



Racialized LGBTI Persons and the Right to Health

Comments to the draft general comment No. 37 on racial discrimination in the enjoyment of the right to health

Submission to the Committee on the Elimination of Racial Discrimination

4 August 2023

Joint submission by:

ILGA World
Mulabi, Espacio Latinoamericano de Sexualidades y Derechos
Manodiversa
Diversa Patagonia
Red Nacional de Refugiados y Migrantes LGBTIQ+

Table of Contents

Introduction.....	1
1. Intersectionality in UN treaty bodies' practice.....	1
2. Comments to the CERD's first draft general recommendation No. 37.....	2
3. LGBTI / SOGIESC health topics of particular concern	2
4. CERD's explorations of the intersection between the right to health and LGBTI communities	4
5. UN Special Procedures' advancements regarding the intersection between the right to health and LGBTI communities....	5
Conclusions	5
Annex 1 – Notes	6
Annex 2 – Information about submitting organisations	8

Introduction

In our diverse world, there is a pivotal need to recognize and address the distinctive challenges faced by marginalized groups, such as racialized persons. Furthermore, it is crucial to acknowledge that within these communities, there are individuals with diverse sexual orientations, gender identities, gender expressions and sex characteristics (SOGIESC).¹ A holistic understanding of the right to health requires considering the intersections between different identities, characteristics, and oppression systems, and this approach has been increasingly adopted by the United Nations (UN), particularly its treaty bodies and special procedures.

This submission explores some of the specific health issues faced by LGBTI² communities. It then delves into the notion of intersectionality as developed and applied by the Committee on the Elimination of Racial Discrimination (CERD). The submission further analyses the need to include LGBTI health issues in CERD's General recommendation No. 37 on racial discrimination in the enjoyment of the right to health, to safeguard the health and well-being of racialized LGBTI communities. By recognizing and addressing the health concerns of LGBTI communities, and further integrating an intersectional approach into the CERD's practice, it will be possible to create an inclusive world where everyone's right to health is upheld.

1. Intersectionality in UN treaty bodies' practice

E. Tendayi Achiume, a former Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance, repeatedly stated that a comprehensive approach to **countering racism** entails an **intersectional approach to understanding and fighting racial discrimination** by accounting for gender, class, migration status, religion, disability status and other social categories.³

UN treaty bodies, notably CERD, have incorporated intersectionality within the scope of their mandates through general recommendations and general comments, concluding observations, and decisions on individual communications.

CERD, in its general recommendation No. 25 on gender-related dimensions of racial discrimination, put into place the four-point typology of intersectional analysis. This analysis requires considering the *form, circumstances, consequences, and remedies* for racial discrimination.⁴ Therefore, the intersections affecting a specific case and generating human rights violations have to be considered, and an intersectional approach has to be applied through the remedies provided.

CERD expanded its understanding of intersectionality in the general recommendation No. 32, for cases in which discrimination occurs based on multiple grounds, and these intertwine with the ground(s) listed in article 1 of the ICERD (race, color, descent or national or ethnic origin). The Committee began to consider expanding grounds of discrimination using intersectionality and stated that 'the "grounds" of discrimination are extended in practice by the notion of "intersectionality" whereby the Committee addresses situations of double or multiple discrimination.'⁵

Therefore, CERD's general recommendations Nos. 25 and 32, among other instruments issued by the Committee, have created a standard requesting the Committee to understand article 1 of the ICERD with an intersectional lens.

Other UN treaty bodies have consistently developed intersectionality throughout their general comments and recommendations, allowing for intersectionality to become part of their activities in a consolidated fashion; as such, intersectionality has become an international human rights law standard.

The Committee on the Rights of Persons with Disabilities (CRPD) has issued various instruments referring to intersectionality.⁶ For instance, its general comment No. 3 provides a wide definition of intersectionality, articulating that:

*The concept of intersectional discrimination recognizes that **individuals do not experience discrimination as members of a homogenous group but, rather, as individuals with multidimensional layers of identities, statuses and life circumstances.** It acknowledges the lived realities and experiences of heightened disadvantage of individuals caused by multiple and intersecting forms of discrimination, which requires targeted measures to be taken with respect to disaggregated data collection, consultation, policymaking, the enforceability of non-discrimination policies and the provision of effective remedies.*⁷

The Committee on the Elimination of Discrimination against Women (CEDAW) has also developed the notion of intersectionality through its general recommendations. For example, through its general recommendation No. 28, intersectionality has been included as a tool to understand article 2 (non-discrimination) of the CEDAW Convention:

*Intersectionality is a basic concept for understanding the scope of the general obligations of States parties contained in article 2. **The discrimination of women based on sex and gender is inextricably linked with other factors that affect women, such as race, ethnicity, religion or belief, health, status, age, class, caste and sexual orientation and gender identity.** Discrimination on the basis of sex or gender may affect women belonging to such groups to a different degree or in different ways to men. States parties must legally recognize such intersecting forms of discrimination and their compounded negative impact on the women concerned and prohibit them. They also need to adopt and pursue policies and programmes designed to eliminate such occurrences, including, where appropriate, temporary special measures [...].*⁸

Furthermore, CEDAW considered the relationship between discrimination and other factors that affect women's lives, and included, among such factors, racial discrimination, health status and being LGBTI:

*In general recommendation No. 28 and general recommendation No. 33, the Committee confirmed that **discrimination against women was inextricably linked to other factors that affected their lives.** The Committee, in its jurisprudence, has highlighted the fact that such factors include women's **ethnicity/race, indigenous or minority status, color, socioeconomic status and/or caste, language, religion or belief, political opinion, national origin, marital status, maternity, parental status, age, urban or rural location, health status, disability, property ownership, being lesbian, bisexual, transgender or intersex, illiteracy, seeking asylum, being a refugee, internally displaced or stateless, widowhood, migration status, heading households, living with HIV/AIDS, being deprived of liberty, and being in prostitution, as well as trafficking in women, situations of armed conflict, geographical remoteness and the stigmatization of women who fight for their rights, including human rights defenders.***⁹

When it comes to country-specific concluding observations, CERD has indeed incorporated intersectionality in the context of LGBTI persons.¹⁰ However, this application has been sporadic rather than consistent, indicating the need for a more systematic and regular approach to address the complexities of intersecting identities and systems of oppression. Patrick Thornberry has stated that 'among possible intersections, disability and sexual orientation have engaged the attention of the [CERD] Committee only to a minor extent, a situation that is liable to change.'¹¹

Therefore, CERD has already incorporated the principles of intersectionality into its practice. We urge the Committee to reflect SOGIESC / LGBTI dimensions of racial discrimination in health in the new general recommendation.

2. Comments to the CERD's first draft general recommendation No. 37

In its draft general recommendation No. 37, CERD has incorporated health topics of broad relevance. Nevertheless, it is imperative to recognize that the enjoyment of health by LGBTI persons is influenced by the intricate intersections of **discrimination based on SOGIESC and racial discrimination**. As Mulabi has stated, 'historic and continuous discrimination hinders access to health care services in conditions of respect for gender identity, sexual orientation and gender expression.'¹² Consequently, the right to health is experienced to a limited extent, underscoring the need for greater attention and tailored recommendations by CERD to ensure the enjoyment of the right to health.

In this context, we ask the Committee to consider revising certain paragraphs of the draft general recommendation No. 37 to encompass groups facing intersectional forms of discrimination, such as LGBTI communities.

For instance, in **paragraph 4**, SOGIESC should also be considered as "key social determinants" that undermine the enjoyment of the right to health globally.¹³ Similarly, SOGIESC should be included in **paragraph 9** of the draft among the 'grounds of discrimination' that intersect with racial discrimination under article 1 of the ICERD and with other intersecting forms of discrimination. **Paragraphs 12(b)(i)** and **38** should also include SOGIESC as grounds of discrimination.

Paragraph 5 of draft general recommendation No. 37, concerning COVID-19, focuses on groups that were disproportionately affected by the pandemic, such as children and persons with disabilities; however, LGBTI communities are excluded from this list, despite substantial evidence¹⁴ indicating that they were among the most severely impacted by the pandemic and often ignored by states. For instance, in the context of Costa Rica,¹⁵ authorities did not include any mention of the LGBTI population in 112 laws and guidelines about the right to health during COVID-19¹⁶, much less other intersections faced by LGBTI communities, such as race, indigenous status, ethnicity, migrant and refugee statuses. It is essential to recognize and include LGBTI communities in the general recommendation to ensure comprehensive responses to the pandemic's effects.

On the other hand, **paragraph 11** which explores the effect of racism and racial discrimination on physical and mental health at the micro- and macro-levels, should explicitly incorporate references to LGBTI persons.¹⁷

Paragraph 20 of the draft is the only instance that includes "gender identity" in the context of racial discrimination in the right to sexual and reproductive health. This provision should be amended by adding sexual orientation, gender expression and sex characteristics – factors that also significantly shape the access to and enjoyment of the right to sexual and reproductive health. For example, intersex children are subjected to non-consensual medical interventions worldwide; and lesbian women experience sexual violence motivated by lesbophobia, do not have access to assisted reproduction, or are subjected to prejudices or incompetence from health care providers.

The lack of data that addresses the intersections between race and SOGIESC is a problem of general concern. Regarding **paragraph 32** about monitoring racial discrimination in the right to health through policies; **paragraph 44** on the collection of quantitative and qualitative data; **paragraph 36** on statistical data and **paragraph 38** on legislation against racial discrimination, we suggest the Committee includes the obligation of States parties to collect data on the access and enjoyment on the right to health disaggregated by race, status, age, class, caste, ethnicity, religion or belief, and SOGIESC. This would be a key strategy for monitoring the situation of racial discrimination with more accuracy, increasing the effectiveness of future public policies and efforts.

The topic of representation in medical research and development, decision-making, healthcare facilities, services and goods, as stated in **paragraph 27**, is crucial for the enjoyment of the right to health by racialized LGBTI persons. Various studies show that discrimination based on SOGIESC in healthcare systems prevents LGBTI individuals from accessing services.¹⁸ At the same time, racial discrimination prevents access to the right to health by Black persons.¹⁹ Hence, it is necessary to underline and investigate the intersections regarding access to health by racialized LGBTI persons. In that sense, we suggest the explicit inclusion of the following groups or situations of vulnerability: race, age, class, caste, ethnicity, religion or belief, and SOGIESC.

The first draft of the general recommendation No. 37 only refers to 'gender identity' and only once. We strongly suggest including references to SOGIESC / LGBTI in different paragraphs of the new general recommendation, thus creating crucially needed frameworks to address and, ultimately, improve the health discrepancies experienced by racialized LGBTI persons.

3. LGBTI / SOGIESC health topics of particular concern

a. Stigma and pathologization

LGBTI individuals face heightened stigma and pathologization; the harmful childhood experiences and adulthood victimization associated with unique and adverse health outcomes²⁰ are well documented.²¹ Similarly, racial and ethnic stigmatization is also shown to result in health inequalities.²² 'Intersectional stigma' is an important tool for comprehending how converging stigmatized identities can have 'complex effects on health behaviors, physical health and mental health' outcomes.²³ Racial and ethnic minority LGBTI people are simultaneously exposed to intersecting forms of prejudice and stigma. While studies have shown that the intersection between race and gender mental health-related stigma influences its severity,²⁴ there is a lack of comprehensive research that demonstrates the health impacts of experiencing intersectional stigma based on both SOGIESC and race, color, descent, national or ethnic origin and migrant or refugee status.

Moreover, colonization processes involved the imposition of Western binary concepts of gender and sexuality on indigenous populations, including indigenous and ancestral identities falling outside of the binary concepts. Instead of being recognized as a valuable part of indigenous communities and cultures, gender and sexually diverse indigenous persons are subjected to pathologization initially imposed by Western psychiatry (now considered outdated and violating human rights of LGBTI persons).

b. Legal gender recognition of trans and gender diverse persons

Legal gender recognition refers to 'laws, policies or administrative procedures and processes which set out how trans and gender diverse people can change their sex/gender marker and names on official identity documents.'²⁵ The legal congruence of one's gender identity is fundamental for the enjoyment of human rights such as health, employment, housing and education. In many cases, trans and gender diverse people are not entitled to legal gender recognition, which leads to violence and discrimination in the form of forced gender reassignment surgeries, psychological assessments, "conversion" therapies, sterilization and divorce. Other barriers include bureaucratic obstacles and difficulties in accessing medical care.²⁶

In recent years, human rights law, at the international, regional and domestic levels, has advanced the protection, promotion and fulfilment of trans and gender-diverse people's rights, and set up legal standards on legal gender recognition based on self-identification. One's self-identified gender is one of the bases of one's identity, and an expression of a free and autonomous decision about how to exist in society. Moreover, legal gender recognition affirms a person's bodily autonomy, as gender identity is often linked to one's gender expression and sex characteristics. Legal gender recognition based on self-identification is key, as it is based on a person's decision, as opposed to abusive mandatory medical procedures and complex legal proceedings and requirements that are intrusive, humiliating, expensive and traumatic.

Moreover, one of the main reasons LGBTI persons decide to migrate is to find better healthcare services in the country of destination,²⁷ including legal gender recognition, access to medical treatment, hormonal treatment, and others²⁸. However, even after arriving to the state of destination, residency and other bureaucratic requirements can be an obstacle to obtain hormonal treatment and health services for trans and gender diverse persons.²⁹

c. Mental health issues

Both LGBTI and ethnic minority populations experience heightened mental health struggles. Studies show that for LGBTI people, stigma and violence directly result in an increased risk of developing mental health problems. For example, in the case of two-spirit populations, indigenous people (specifically American Indian/Alaska Native people) can experience 'survivor guilt, anxiety, low self-esteem, anger, sadness, suicidal and self-destructive behavior and despair.'³⁰ Other research shows that structural inequalities such as racism, ethnocentrism and poverty can exacerbate existing mental health struggles experienced by LGBTI people such as depression, anxiety, post-traumatic stress, substance abuse and suicidality.³¹ According to a study conducted in the US, 83% of Black LGBTQ individuals reported that discrimination has negatively affected their physical well-being (compared to only 61% of white respondents); and for psychological well-being the rates amounted to 95% for Black LGBTQ individuals, compared to 88% for white respondents.³² Another study showed that 56% of Native transgender and gender nonconforming respondents had attempted suicide, as compared with 41% of all other transgender groups.³³

d. HIV / AIDS

The disparity and the disproportionality in the availability of and access to the prevention, treatment and care related to HIV among Black persons is not very documented worldwide, and the lack of data is a problem of international concern. Data from the United States can help demonstrate this scenario. According to the Center for Disease Control and Prevention, 'at current rates, 1 in 6 men who have sex with men (MSM) will be diagnosed with HIV in their lifetime, including 1 in 2 black MSM, 1 in 4 Latino MSM, and 1 in 11 white MSM.'³⁴ Another report enhanced that '62% of Black transgender women and 35% of Hispanic/Latina transgender women surveyed were living with HIV, compared to 17% of white transgender women.'³⁵

Additionally, the statistics highlight issues regarding access to treatment and care by LGBTI persons with HIV. Due to stigma and discrimination, there is widespread mistrust among racialized people relating to the healthcare system that delays initiation and diminishes adherence to antiretroviral therapy, which can lead to advanced stages of HIV. The following recommendations are suggested to increase visibility of the intersection between HIV, SOGIESC and racialized communities:

- Encourage and support comprehensive data collection and research on HIV-related disparities among LGBTI racialized populations. This should include data on access to prevention, treatment and care, and the impact of stigma and discrimination on healthcare-seeking behaviors;
- Implement culturally sensitive education campaigns to increase knowledge and reduce stigma associated with HIV and PrEP, and provide training to healthcare providers on cultural competency and sensitivity, and SOGIESC issues;
- Promote education and awareness campaigns aimed at reducing stigma and discrimination related to HIV, race and SOGIESC, which should challenge negative stereotypes and promote inclusivity, diversity, and acceptance.

e. 'Corrective' rape

The term "corrective" rape highlights a practice that involves rape in an attempt to 'correct', 'punish' or 'cure' the person's perceived non-conformity to traditional gender or sexuality norms. Initially, it referred to 'rape perpetrated by straight men against lesbians in order to "correct" or "cure" their homosexuality';³⁶ however, it is now used broadly to refer to 'any hate crime that entails the rape of a member of a group that does not conform to gender or sexual orientation norms. The motive of the perpetrator is to "correct" the individual, fundamentally combining gender-based violence and homophobic violence.'³⁷ The Inter-American Commission on Human Rights has reported the existence of 'corrective' rapes against LBT women, including women that are perceived as 'masculine' or that defy traditional norms on the basis of their SOGIE.³⁸ The Special Rapporteur on the right to health identified that LBT women 'are particularly vulnerable to [this type of] violence'.³⁹ Furthermore, Afro-Peruvian LGBTI persons reported the occurrence of 'corrective' violence, and 'stated that fear, harassment and violence had been normalized, that basic and routine activities were often traumatizing, and that they were disproportionately exposed to the risk of violence and impoverishment.'⁴⁰

Other 'corrective' violent attitudes are committed particularly against Black trans women. For instance, state agents such as police officials, use 'moral' corrective discourses that legitimize violence against this community and have the goal of 'de-homosexualizing' the society. These 'corrective' violent attitudes involve cutting these women's hair, burning their clothes, humiliating them in public spaces, among others.⁴¹ In some cases, 'corrective' rapes are carried out by policemen against Black trans women. State officials use their condition of authority to promote violence against Black trans women. Because policemen are the perpetrators, victims / survivors become the subjects of violations when they want to report these cases, given that these actions occur in the same area where the police offices are located.⁴² In the Colombian context, Afro-Colombian lesbian women have been victims of 'corrective' rapes, and the non-international armed conflict context worsened this situation.⁴³

f. Intersex health disparities

Healthcare issues faced by racial and ethnic minorities intersect and overlap with the human rights violations experienced by intersex populations across the globe. These populations share experiences in facing barriers to healthcare, including stigma and bias,⁴⁴ poor quality healthcare,⁴⁵ and lack of appropriately trained medical professionals.⁴⁶ In particular, research on intersex genital mutilation shows that these involuntary so-called 'genital normalizing surgeries' are undertaken early in childhood without informed consent, are rarely medically necessary,⁴⁷ can have life-long mental health impacts,⁴⁸ and lead to permanent and irreversible bodily harm (potentially causing sterility, chronic pain, impaired sexual function, post-surgical depression, trauma, and scarring).⁴⁹ Due to the lack of medical comprehension of intersex variations, concern has been expressed regarding the pathologization of intersex people, and the subsequent correlation with human rights violations against this population.⁵⁰ Further research needs to be done on the intersection and overlap between intersex healthcare disparities, and the racial and ethnic discrimination that impacts the right to health.

g. 'Conversion' therapies

'Conversion' or 'reparative' therapies seek to transform 'a non-heterosexual person into a heterosexual person, and a trans or gender-diverse person into a cisgender person.'⁵¹ They are "very frequent" in Africa and "quite frequent" in Latin America, the Caribbean and Asia.⁵² These practices could include electric shock, medication, psychotherapy, spiritual interventions or faith "healings",⁵³ take place in psychiatric institutions, specialized camps or places of worship,⁵⁴ and are carried out by healthcare professionals, clergy members or spiritual advisers in the context of religious practice.⁵⁵

These practices are carried out globally; however, 'in Africa they are driven by criminal laws that make LGBTQ people second-class citizens, negative rhetoric categorizing LGBTQ identities as un-African, and conservative religious and cultural ideologies which consider same-sex relations deviant and unacceptable.'⁵⁶ These discriminatory legislations thus legitimize and normalize 'conversion' therapies.

'Conversion' therapies may even be considered as a form of torture or ill-treatment.⁵⁷ Furthermore, these practices have negative consequences such as suicidal thoughts, permanent physical harm, suicide attempts, anxiety and depression.⁵⁸

h. Discrimination from health and medical professionals

Discrimination from health and medical professionals against racialized persons, indigenous peoples, migrants and refugees that are LGBTI has serious consequences for individuals' health and well-being as it impacts the quality of health services received and even deters people from attending medical institutions. Cisheteronormativity is often a political regime of states⁵⁹ and medical practices are centered around it, along with prejudices and moral objections.⁶⁰ LGBTI persons, for instance, may face not only homophobia and/or transphobia by health professionals, but also xenophobia, due to their citizenship⁶¹. This can be worsened by one's gender expression and/or sexual characteristics. Such discrimination can manifest in various forms, such as:

- **Stereotyping and bias:** Health professionals may hold discriminatory stereotypes, leading to biased treatment. This can result in inadequate or inappropriate care, as medical professionals may make assumptions or generalizations that do not align with the individual's specific needs. This discrimination can deter LGBTI persons from attending appointments or even engaging with health care systems.
- **Unequal access to care and disparities in treatment:** Discrimination can contribute to disparities in the quality and type of care provided. Racialized individuals, indigenous peoples, migrants and refugees that are also LGBTI individuals, may receive substandard or unequal treatment compared to other patients. This can result in delayed diagnoses, inadequate management of health conditions and poor health outcomes. In the case of Chile, civil society organizations have requested the government to train medical personnel working at healthcare services aimed at fostering a non-discriminatory environment towards LGBTI migrants.⁶²
- **Lack of trust:** Discrimination erodes the trust between patients and healthcare providers. When people that belong to these marginalized communities experience discrimination, they may be hesitant to seek healthcare or disclose information about their health due to fear of mistreatment or judgement. This can lead to delayed and/or erroneous diagnosis, ineffective treatment and worsened health outcomes.

In a study about the healthcare experiences of transgender people of color conducted in the US, all participants described healthcare experiences where providers responded negatively to their race/ethnicity and/or gender identity. A majority of participants believed they would be treated better if they were cisgender or white. Participants commonly cited providers' assumptions about TPOC as a pivotal factor in negative experiences. A majority of participants sought out healthcare locations designated as LGBT-friendly in an effort to avoid discrimination, but feared experiencing racism there. A minority of participants expressed a preference for providers of color; but a few reported reluctance to reveal their gender identity to providers of their own race due to fear of transphobia.⁶³

In Costa Rica, Afro-LGBTI individuals encounter many challenges when accessing healthcare services. Afro-lesbian women have reported the imposition of heteronormative perspectives during gynecological appointments and health professionals disregard their unique experiences as lesbian women. This imposition can be unsettling to the extent that lesbian women subsequently decide not to seek future consultations of this nature or abandon medical care altogether. Moreover, Afro-lesbian women heavily rely on the public health system as they are among the more economically disadvantaged.

When interacting with healthcare professionals, Afro-LGBTI persons experiences are marked by stereotypes and prejudices. They face comments insinuating a possible link with HIV/AIDS. Furthermore, relevant information about the medical center's services is intentionally withheld and physical contact with individuals from the Afro-LGBTI community is actively avoided, based on discriminatory stereotypes, such as promiscuity and high prevalence of sexually transmitted infections. Derogatory remarks are often overheard among medical staff.

There is a lack of established protocols for providing specialized care, particularly for Afro-trans people. Health professionals and administrative personnel lack the necessary training to address their specific needs, which exacerbates feelings of alienation and discomfort during medical interactions. When complaints are identified, there is a tendency to downplay their relevance. These situations hinder the possibility of addressing any concerns, leaving the mental and physical health of Afro-LGBTI persons in a precarious state.

Addressing discrimination in healthcare requires a multifaceted approach. It involves promoting cultural competency and sensitivity among healthcare professionals, increasing diversity in the healthcare workforce, implementing policies to eliminate biases, providing education and training on the particular health needs of Afro-LGBTI persons and fostering an inclusive and welcoming healthcare.

Racialized LGBTI persons experience aggravated or special challenges in accessing health care, including in relation to stigma and pathologisation, barriers to legal gender recognition, mental health issues, HIV/AIDS prevention and treatment, 'conversion therapies' and 'corrective rapes', intersex health disparities, and discrimination from health professionals. We urge the Committee to consider these aspects in the development of the new general recommendations.

4. CERD's explorations of the intersection between the right to health and LGBTI communities

The intersection between the right to health, racial discrimination and LGBTI communities is still a rare topic in CERD concluding observations on states. For instance, in 2014-2016, the Committee did not issue any such recommendations.

Starting from 2017, however, the Committee has occasionally addressed the intersection between the right to health and LGBTI racialized communities. In the case of **Australia**, CERD expressed concerns 'about the reportedly high rate of suicide among indigenous peoples, and in particular lesbian, gay bisexual, transgender, queer and intersex individuals.'⁶⁴ In 2019, in its recommendations to **Colombia**, CERD was concerned 'about the increase in discriminatory views, racial hatred and xenophobia in the State party, especially towards migrants, in particular migrants living with HIV and lesbian, gay, transgender, bisexual and intersex migrants.'⁶⁵

In 2021, the Committee included the intersections between racial discrimination and LGBTI in the concluding observations of **Thailand**. The focus was placed on LGBTI persons belonging to ethnic and ethno-religious groups or indigenous peoples.

*The Committee notes with concern the reports of intersecting and multiple forms of discrimination faced by women, children, persons with disabilities and lesbian, gay, bisexual, transgender and intersex persons belonging to ethnic and ethno-religious groups or indigenous peoples, or those who are migrants, refugees or asylum seekers. The Committee notes with concern the reports of various specific barriers faced by these groups in the exercise of their civil, political, economic, social and cultural rights, in particular access to education, health care and employment.*⁶⁶

In 2022, a comprehensive recommendation regarding the right to health of racialized LGBTI persons was issued by CERD to **Brazil**. The Committee manifested its concern about 'the reports of undignified and violent obstetric practices experienced by Afro-Brazilian women, including women with disabilities and those who identify as LGBTQI+ women, during the provision of sexual and reproductive services.'⁶⁷ Moreover, the Committee recommended that Brazil:

*Increase anti-racism and human rights-based training of all health-care professionals involved in the provision of sexual and reproductive health care to Afro-Brazilian, indigenous and Quilombola women, including those with disabilities and who identify as LGBTQI+ women, while also ensuring accountability and remedies for any forms of obstetric violence.*⁶⁸

We highly commend the Committee's recommendations on the right to health as pertaining to racialized LGBTI persons and communities. We ask CERD to continue and deepen this practice, and to reflect it in its new general recommendation.

5. UN Special Procedures' advancements regarding the intersection between the right to health and LGBTI communities

The right to health of racialized LGBTI people, including indigenous, migrant, and African descendants, has been deeply impacted by historical and systematic injustices due to slavery, colonialism, xenophobia, transphobia, homophobia, sexism and racism.⁶⁹ Under the UN mechanisms of special procedures, various mandates have documented the challenges faced by racialized LGBTI individuals in the realization of their right to health.

For instance, it has been pointed out that access to healthcare becomes challenging for LGBTI migrants during their migration route and upon reaching their destination countries. Many trans and non-binary migrants interrupt their gender transition treatments, resort to hazardous self-medication and expose themselves to health risks.⁷⁰ This vulnerability worsens upon arrival, as they face increased discrimination fueled by xenophobia, transphobia, and homophobia. In Spain, trans migrant sex workers are particularly susceptible to health-related issues, while in Ireland, research has revealed that over 50% of LGBT migrants rated their mental health negatively.⁷¹

Afro and indigenous LGBTI persons also referred to exclusion in the health system. In Peru, trans persons of color shared the high difficulties they face when accessing to health care.⁷² Moreover, a recent study in the United States determined that '23% of LGBT adults of colour, 22% of trans adults, and 32% of trans adults of colour have no form of health coverage. Black LGBT adults (23%), Latinx LGBT adults (24%) and all transgender women (29%) are most likely to have avoided going to the doctor because of costs.'⁷³ In Canada, Two-Spirit persons also highlighted the lack of access to health and safety services during the country visit of the Special Rapporteur on violence against women and girls.⁷⁴

Both the Working Group on People of African Descent and the Independent Expert on SOGI demonstrated how the institutional racism of health centers during the COVID-19 response generated stigma and exclusion of racialized LGBTI people which impeded a proper protection against contagion.⁷⁵

According to the Special Rapporteur on health, 'the full picture of the impact of racism on the right to health cannot be discerned without disaggregating health data by race, ethnicity, gender, age, sexual orientation, gender identity, disability, rural or urban location, among other factors.'⁷⁶ She also described, as an example of good practices in public health interventions, a case from Brazil where 'the National Policy for the Integral Health of the Black Population, besides indicating the diseases that most affect the Black population, includes specific objectives to incorporate the theme of combating gender and sexual orientation discrimination, with an emphasis on the intersections with the health of the Black population.'⁷⁷

A number of UN special procedures mandates, notably those focusing on racial discrimination, the right to health and SOGI, have addressed issues faced by racialized LGBTI persons in accessing health care. This confirms the need to update the draft general recommendation to include direct references to LGBTI / SOGIESC.

Conclusions

1. It is crucial that CERD acknowledges the presence of LGBTI individuals within racialized groups, ethnic minorities, indigenous peoples and refugees. Achieving a comprehensive understanding of the right to health demands recognition of the intersections between these identities and power systems.
2. It is essential to recognize that the enjoyment of health by many LGBTI persons is intricately influenced by the intersections of SOGIESC and racial discrimination.
3. CERD and other UN treaty bodies have integrated an intersectional approach into their practice, to the extent that intersectionality has become a human rights standard. Embracing intersectionality demands CERD to pay attention to the specific health issues that confront LGBTI communities.
4. CERD has included LGBTI communities in its concluding observations on several occasions. It is crucial for CERD to consistently consider various intersections, including those related to SOGIESC, in its work. Furthermore, it is essential for CERD to prioritize the right to health of LGBTI individuals in its concluding observations.
5. By incorporating LGBTI health concerns and tailored recommendations into the new general recommendation No. 37, it will be possible to work towards safeguarding the right to health of racialized LGBTI communities.
6. To achieve an intersectional approach, certain revisions should be made to the draft general recommendation No. 37. Paragraphs should explicitly encompass SOGIESC as "key social determinants" and as "grounds of discrimination". Moreover, COVID-19's impact on LGBTI communities must be recognized, and references to LGBTI / SOGIESC should be made concerning the effect of racial discrimination on physical and mental health, sexual and reproductive health, and the need to collect data disaggregated by SOGIESC.
7. Considering the lack of data addressing the intersections between racial discrimination, ethnicity, migrant and refugee status, indigenous status and SOGIESC, CERD should emphasize the obligations of States parties to collect comprehensive data on the right to health that include the intersections between the topics mentioned.

Annex 1 – Notes

¹ **Sexual orientation** refers to each person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender.

Gender identity refers to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms.

Gender expression refers to each person's presentation of the person's gender through physical appearance – including dress, hairstyles, accessories, cosmetics – and mannerisms, speech, behavioral patterns, names and personal references, and noting further that gender expression may or may not conform to a person's gender identity.

Sex characteristics refers as each person's physical features relating to sex, including genitalia and other sexual and reproductive anatomy, chromosomes, hormones, and secondary physical features emerging from puberty.

For these definitions see, The Principles on the application of international human rights law in relation to sexual orientation and gender identity (Yogyakarta Principles) and The Additional Principles and State obligations on the application of international human rights law in relation to sexual orientation, gender identity, gender expression and sex characteristics to complement the Yogyakarta Principles (Yogyakarta Principles plus 10), available at <https://yogyakartaprinciples.org>.

² Lesbian, gay, bisexual, trans and intersex.

³ Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance, Report to UNGA, [A/76/434](#) (2021) 88 (b).

⁴ CERD, 'General Recommendation XXV on gender-related dimensions of racial discrimination', [A/55/18](#) (2000) 5: "As part of the methodology for fully taking into account the gender-related dimensions of racial discrimination, the Committee will include in its sessional working methods an analysis of the relationship between gender and racial discrimination, by giving particular consideration to: (a) The form and manifestation of racial discrimination; (b) The circumstances in which racial discrimination occurs; (c) The consequences of racial discrimination; and, (d) The availability and accessibility of remedies and complaint mechanisms for racial discrimination."

⁵ CERD, 'General Recommendation No 32 on the meaning and scope of special measures in the International Convention on the Elimination of All Forms of Racial Discrimination' [CERD/C/GC/32](#) (2009) 7: "The principle of enjoyment of human rights on an equal footing is integral to the Convention's prohibition of discrimination on grounds of race, colour, descent, and national or ethnic origin. The "grounds" of discrimination are extended in practice by the notion of "intersectionality" whereby the Committee addresses situations of double or multiple discrimination - such as discrimination on grounds of gender or religion - when discrimination on such ground appears to exist in combination with a ground or grounds listed in article 1 of the Convention [...]."

⁶ See, for instance, CRPD, 'General Comment No 3 on women and girls with disabilities' [CRPD/C/GC/3](#) (2016); 'General Comment No 4 on the right to inclusive education' [CRPD/C/GC/4](#) (2016); 'General Comment No 6 on the right to inclusive education, on equality and non-discrimination' [CRPD/C/GC/6](#) (2018).

⁷ CRPD, 'General Comment No 3 (n 6) 16.

⁸ CEDAW, 'General recommendation No 28 on the core obligations of States parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women' [CEDAW/C/GC/28](#) (2010) 18.

⁹ CEDAW, 'General recommendation No 35 on gender-based violence against women, updating general recommendation No 19' [CEDAW/C/GC/35](#) (2017) 12.

¹⁰ See, for example, CERD, Concluding observations: Portugal [CERD/C/PRT/CO/18-19](#) (2023) 14; Concluding observations: Russian Federation [CERD/C/RUS/CO/25-26](#) (2023) 17(a); Concluding observations: Brazil [CERD/C/BRA/CO/18-20](#) (2022) 6.

¹¹ Patrick Thornberry, *The International Convention on the Elimination of all Forms of Racial Discrimination: A Commentary* (OUP 2016) 137.

¹² Mulabi, *IV Producto: Informe país de la situación de los derechos humanos de las personas LGBTI con enfoque en COVID-19* (2022) 15.

¹³ Inter-American Commission on Human Rights, "Economic, Social, Cultural and Environmental Rights of Persons of African Descent: Inter-American Standards to Prevent, Combat and Eradicate Structural Racial Discrimination" (2021), [OEA/Ser.LV/II](#). See para. 50: "the IACHR finds it essential to shed light on the relationship between different categories of vulnerability (age, gender, migratory status, disability, sexual orientation and gender identity, socioeconomic status, inter alia), and how they intersect with African Descent ethno-racial background giving rise to patterns of structural racial discrimination." Para. 179: "In this context, the Commission and its REDESCA stress the duty of the States of the region to design and implement health policies focused on the African Descent population to guarantee its access and coverage in the health system, as well as guarantee non-discrimination in the exercise and enjoyment of this right. For the design of these policies, from a human rights approach, it is crucial to take into account the intersection between this ethno-racial background, and other conditions such as gender, disability, condition as a child or adolescent or older person, deprivation of liberty, belonging to LGBTI groups, or socioeconomic background, among other factors."

¹⁴ Inter-American Commission on Human Rights (IACHR), *Pandemic and Human Rights* (2022), [OEA/Ser.LV/II](#). See section 4.2, 'Main impacts of the pandemic on groups in situation of special vulnerability and historical discrimination'; "[Resolution 1/2020: Pandemic and Human Rights in the Americas](#)" (2020). The IACHR considered "LGBTI people" as part of "III. Particularly vulnerable groups." See also paras. 68-71, focused on LGBTI persons. See also, IE SOGI, *The impact of the COVID-19 pandemic on the human rights of LGBT persons*, Report to the UNGA [A/75/258](#) (2020). This report states that 'information received allows the IE SOGI to conclude that COVID-19 has a disproportionate impact on LGBT persons; that, with few exceptions, the response to the pandemic reproduces and exacerbates the patterns of social exclusion and violence already identified by the IE SOGI; and that urgent measures must be adopted by States and other stakeholders to ensure that pandemic responses are free from violence and discrimination.'

¹⁵ Mulabi, *IV Producto* (n 12) 21-22. Evidence also suggests that trans and gender-diverse individuals were one of the most affected by the pandemic; for instance, some were asked by health care professionals about their previous identification document, that did not reflect their gender identity, and the supply of antiretrovirals was shortened.

¹⁶ *ibid* 17.

¹⁷ See sub-section of this report titled 'Mental health issues: Suicidal ideation, depression, anxiety, use of substances, stress and isolation.'

¹⁸ American Progress, '[Discrimination Prevents LGBTQ People From Accessing Health Care](#)' (2018).

¹⁹ Sara Hamed et al, '[Racism in healthcare: a scoping review](#)' (2022), 22 *BMC Public Health* 998.

²⁰ Diane E Elze, 'The Lives of Lesbian, Gay, Bisexual, and Transgender People: A Trauma-Informed and Human Rights Perspective' in Lisa D Butler, Filomena M Critelli and Janice Carello (eds), *Trauma and Human Rights: Integrating Approaches to Address Human Suffering* (Palgrave Macmillan 2019).

²¹ ML Hatzenbuehler, 'Social factors as determinants of mental health disparities in LGB populations: implications for public policy' (2010) 4 *Soc Issues Policy Rev* 31.

²² World Health Organization, '[Tackling structural racism and ethnicity-based discrimination in health](#)'.

²³ Janet M Turan et al, '[Challenges and opportunities in examining and addressing intersectional stigma and health](#)' (2019) 17 *BMC Med* 7.

- ²⁴ Anne L Stangl et al, [‘The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigma’](#) (2019) 17 BMC Med 31.
- ²⁵ Zhan Chiam et al, *Trans Legal Mapping Report 2019: Recognition before the law* (ILGA World 2020).
- ²⁶ IE SOGI, Report to UNGA [A/72/172](#) (2017).
- ²⁷ Gobierno de Chile, *Dossier temático de Migración Mesa LGBTIQ+* (2022) 5.
- ²⁸ Catherine Galaz, ‘Salud y construcción de la diferencia sexual y racial’, PRODEMU, Universidad de Chile 16.
- ²⁹ *ibid* 19.
- ³⁰ The Fenway Institute, [Health Care Considerations for Two Spirit and LGBTQIA+ Indigenous Communities](#) (2022).
- ³¹ National LGBT Health Education Center, [Understanding and Addressing the Social Determinants of Health for Black LGBTQ People](#) (2019).
- ³² Center for American Progress, [Discrimination and Experiences Among LGBTQ People in the US: 2020 Survey Results](#) (2021).
- ³³ Centers for Disease Control and Prevention, [Suicide: 2002 Official Final Data](#) (2004).
- ³⁴ HIV.gov, [Half of black gay men and a quarter of Latino gay men projected to be diagnosed within their lifetime](#) (2016).
- ³⁵ Centers for Disease Control and Prevention, [Transgender Women Urgently Need More HIV Prevention and Treatment Services. New CDC Data Shows](#) (2021).
- ³⁶ Sarah Doan-Minh, [‘Corrective Rape: An Extreme Manifestation of Discrimination and the State’s Complicity in Sexual Violence’](#) (2019) 30 Hastings Women’s Law Journal 167.
- ³⁷ Waruguru Gaiitho, [Curing ‘corrective’ rape: Conceptualising a dual-pronged approach to sexual violence against Black lesbians in South Africa](#) (LeidenLawBlog, 2021).
- ³⁸ IACHR, *Violencia contra personas LGBTI* (2015), [OAS/Ser.LV/II.rev.2](#). See also, Agencia Presentes Org, [De qué hablamos cuando hablamos de violencia a personas LGBT+](#) (2023).
- ³⁹ Special rapporteur on the right to health, Report to HRC [A/HRC/47/28](#) (2021) 54.
- ⁴⁰ Working Group of Experts on People of African Descent, Country Visit to Peru [A/HRC/45/44/Add.2](#) (2020) 69.
- ⁴¹ Instituto Internacional sobre Raza, Igualdad y Derechos Humanos, [La deuda pendiente con la población Afro-LGBT en Brasil, Colombia, Perú y República Dominicana](#) (2021) 52.
- ⁴² *ibid* 51.
- ⁴³ IACHR, *Economic, Social, Cultural and Environmental Rights of Persons of African Descent: Inter-American Standards to Prevent, Combat and Eradicate Structural Racial Discrimination* (2021), [OEA/Ser.LV/II](#) 57.
- ⁴⁴ Laetitia Zeeman and Kay Aranda, [A Systematic Review of the Health and Healthcare Inequalities for People with Intersex Variance](#) (2020) 17 Int J Environ Res Public Health 6533.
- ⁴⁵ UN OHCHR, [Human Rights Violations Against Intersex People](#) (2019) 28.
- ⁴⁶ Human Rights Watch, [I Want to Be Like Nature Made Me: Medically Unnecessary Surgeries on Intersex Children in the US](#) (2017).
- ⁴⁷ Pan American Health Organization, [‘Therapies’ to change sexual orientation lack medical justification and threaten health](#) (2012).
- ⁴⁸ Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Report to UNGA, [A/HRC/22/53](#) (2013) 18.
- ⁴⁹ Legal Resources Centre, [Submissions to the Office of the United Nations High Commission for Human Rights on Youth and Human Rights Issues](#) 7-13.
- ⁵⁰ *ibid*.
- ⁵¹ UN OHCHR, [Acabar con las ‘terapias de conversión’, la lucha de un experto en derechos humanos](#) (2022).
- ⁵² *ibid*.
- ⁵³ Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Report to UNGA [A/74/148](#) (2019).
- ⁵⁴ IE SOGI, Report to UNGA [A/74/181](#), (2019).
- ⁵⁵ IE SOGI, Report to HRC [A/HRC/38/43](#) (2018).
- ⁵⁶ Outright International Africa Programme, [When Conversion ‘Therapy’ Practices Amount to Torture, All African Governments Must Act](#) (2023).
- ⁵⁷ Principle 10 of the Yogyakarta Principles (n 1). The Special Rapporteur on torture has suggested that ‘given that “conversion therapy” can inflict severe pain or suffering, given also the absence both of a medical justification and of free and informed consent, and that it is rooted in discrimination based on sexual orientation or gender identity or expression, such practices can amount to torture or, in the absence of one or more of those constitutive elements, to other cruel, inhuman or degrading treatment or punishment.’ Report to UNGA, [A/74/148](#) (2019).
- ⁵⁸ European Parliament, [Bans on conversion ‘therapies’. The situation in selected EU Member States](#) (2022) 2.
- ⁵⁹ Catherine Galaz (n 28) 5.
- ⁶⁰ *ibid* 14.
- ⁶¹ *ibid*.
- ⁶² Gobierno de Chile (n 27) 18.
- ⁶³ Susanna D Howard et al, ‘Healthcare Experiences of Transgender People of Color’ (2019) 34 Journal of General Internal Medicine 2068.
- ⁶⁴ CERD, Concluding observations: Australia [CERD/C/AUS/CO/18-20](#) (2017) 23-24.
- ⁶⁵ CERD, Concluding observations: Colombia [CERD/C/COL/CO/17-19](#) (2020) 10.
- ⁶⁶ CERD, Concluding observations: Thailand [CERD/C/THA/CO/4-8](#) (2022)13.
- ⁶⁷ CERD, Concluding observations: Brazil (n 10) 16(d).
- ⁶⁸ *ibid* 17 (e).
- ⁶⁹ Working Group of Experts on People of African Descent, ‘The Urgency of Now: Systemic Racism and the opportunities of 2021, Report to the UNGA [A/76/302](#) (2021) 64.
- ⁷⁰ IE SOGI, Report to the UNGA [A/74/181](#) (2019) 54.
- ⁷¹ *ibid* 58.
- ⁷² Working Group of Experts on People of African Descent, Report of the Working Group of Experts on People of African Descent on its visit to Peru [A/HRC/45/44/Add.2](#) (2020) 69.
- ⁷³ IE SOGI (n 14) 26.
- ⁷⁴ Special Rapporteur on violence against women and girls, Report on the mission to Canada [A/HRC/41/42/Add.1](#) (2019) 55.
- ⁷⁵ Working Group of Experts on People of African Descent, Report of the Working Group of Experts on People of African Descent: COVID-19, systemic racism and global protests, Report to the HRC [A/HRC/45/44](#) (2020) 26; IE SOGI (n 73) 37.
- ⁷⁶ Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report to UNGA [A/77/197](#) (2022) 8.
- ⁷⁷ *ibid* 75.

Annex 2 – Information about submitting organisations

ILGA World (International Lesbian, Gay, Bisexual, Trans and Intersex Association), <https://ilga.org>, established in 1978, is a federation of more than 1,700 organisations from over 160 countries and territories campaigning for lesbian, gay, bisexual, trans and intersex (LGBTI) human rights. ILGA World enjoys the ECOSOC status, consistently engaging with UN human rights bodies, and conducts legal and socio-economic research on the situation of LGBTI persons. ILGA World supports local LGBTI civil society groups engaging with United Nations treaty bodies, special procedures and the Human Rights Council. It also produces research publications on social and legal situation of LGBTI persons. This includes [Annual Treaty Bodies Reports](#), [Treaty Bodies Strategic Litigation Toolkit](#), [Special Procedures Factsheets](#) and [ILGA World Database](#).

Mulabi is a non-governmental, non-profit, horizontal organization that brings together activists from the Global South of diverse identities (sexual, gender, ethnic, nationality and others). It works on sexualities and rights from a critical and celebratory point of view, promoting empowerment and autonomy especially for the most excluded people. Mulabi disseminates Latin American perspectives on these issues, using as its main strategy the common construction of transformative knowledge.

Manodiversa aims to fill gaps in Bolivia and the world, as there is currently no continuous and planned work focused on bisexual individuals, older adults, indigenous communities, peasants, native people, Afro-descendants, and people living in rural and peri-urban areas. Until now, only sporadic and unsustainable interventions have been carried out.

Diversa Patagonia is a regional NGO established in 2021 with the purpose of working to educate, make visible and defend the human and social rights of people with diverse sexual orientations, gender identities and expressions, and sexual characteristics (SOGIESC) of the Aysén Region, Chilean Patagonia.

Red Nacional de Refugiades y Migrantes LGBTIQ+ was created in 2020 seeking to make visible the forced migrations of diverse people who seek an opportunity to improve their living conditions in Chile, and also to protect their lives from the persecution by the States of their countries of nationality, due to their gender expression, sexual orientation and gender identity, situations that today are invisible, by the non-recognition by States of the human rights of diverse people.