health care also entails delivering health services in a person-centred, rights-based, non-judgemental way, such as by using the preferred pronouns of trans and gender-diverse people *(69, 70, 71, 72)*.



10. Why is HIV often discussed in relation to MSM and transgender people?

HIV transmission can occur during unprotected sex (that is, sex without condoms and without taking (PrEP)) between individuals if one of them is HIV positive and has not achieved and maintained an undetectable viral load *(73)*. This can happen between sexual partners of the same or different gender. HIV prevalence among "key populations" (explained shortly), including MSM and transgender people, is generally higher than in the general population, although it varies by geographical area *(74, 75, 76)*.

Since the beginning of the HIV epidemic in the early 1980s, one of the most affected and visible population groups was men who have sex with men, including gay and bisexual men. For that reason, HIV was initially known as "Gay-Related Immunodeficiency". This historic stigma still exists in many communities and is why gay men are often associated with HIV.

MSM and transgender people have an increased risk of HIV and other sexually transmitted infections partly because of sexual network effects *(77, 78)*. Any sexual network in which people have multiple and concurrent sex partners is especially conducive to the transmission of HIV and other sexually transmitted infections. Most recent data from the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 2022 have shown high HIV prevalence among transgender people, with reported values ranging from a median of 2% in eastern Europe and central Asia (three reporting countries) to 43% in East and Southern Africa (two reporting countries) *(79)* (Box 6).

However, it is important to note that, for these populations, violence, discrimination and other human rights violations – as well as negative experiences with health care providers – hinder access to health care and social services, as well as to HIV prevention, treatment and care services *(39)*. These issues are further exacerbated as individuals experience multiple forms of disadvantage, based on race, ethnicity, socioeconomic status, migration and legal status, as well as sexual orientation and gender identity.

MSM and transgender people have been identified as "key populations", a term that refers to people at elevated risk of HIV acquisition, who face systemic marginalization and discrimination. These populations also include sex workers, prisoners and people who inject drugs. Overall, key populations and their sexual partners accounted for 55% of adult (15-49) new HIV infections worldwide in 2022, and 80% of infections outside sub-Saharan Africa *(80)*. Addressing the incidence and prevalence of HIV and other STIs among key populations means addressing the legal and policy barriers that hinder their access to health care. Addressing these barriers includes decriminalizing both same-sex relations and gender identity and expression that is different from sex at birth *(49, 50, 81)*.

Box 6: HIV risk for MSM and transgender people

Epidemiological data from 2022 indicate that the risk of HIV acquisition among men who have sex with men is 23 times higher than it is among adults (15-49), and 20 times higher for adult transgender women than for cisgender adults (15-49) *(80)*. These health disparities are driven by human rights violations, discrimination and marginalization throughout health and social care services, which impact access to HIV prevention, testing and treatment services *(28)*.

11. What has the UN said about sexual and gender minorities?

One of the purposes of the UN, as enshrined in the UN Charter, is to promote and encourage respect for human rights and fundamental freedoms for all (*82*). The respect, protection and fulfilment of internationally recognized human rights, such as the right to the highest attainable standard of health and the right to non-discrimination, require that all people have access to high-quality and affordable health services, including those related to sexuality and sexual health, without discrimination *(19, 20, 21, 83)*. In keeping with this, everyone – regardless of their sexual orientation, gender identity, gender expression or sex characteristics – is entitled to enjoy the same rights, free from violence and discrimination.

As UN Secretary-General António Guterres stated, "The rights enshrined in the Universal Declaration of Human Rights belong to everyone, everywhere. They are independent of nationality, gender, sexual orientation, race, religion, belief or any other status *(84)*." He has appealed "to all governments and societies to promote the values of tolerance and respect for diversity, and to build a world where no one has to be afraid because of their sexual orientation and gender identity *(85)*." In 2015, the UN system – including WHO – endorsed a joint statement calling for an end to violence and discrimination against lesbian, gay, bisexual, transgender and intersex people *(17)*.

In July 2013, OHCHR launched UN Free & Equal, a global UN public-information campaign aimed at promoting equal rights and fair treatment of LGBTIQ+ people *(33)*. In 2016, the UN Human Rights Council appointed an Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity. The Independent Expert's mandate includes evaluating the implementation of existing international human rights instruments (regarding measures aimed at ending violence and discrimination against people based on their sexual orientation or gender identity), and identifying and addressing the root causes of violence and discrimination *(86)*.

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