

LGBTI+ HEALTH EQUITY

A GLOBAL REPORT OF **50 FAST-TRACK CITIES**



FAST-TRACK
CITIES

IAFAC
INTERNATIONAL ASSOCIATION
OF PROVIDERS OF AIDS CARE



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About IAPAC

The International Association of Providers of AIDS Care (IAPAC) was founded in 1985 with a mission to improve access to and the quality of prevention, care, treatment, and support services delivered to people living with and affected by HIV and comorbid diseases, including tuberculosis and viral hepatitis (HBV and HCV). With more than 30,000 members globally and programming in over 150 countries, IAPAC is the largest association of clinicians and allied health professionals working to end the epidemics of HIV, TB, and viral hepatitis by 2030.

About Fast-Track Cities

The Fast-Track Cities initiative leverages data-driven, equity-based public health policy and implementation science to mobilize and support cities and municipalities worldwide in their efforts to achieve Sustainable Development Goal (SDG) 3.3 — ending the epidemics of HIV, tuberculosis (TB), and viral hepatitis (HBV and HCV) by 2030 — and SDG 11 — making cities and municipalities inclusive, safe, resilient, and sustainable. The initiative is a global partnership between cities and municipalities around the world and four core partners: the International Association of Providers of AIDS Care (IAPAC), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Human Settlements Programme (UN-Habitat), and the City of Paris. Launched on World AIDS Day 2014, the network has grown to include more than 350 cities and municipalities.

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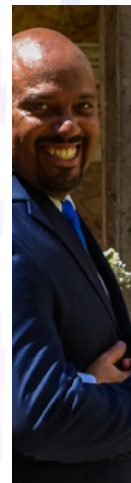
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Introductory Letter

Last year — in the midst of COVID-19 (a global pandemic unlike anything we have seen in the last century) — the International Association of Providers of AIDS Care (IAPAC) began an ambitious plan to launch a global report on LGBTI+ health equity during Copenhagen 2021, a WorldPride celebration and human rights forum. The report, which we are launching today, is unique for its focus on cities, where half of the world's 7 billion citizens live, and because it allows us to compare LGBTI+ health equity issues globally. We selected 50 cities that are or soon will be part of the Fast-Track Cities network to serve as examples in a report aimed at informing current and future Fast-Track Cities as well as all of those working to end LGBTI+ health inequities.

The link between LGBTI+ health equity and our work at IAPAC is perhaps obvious given the longstanding and staggering disparities that LGBTI+ individuals face with respect to HIV. While HIV continues to be a critical issue in LGBTI+ health, we cannot allow that to be the only LGBTI+ health topic that is studied, discussed, funded, and actioned. Fundamentally, LGBTI+ health equity is about stigma, discrimination, and injustice, but also about resilience. The history of conditions facing LGBTI+ communities has led to myriad health inequities — including physical, mental, and behavioral — that are all interwoven.

Globally, 275 key informants from four geographic regions scored their local LGBTI+ quality of life an average score of 3.2 on a 1 to 5 scale — about halfway between “poor” and “excellent.” No region came close to perfect on markers of LGBTI+ health equity, including access to care, quality of life, and nondiscrimination. Even cities with relatively good scores had room for improvement. And while cities that had better policies and more community visibility tended to score better among key informants, there were some surprises. For example, Tokyo scored slightly lower on LGBTI+ quality of life than did Kampala, where an anti-LGBTI+ political agenda has made headlines for years.

These results reveal two important insights. First, no one factor is determinative in LGBTI+ well-being, and many aspects of health equity (e.g., social determinants of health, quality care, nondiscrimination) must all be addressed to achieve better outcomes. Inclusive policies on paper will do little to change LGBTI+ health inequities if they are not correctly implemented and if cultural change does not occur concurrently. Moreover, the colliding COVID-19 and HIV pandemics have taught us that medical and scientific advancements can increase health inequities if entire populations are denied access to their benefits.

Second, LGBTI+ community leaders likely judge their city based on local factors, such as how LGBTI+ people are faring relative to non-LGBTI+ people locally and compared to other LGBTI+ people regionally — not in terms of global conditions. This helps explain how key informants in cities with vast differences in wealth, for example, often scored LGBTI+ socioeconomic problems as being roughly equal. The results should encourage those working in areas considered to be LGBTI+ inclusive that there is still much work to be done; the report should also bring pride to LGBTI+ advocates working in difficult conditions, knowing that their communities are more resilient than many people might think.

The bottom line is that we cannot adequately address HIV and other health conditions without including LGBTI+ populations, and we cannot adequately serve LGBTI+ populations unless we understand the diversity and complexity of these communities and their needs. Those of us working in the field of health and in any other topic area relevant to LGBTI+ health equity must recommit ourselves to working holistically to end the disparities these communities face. No one law, policy, or program will fix these challenges; rather, we must address the pervasive issues of stigma and inequality that comprise their core. Doing so begins with understanding what we know about disparities, and what we still need to learn, and in that respect, I hope this report will contribute to ending LGBTI+ health inequities.

In solidarity with LGBTI+ communities,

18 August 2021
Washington, DC

Executive Summary

BACKGROUND

Sexual and gender minority groups experience health disparities because of myriad overlapping social-ecological, cultural, and political factors. Lesbian, gay, bisexual, transgender, intersex, and other sexual and gender minority (LGBTI+) populations have higher incidence and prevalence of life-threatening physical conditions, mental health problems, chronic and infectious disease risk, violence and victimization, and discrimination; experience significant barriers to accessing health care, treatment, and retention in care; and face substantial threats to quality of life. Understanding and improving the health of LGBTI+ communities is critical to the goals of the Fast-Track Cities initiative because of the disproportionate burden of HIV among this population but also because of the interconnectedness between HIV and other health and social conditions facing them. The main objective of this project is to advance health equity among LGBTI+ individuals across current and prospective Fast-Track Cities by studying and comparing LGBTI+ health inequities. Fast-Track Cities are signatories of the *Paris Declaration on Fast-Track Cities* and thus members of the Fast-Track Cities network, and they have committed to ending AIDS as a public health threat by 2030.

METHODS

This study examined 50 current and prospective Fast-Track Cities, including 10 from Africa, 20 from the Americas, five from the Asia-Pacific region, and 15 from Europe. The study included two components. First, a key informant survey was conducted among individuals who study, work, or volunteer in LGBTI+ health equity related fields and who have knowledge of their local LGBTI+ community. Participants were recruited through virtual outreach and snowball sampling. The second component of the study were comprehensive assessments of publicly available data and policies. Four domains were developed for assessing health equity among LGBTI+ populations: health outcomes, socioeconomic factors, community trauma, and community resiliency. These domains were designed to assess health equity in broad terms that includes social determinants of health and underlying socioeconomic, political, and legal conditions that affect health equity.

RESULTS

Overall, 275 key informants rated quality of life for LGBTI+ people at 3.2 out of 5, about in the middle between a “poor” rating of one and an “excellent” rating of five. Only 15 key informants worldwide said that LGBTI+ quality of life in their city was “excellent.” The regional averages ranged from a low of 2.7 in the African cities to a high of 3.6 in the Asia-Pacific region cities, with the Americas and Europe falling in the middle with scores of 3.2 and 3.3, respectively. However, within each region there was wide variability; for example, in the Asia-Pacific region, Quezon City scored a 4.0 while Tokyo scored only 2.2.

Data assessments revealed many health disparities among LGBTI+ people, including with respect to HIV, sexually transmitted infections (STIs), mental health, substance use, and noncommunicable diseases. However, many cities lacked data beyond HIV among sexual minority men and transgender women, and some other conditions with respect to sexual minority men only. These results indicate a dire need for disaggregated data on LGBTI+ health, particularly at the local level, where interventions are implemented.

How Concerning are Issues Relating to Social Determinants of Health, on a 1-4 Scale?*

Housing access	3.2
Gender identity discrimination	3
Intersectional discrimination	3
Employment access	2.9
Sex worker treatment	2.9
Criminal justice for people of color	2.8
Sexual orientation discrimination	2.7
Police mistreatment	2.6
HIV status discrimination	2.4
Food access	2.4
Police targeting	2.3

* Scores on a scale of 1 (“not a problem”) to 4 (“serious problem”).

HIV-related services received by far the best rating when looking at access to care for LGBTI+ individuals, scoring a 3.8 on a 1 to 5 scale. Primary care was next, with a score of 3.1, followed by mental health care at 2.8, and gender-affirming care at 2.7. These trends were relatively consistent across the study's four regions and reaffirm the status of HIV care providers as leaders in LGBTI+ health equity, but also highlight the need for more focus on mental health and services for transgender individuals.

The vast majority of key informants found issues relating to social determinants of health — including socioeconomic opportunity, discrimination, and criminal justice involvement — to be at least somewhat problematic for their communities. Globally, housing access was rated as the most pressing challenge, with a score of a 3.2 on a 1 to 4 scale, in which a 1 indicated the issue was “not a problem,” 2 indicated a “minor problem,” 3 indicated a “moderate problem,” and 4 indicated a “serious problem.” Housing was followed by gender identity-based discrimination (3), discrimination against LGBTI+ people with multiple marginalized identities (3), employment access (2.9), and issues relating to sex work (2.9). In most cities, sexual orientation-based discrimination (2.7) and HIV discrimination (2.4) were found to be less problematic than gender identity discrimination (3), although there was some variation by city. Among socioeconomic issues, food access (2.4) was rated well below employment opportunities (2.9) and housing access (3.2), and among criminal justice issues, problems such as mistreatment by police (2.6) and the impact on LGBTI+ people of color (2.8) were rated higher than whether LGBTI+ people are being targeted or arrested by police due to anti-LGBTI+ bias (2.3).

While the severity of these social challenges varied between regions and individual cities, many of the trends were consistent. Most key informants found socioeconomic challenges to be problems for their community regardless of the overall wealth or poverty in their city. For example, the three cities in which the problem of housing access was most highly rated were San Francisco (where every key informant said it was a “serious problem”), Denver, and Dublin; these cities may be wealthy on a global scale, but the survey results demonstrate that inequities facing LGBTI+ people persist. Key informants rated the response by local institutions to these socioeconomic challenges to be at or below the midway point on a 1 to 5 scale; for example, the local response to LGBTI+ housing problems was rated just a 2.6.

Similarly, while LGBTI+ nondiscrimination laws varied widely, key informants considered discrimination against LGBTI+ people to be a problem in every city. Many key informants noted nondiscrimination policies as being a positive factor for those cities that had enacted them, and a prospectively positive factor for those who desired them, but concerns relating to underlying stigma and discrimination were universally reported. This helps explain how only 6% of key informants globally said that gender identity-based discrimination was “not a problem” in their city, despite the fact that more than 6% of them hailed from cities where nondiscrimination policies are in place.

In terms of sources of resilience, community-based organizations (CBOs) and informal social networks were the two most common sources named by key informants. When asked which type of entity best engaged with local LGBTI+ communities, CBOs scored highest at 3.9 globally compared to 3.1 healthcare providers, 3.0 for local government, and a 2.9 for the private sector. Suggestions for improving resilience included more and equitable access to funding for local CBOs; visible support from local political, community, and religious leaders; policies that recognize LGBTI+ identities and address discrimination; consistent, institutionalized, and authentic engagement with LGBTI+ communities; a stronger focus on subpopulations within the LGBTI+ population that face particularly strong challenges, such as transgender people and racial and ethnic minorities; and education of the public and those in the healthcare field to reduce LGBTI+ stigma, including within the context of improving health services.

RECOMMENDATIONS

To address both the health inequities documented in this research and the gaps in data that it revealed, action is needed at all levels of government and from external partners. While the focus of this report is on cities, urban and municipal leaders are most effective when they have the support — rather than opposition — of national and international actors. More detailed recommendations are included at the end of the report, but following is a summary of the overarching recommendations:

- 1. PRIORITIZE** the elimination of inequities within LGBTI+ communities. These include those affecting racial and ethnic minorities, immigrants, low-income individuals, and people with disabilities, as well as needs specific to transgender and nonbinary people.
- 2. ADDRESS** underlying socioeconomic factors. Issues such as access to housing, employment, and food were identified as LGBTI+ community challenges by the majority of key informants, even in resource-rich settings.
- 3. IMPROVE** inclusive data collection. There is a dearth of disaggregated data to offer insights into LGBTI+ health, particularly outside of HIV and notably relevant to key populations beyond sexual minority men.
- 4. ADDRESS** criminal justice disparities. Even in places where LGBTI+ identities are not formally criminalized, issues relating to police mistreatment, sex work laws, and criminalization of HIV exposure were identified as barriers to LGBTI+ health equity.
- 5. ENSURE** LGBTI+ nondiscrimination. Many cities lacked even basic LGBTI+ legal protections, including nondiscrimination ordinances or laws, and even where these legal protections exist, many key informants reported the need for better education and awareness to address LGBTI+ stigma.
- 6. ENGAGE** LGBTI+ communities. While most cities had some formal means in place of engaging with LGBTI+ communities, key informants indicated that more engagement was needed, and rated CBOs as better than other local actors in their efforts to sustain engagement.
- 7. RECOGNIZE** gender minorities and their health needs. Healthcare services for transgender people were rated well below general LGBTI+ inclusive care, and key informants noted that discrimination based on gender identity was a major concern.
- 8. IMPROVE** health systems. Key informants revealed a dire need for training and inclusion measures to improve the LGBTI+ experience in accessing and utilizing LGBTI+ inclusive health services.
- 9. FOSTER** multisectoral collaboration. While this report is focused on cities, the LGBTI+ health challenges identified herein require collaboration between local, national, and international entities, including multisectoral representation. The Fast-Track Cities initiative itself offers evidence that such an approach is possible and effective.
- 10. SUPPORT** HIV service providers as LGBTI+ care leaders. These providers scored better than others in health systems and can help lead the way in policy and practice.

CONCLUSION

THE LGBTI+ HEALTH INEQUITIES IDENTIFIED IN THIS REPORT ARE WIDE-RANGING AND PERVASIVE.

While many differences exist between local contexts, the underlying stigma, discrimination, and lack of visibility that causes these inequities are largely the same, as are the sources and effects of the LGBTI+ communities' resilience and the policies that could foster change. Ending health inequities must include addressing social determinants of health (e.g., housing, employment, public safety) that are intertwined with health conditions. Lasting and widespread progress must be achieved through a multisectoral and multilateral approach in which diverse actors — including city governments and local communities — are helping lead the way.

Background

LGBTI+ COMMUNITIES AND THEIR HEALTH

SUSTAINABLE DEVELOPMENT GOALS AND FAST-TRACK CITIES

To address LGBTI+ health equity in Fast-Track Cities, the issue must be framed within the context of the Sustainable Development Goals (SDGs) and the Fast-Track Cities initiative. The SDGs were launched in 2015 as part of the *2030 Agenda for Sustainable Development*.¹ In relation to LGBTI+ communities, SGD 3 calls for United Nations (UN) member-states to “[e]nsure healthy lives and promote well-being for all at all ages,” and it includes subgoals that relate directly to areas where LGBTI+ populations experience disparities. These include with respect to efforts to end the HIV epidemic, ensure access to sexual and reproductive health services, and realize the right to universal healthcare. While SDG 3 is the goal within which health is explicitly addressed, all of the SDGs are relevant to health in that they address social determinants of health, or “the non-medical factors that influence health outcomes” and “the conditions in which people are born, grow, work, live, and age.”² The SDGs that address inequality, resilience, and sustainability all relate to health in important ways. Moreover, SDGs 10 and 11 relate quite explicitly to LGBTI+ health in particular, calling for UN member-states to achieve gender equality and promote inclusive societies.

LGBTI+ HEALTH EQUITY DEFINITIONS AND CONCEPTS

The populations that make up LGBTI+ communities are diverse even within a single city or neighborhood. On a global scale, these communities are even more challenging to define and discuss in uniform terminology. In broad strokes, however, LGBTI+ communities can be described as those comprised of sexual and gender minorities, as well as intersex individuals and those with related identities.

Sexual minorities are individuals whose sexual attraction, behavior, and/or identity is something other than exclusively heterosexual. Some individuals who have sexual relationships that would be described as non-heterosexual — for example, a man who has sexual relations with men and women — may still identify as heterosexual, especially given the different cultural contexts in which sexual orientation is interpreted. While such an individual would not identify as being part of an LGBTI+ community, many of the health risks, stigma, and potential discrimination that they would encounter would be similar. Gay, lesbian, and bisexual are among the most common sexual minority identities, but there are many others, especially outside of the English language and the perspective of the global North.

Gender minorities include individuals whose gender identity is something other than cisgender and may also include individuals whose gender expression rather than identity does not conform with established social norms. Cisgender individuals are those whose sex assigned at birth is the sex or gender with which they identify. For example, someone who was identified as female at birth and who currently identifies as female is likely to identify as cisgender, even if that term is still largely unknown among people outside of the LGBTI+ community. Therefore, gender minorities are typically those whose gender is something other than the sex they are assigned at birth. For example, a person who was assigned female at birth but who actually identifies as male would be a transgender man, and a gender minority. This population also includes a growing number of people who identify as not being either male or female (e.g., genderqueer individuals, nonbinary individuals), those whose gender identity shifts over time (i.e., gender fluid individuals), and those who identify as having no gender at all (i.e., agender individuals). To understand the concept of gender minorities, it is important to understand the difference between sex, which is assigned at birth and is generally related to biological characteristics, and gender — a social construct built around societal and individual norms and individual senses of self.

Intersex individuals are those whose sex characteristics do not fall exclusively into those associated with males or females. These can include differences in chromosomes, primary sex characteristics (i.e., genitalia), secondary sex characteristics, and/or other factors. Most individuals who are intersex are nonetheless assigned male or female at birth, and many are exposed to treatment (criticized by advocates) that attempts to put them in conformity with the sex selected by their healthcare provider or parents, often without the knowledge or consent of the individual. Because intersex identities relate to sex rather than sexual orientation or gender, intersex individuals do not necessarily consider themselves part of sexual or gender minorities, respectively, unless they also happen to have a sexual orientation or gender identity that places them within those categories.

In this report, the acronym LGBTI+ is used as an umbrella term to describe this broad population. Some of the health inequities and needs facing members of this population are similar, yet many are different. Nonetheless, the underlying influences of stigma and discrimination that facilitate the health inequities facing this community are largely interrelated, as are many of the solutions, such as antidiscrimination laws, clinical and service provider trainings, and community outreach. Additionally, members of this population have often banded together to increase their political power and influence, an important practical step given the marginalization they have faced. Therefore, while more research that focuses with exactitude on subpopulations within this broader community is needed, it is also useful to explore the strengths and challenges of LGBTI+ communities as a whole — largely the approach taken by this report. This approach is also necessary in large-scale research (such as what is presented in this report) given the varying approaches taken in data collection — for example, defining sexual minorities by sexual behaviors versus attractions versus identities — which can produce subtle or major differences in the results that require a nuanced rather than direct comparison.

Finally, this report mostly discusses “equity” rather than “equality.” Equality means that two or more things are equal, whereas equity accounts for differing needs as well as concepts relating to justice. For example, providing the same sexual health outreach and services to all individuals might be equal, but it might not be equitable if certain populations have different risks or needs. Similarly, it is important to acknowledge that the differences in health outcomes between LGBTI+ people and others are not only unequal, but are also inequitable, in that they are the result of stigma, discrimination, and other unjust social conditions.

EXPLORING LGBTI+ HEALTH INEQUITIES

There are myriad LGBTI+ health inequities and issues that manifest in different ways across the life course. These are mostly explained, often nonexclusively, by two factors: inherent differences between LGBTI+ people and others, and social conditions that impact LGBTI+ health. For example, transgender individuals need certain forms of care (i.e., gender-affirming hormone therapy) that cisgender people generally do not; they also face difficulties accessing that care for socially constructed reasons (e.g., discrimination, lack of competent providers, underlying financial insecurity due to limited opportunity). Therefore, the unique needs and challenges regarding gender-affirming care reflects both different necessities and also issues related to social justice. The former are important to know, understand, and respond to, but cannot be changed; the latter can be changed through advancing positive policies and changing social conceptions. Higher rates of tobacco use, on the other hand, are an example of a problem affecting the LGBTI+ community not because of an inherent difference in health needs, but rather because of changeable factors in society, such as the targeting of the community by tobacco company advertising and marketing, as well as the minority stress that may cause LGBTI+ people to feel the need to smoke. This concept is critical in that it explains that LGBTI+ health disparities exist not because LGBTI+ people are inherently risky, unsafe, or unhealthy, but because they have different needs from the general population that are frequently not met, and because they face persistent, underlying LGBTI+ related stigma and discrimination.



Physical and Sexual Health

As has been noted, sexual health disparities among LGBTI+ populations — particularly disparities relating to HIV — are among the most widely documented. The Joint United Nations Programme on HIV/AIDS (UNAIDS) reports that the risk of acquiring HIV among transgender and other gender minority individuals is 13 times that of the cisgender population.³ They also found sexual minority men to be at 26 times higher risk for acquiring HIV than other men, with this population comprising 23% of new HIV infections worldwide — a highly disproportionate number compared to their share of the population.⁴ Risk behaviors for HIV acquisition are similar to those of other sexually transmitted infections (STIs) and HIV and certain STIs can also have synergistic relationships in which contracting one makes an individual more susceptible to contract another and/or experience negative health outcomes as a result.⁵ This helps explain why LGBTI+ individuals also have a disproportionate burden of other syndemic conditions such as syphilis or comorbid conditions such as hepatitis C virus (HCV) infection.^{6,7}

Beyond sexual health, there are various physical health conditions for which LGBTI+ populations may be at greater risk. Major noncommunicable disease factors include tobacco and alcohol use as well as insufficient exercise and poor diet.⁸ These risk factors are likely more prevalent among LGBTI+ populations for the reasons described below regarding mental and behavioral health, as well as social determinants of health, and a lack of access to culturally competent care that would allow physical conditions to be quickly diagnosed and effectively treated.

Mental and Behavioral Health

The significant inequities that LGBTI+ people face with respect to mental and behavioral health can be understood through a minority stress framework, in which individual and structural discrimination, stigma, and bias are seen to cause negative mental health outcomes for the population.⁹ At least some level of anti-LGBTI+ bias is found in nearly every society, with much of it being state-sponsored or at least not fully banned. For example, in a global survey of laws relating to sexual minorities, not a single country met every indicator of protections and social recognition for LGBTI+ people.¹⁰ Thus, through the minority stress framework mental health inequities for the LGBTI+ population can be reasonably projected globally, even where research does not exist.

Additionally, there is a large body of literature to provide specific examples of minority stress and/or negative mental health outcomes in a variety of settings. A global review found that LGBTI+ people experienced higher levels of emotional distress, victimization, and other negative health factors, and also faced barriers to getting related care.¹¹ Another international systemic review found specifically that self-stigmatization among gender minorities (a factor of minority stress) was an important factor related to increased incidence of depression, anxiety, and suicidality among this population.¹² Stress within LGBTI+ circles was another factor associated with anxiety and less connectedness to the community among sexual minority women.¹³

Substance use, minority stress, and other mental health conditions are all interconnected among LGBTI+ populations, causing these issues to compound one another.¹⁴ For example, one study found that sexual minority women were more likely to consume alcohol on days when they experienced instances of minority stress or discrimination.¹⁵ In the United States, sexual minority adults were about 50% more likely to have past year tobacco use than were their heterosexual peers,¹⁶ a disparity that arises out of LGBTI+ individuals using tobacco to cope with stress, as well as tobacco companies leveraging LGBTI+ social vulnerabilities to aggressively market their products to this population.¹⁷

Youth and Aging

Health issues can evolve in LGBTI+ people throughout their life cycle, with LGBTI+ youth and older adults facing particular challenges and needs. For example, among youth, bullying in schools is a major problem that denies educational opportunities and creates mental health and other challenges.¹⁸ The UN Independent Expert on sexual orientation- and gender identity-based violence has called for a global ban on efforts to “convert” LGBTI+ people to cisgender and/or heterosexual identities,¹⁹ a practice that disproportionately affects youth and that is legal in most jurisdictions.²⁰ One issue affecting transgender and nonbinary youth in particular is the need to access to gender-affirming care, which they are too often denied despite their vital importance in the lives of this population, according to experts.²¹

With respect to aging, LGBTI+ older adults face many challenges due to their lower levels of social support, including decreased likelihood of being partnered and having children, as well as lower levels of financial support, given a lifetime of compounded limits to their socioeconomic opportunities.²² In places where LGBTI+ rights and social acceptance have been expanding rapidly in recent years, LGBTI+ older adults have not been able to benefit — in terms of their health, socioeconomic standing, internalized acceptance, and acceptance from their peers — to the degree that have younger individuals. This is further complicated by the increased needs faced by older adults with respect to health, housing, and social support.

Intersectionality

Intersectionality is the concept that people of color who are also members of another marginalized identity face unique forms of discrimination. For example, women of color do not just face racism and sexism, but rather encounter intersectional discrimination as women of color that is unique to their population and must be independently understood and addressed.²³ Kimberlé Crenshaw, who originated the concept of intersectionality, has since applied the concept to LGBTI+ people of color.²⁴ Thus, it is important to understand intersectionality not as just interconnected forms of identity, which are part of everyone’s identities, but rather intersecting forms of oppression, a condition that applies only to people who confront multiple forms of marginalization. While this concept will look different across societies, the idea of intersectionality as a framework remains consistently useful and important. For example, issues of race and ethnicity are very different in Amsterdam, Kigali, and Mexico City (three of the Fast-Track Cities featured in this report), each of these societies has both internal dynamics and global contexts (i.e., colonialism) that make the concept of intersectionality important to understanding local LGBTI+ equity. In the United States, for instance, Black transgender and nonbinary individuals are five times more likely to be living with HIV than transgender and nonbinary people in general, and are also more likely to have attempted suicide, been sexually assaulted, or faced violence while incarcerated.²⁵



Social Determinants of Health

In assessing the status of LGBTI+ health equity — and LGBTI+ equity in general — it is critical to consider the underlying social determinants of health that effect LGBTI+ communities. These social determinants are interrelated with LGBTI+ health issues. For example, lack of access to a safe and inclusive education early in the life could cause an LGBTI+ person to have reduced employment opportunities in the future, thus limiting access to adequate housing, nutritious food, and quality healthcare. Most countries do not have full legal protections against LGBTI+ discrimination in areas such as employment and housing,²⁶ and even in jurisdictions that do ban or protect against such discrimination, it still occurs.²⁷ Furthermore, equal access to one aspect of socioeconomic opportunity does not ensure equitable access; for example, a discrimination-free housing market that does not have supports for those who have been denied educational or employment opportunities may be equal, but not equitable.

Criminal Justice Systems

Criminal justice is another issue that has an impact on the health of LGBTI+ individuals, and it is closely intertwined with many social determinants of health. In addition to countries that actually criminalize LGBTI+ identities or behaviors, other criminal laws — such as those criminalizing the transmission of HIV or sex work — can have a disproportionate effect on LGBTI+ people. Moreover, LGBTI+ people are both disproportionately represented in criminal justice systems and can face violence and abuse once in such systems.²⁸ Involvement in the criminal justice system has significant health implications for LGBTI+ people, not only because it impacts other social determinants (by depriving individuals of employment, education, and stable housing, for example) but also because of the connection between criminal justice involvement and mental health²⁹ and conditions such as HIV, HCV, and TB.³⁰

Healthcare Access

Many LGBTI+ health disparities can be caused or compounded by a lack of access to affordable, quality, and culturally competent or responsive care. In countries where LGBTI+ identities or behaviors are criminalized, “coming out” to one’s healthcare provider can have deleterious effects, and in countries where the “promotion” of LGBTI+ identities or behaviors is illegal, providing care to these individuals can represent a criminal act. Furthermore, harmful medical practices such as conversion therapy are harmful in and of themselves, but also serve to discourage future healthcare use; these harmful practices are not banned in the vast majority of jurisdictions.³¹ Another challenge for LGBTI+ healthcare access is a lack of culturally competent healthcare providers who are both able to respectfully interact with LGBTI+ individuals and who understand and respond to their unique health needs.

Urban Health

Finally, while much of this report applies to LGBTI+ health equity broadly, its specific focus is on 50 urban settings. Cities can provide both advantages and disadvantages to LGBTI+ health equity. For example, LGBTI+ resources of all types tend to be concentrated in urban areas, and also may be more accessible due to the presence of public transportation. There are also more healthcare and service providers from which to choose, increasing the chance that LGBTI+ people can confidentially find competent care. On the other hand, the social determinants of health that are particular to or exacerbated in urban areas — which are context-dependent but can include poverty, violence, poor environmental health, and other factors — impact LGBTI+ populations as they do all others. Additionally, because of the underlying socioeconomic vulnerability of LGBTI+ individuals, issues such as poor environmental health due to pollution, unsafe building conditions, and overcrowding might have a more significant impact on LGBTI+ people than non-LGBTI+ people. Therefore, while every city (and its contrasting non-urban surrounding environment) is different, urban health concerns such as these should be considered in assessing LGBTI+ health equity in cities.



Methods

Designing a Global LGBTI+ Health Report

Fifty cities were selected for inclusion in this study, representing four regions: Africa (10), the Americas (20), Asia-Pacific (5), and Europe (15). All but one of the selected cities (Tokyo) are signatories of the *Paris Declaration on Fast-Track Cities* and thus members of the network of more than 350 Fast-Track Cities that have committed to ending the epidemics of HIV, TB, and viral hepatitis by 2030.

Cities Included in the Study

REGION	CITIES
AFRICA	Bamako, Durban (eThekweni), Kampala, Kigali, Lagos, Lusaka, Maputo, Nairobi County, Yaoundé, Windhoek
AMERICAS	Atlanta, Baton Rouge, Buenos Aires, Charleston, Chicago, Columbia, Dallas, Denver, District of Columbia, Kingston, Mexico City, Miami-Dade County, Montréal, New Orleans, New York City, Oakland, Phoenix, Rio de Janeiro, São Paulo, San Francisco
ASIA-PACIFIC	Bangkok, Melbourne, Quezon City, Taipei, Tokyo
EUROPE	Amsterdam, Athens, Berlin, Brussels, Copenhagen, Dublin, Glasgow, Kyiv, Lisbon, London, Madrid, Milan, Paris, Prague, Vienna

Four domains were developed for assessing health equity among LGBTI+ populations, based on a review of existing research on this topic: health outcomes (e.g., prevalence of HIV, mental health conditions, noncommunicable diseases), socioeconomic factors (e.g., employment, housing), community trauma (e.g., discrimination, criminal justice), and community resilience (e.g., civic engagement, resources). These domains were designed to assess health equity in broad terms that includes social determinants of health and underlying socioeconomic, political, and legal conditions that affect health equity. These domains formed the foundation of a two-pronged study whose protocol was granted an institutional review board waiver by Pearl IRB.

This study used two means of gathering data. The first method was an assessment conducted by study personnel regarding health equity across the four domains in each city. Data were collected for regional and global

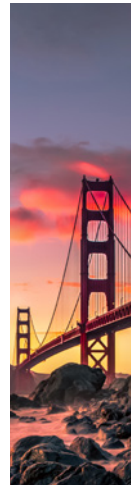
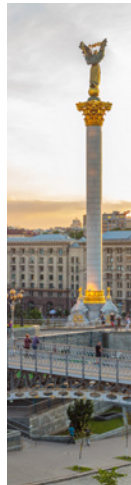
analyses based on a series of indicators selected to cover a range of topics within each domain. Researchers sought city-specific, population-wide data with sexual orientation and gender identity disaggregated for each indicator. When such data were not available, researchers gathered alternative data, such as national data, data from smaller studies, or data that only included a subpopulation of the LGBTI+ community. Some indicators were based on factors beyond public health data. For example, several indicators relate to the criminalization of acts or identities related to LGBTI+ health.

The second method of research was a key informant survey designed to gather the expert opinions of individuals who study, work, or volunteer in fields related to LGBTI+ health equity across the study's four regions. The survey was shared with local contacts in the cities selected for the study, who were asked to participate in the survey themselves if they qualified and/or to share the survey with colleagues, to allow for virtual snowball sampling. The survey was made available in English, French, Portuguese, and Spanish, and included both numerical and open response questions, including several questions across each of the four domains plus a question on overall quality of life for local LGBTI+ people. Some questions utilized a 1 to 5 scale, in which 1 was "poor" and 5 was "excellent," with regard to the availability of services or the performance of different local institutions. Other questions asked key informants to rate potential challenges (i.e., housing access) as being "not a problem," a "minor problem," a "moderate problem," or a "serious problem." City, regional, and global averages were created for the numerical responses and thematic analyses were conducted for open responses.

The following limitations exist with respect to the study:

- There are many gaps in data around LGBTI+ populations and differing cultural understandings and methods of assessing LGBTI+ identities. This makes comparability of data a challenge and thus requires a more nuanced analysis of the data.
- While the key informant survey was open to the public, IAPAC and Fast-Track Cities initiative contacts were encouraged to share the survey with others, thus participation was biased towards those who are connected to IAPAC and/or the Fast-Track Cities network. It is possible that the survey participants were more likely to work in HIV or related fields and were more likely to engage in collaboration with major institutions than the average LGBTI+ health activist or professional. This survey bias towards those who are better connected with major institutions and international collaboration may have been furthered by the limited number of languages in which the survey was available.
- Finally, the cities selected for this study, because they form a part of the Fast-Track Cities network, are perhaps more favorable towards LGBTI+ populations than the global average of cities, not to mention smaller municipalities and rural areas. Therefore, while this study presents findings that might be widely useful outside of the 50 selected cities and the Fast-Track Cities network in general, the results may understate the extent of LGBTI+ inequities in other urban, peri-urban, and nonurban areas.

Notwithstanding these limitations, this study was designed to help identify and fill gaps in the global LGBTI+ health literature — including the lack of consistent and comparable data across cities and regions — and to act as a catalyst for future research and action.



Quality of Life on a 1-5 Scale in a Sample of 20 Cities*

Tokyo	2.2
Kampala	2.3
Athens	2.8
Kingston	2.8
Dublin	3
Maputo	3
Mexico City	3.2
Charleston	3.2
Miami	3.3
New Orleans	3.3
Bangkok	3.4
Chicago	3.4
London	3.4
Copenhagen	3.5
Denver	3.6
Phoenix	3.6
San Francisco	3.6
Melbourne	3.8
New York City	4
Quezon City	4

* Scores on a scale of 1 ("poor") to 5 ("excellent").

Results

Global, Regional, and City Analyses

This report is novel for its focus on LGBTI+ life in diverse cities but is also in the minority of LGBTI+ research due to its global focus. While the health and well-being of LGBTI+ communities look very different across contexts, this report found a great deal of similarity in the issues and the relative severity of health, policy, socioeconomic, and other challenges LGBTI+ people face.

This section of the report begins with a global overview of research findings and proceeds into regional analyses. Three cities from each region were also selected for individual analyses to provide more in-depth examples of the research findings.

GLOBAL OVERVIEW

In total, there were 275 survey respondents (or key informants) globally who were deemed eligible for inclusion, of whom the majority (51%) are associated with non-profit organizations, 21% with clinics or hospitals, 12% with government, 9% with academia, and the remainder with other settings.

Quality of Life and Care

The overall quality of life for LGBTI+ people was rated at 3.2 out of 5 (mode: 3; SD: 0.95), about in the middle between a "poor" rating of 1 and an "excellent" rating of 5. Only 15 of 275 key informants worldwide said that LGBTI+ quality of life in their city was "excellent," demonstrating significant room for improvement. While there was some correlation between the quality of life score and factors such as local LGBTI+ laws and socioeconomic conditions, there was still a surprising diversity in which cities scored poorly or well. For example, Tokyo and Kampala scored about evenly (2.2 and 2.3, respectively) at the bottom of a sample of cities, despite LGBTI+ people in Tokyo having a better legal landscape and an overall

stronger economy and health system. Similarly, New York City and Quezon City both achieved a relatively high score of a 4 out of 5, despite residents of Quezon City experiencing fewer legal protections and having a less established LGBTI+ community. These results likely reflect the fact that quality of life for LGBTI+ people is largely conceptualized on a local rather than a global basis. Key informants may think about their local LGBTI+ community's quality of life in terms of the overall quality of life among people in their city, and perhaps how their experiences of LGBTI+ life in their city compare to perceptions of LGBTI+ life elsewhere in their country. More than anything, the survey findings suggest that conventional wisdom about where LGBTI+ communities enjoy better or worse conditions stands to be questioned, and that this topic merits more research.

“Health, legal, and educational professionals are not trained in matters related to the LGBTI+ community... [There is a] lack of knowledge on the primary needs facing the community.”

With respect to healthcare access, the knowledge and cultural competency of clinical health providers was ranked slightly better (3.1 out of 5; mode: 3; SD: 1.01) than was that of mental health service providers (2.8 out of 5; mode: 2; SD: 1.08), although both rankings were concerning given the critical need for all health providers to address existing inequities. The availability and affordability of gender-affirming care for gender minorities was also rated poorly, with an average score of 2.7 out of 5 (mode: 3; SD: 1.16), suggesting that the healthcare needs of transgender and gender-nonconforming individuals should be a priority in addressing LGBTI+ health equity. According to the assessments, most cities in which access to gender-affirming care was guaranteed, and where other policies that facilitate access were in place (e.g., access to documents reflecting one's name and gender, access to gender-based facilities of one's choice) were in the Americas.³² However, it bears noting that these policies reflect fairly new trends and, in the United States in particular, have been met with a backlash that has also spurred anti-transgender policies and legislation.³³

Key Informant, Maputo

The availability of low-cost, low-barrier HIV services for LGBTI+ people fared better than other areas of healthcare access, with an average score of 3.8 out of 5 (mode: 4; SD: 1.07). This relative strength is promising given that all cities included in the study are part of the Fast-Track Cities initiative and have thus committed to ending AIDS as a public health threat by 2030. This result is also important given the persistent HIV-related disparities facing LGBTI+ people in these 50 cities, as described below. Regarding HIV prevention services in particular, 29 key informants discussed access to pre-exposure prophylaxis (PrEP) in their qualitative responses, including 10 who raised concerns, including about availability and cost, lack of knowledgeable providers to prescribe PrEP, stigma within the healthcare system against those who use PrEP, and lack of awareness within the LGBTI+ community on the use of PrEP. Nine key informants, on the other hand, said that PrEP access has been improving and noted this as being a positive for their community. The remainder discussed their involvement with PrEP without making a negative or positive commentary regarding its availability. Beyond PrEP, there were various key informant comments regarding how LGBTI+ stigma and discrimination, as well as a lack of comprehensive sexual health education, were hindering HIV prevention measures, including the use of condoms and other safer sex methods.

Health Outcomes

Globally, HIV continues to be a major public health concern among LGBTI+ populations. There have been continued improvements in HIV prevention and treatment, yet sexual minority men — often referred to as men who have sex with men (MSM) in the HIV literature — remain one of the populations most affected by HIV across the globe. Data on HIV prevalence in assessments of the selected cities were relatively complete for sexual minority men, with city-specific estimates varying in great degree based on specific subgroups of sexual minority men and sampling methods. There was a general lack of HIV prevalence data available among the transgender community; however, these data were more readily available among transgender women compared to transgender men who report having cisgender male sexual partners. Among the cities with HIV prevalence data reported for both MSM and transgender women (two groups that are sometimes wrongly conflated), transgender women universally experienced the greatest disparity. For example, in Rio de Janeiro, 54.0% of transgender women were living with HIV compared to 13.9% of MSM. Although effective testing and treatment of chlamydia, gonorrhea, and syphilis have been available for decades, eradication of these diseases remains an elusive objective for LGBTI+ populations globally. A similar pattern with respect to lifetime prevalence of bacterial STI emerged, with CT (up to 26.0%), GC (up to 18.3%), and syphilis (up to 37.9%) data available in the majority of cities among sexual minority men, but mostly absent for all other LGBTI+ populations.³⁴

The prevalence of mental health problems among LGBTI+ populations is higher when compared to non-LGBTI+ populations, according to the assessments, although not to the level of serious pathology. Specifically, mental health problems such as depression, anxiety, and post-traumatic stress disorder (PTSD) were high across cities for this assessment. Although the majority of the cities had data on the prevalence of depression among sexual minority men, this was not the case for both anxiety and PTSD, and certainly not the case for other LGBTI+ populations. Furthermore, in general, availability of suicide data is scant among LGBTI+ populations, particularly outside of the Americas.

Data revealed alarmingly high rates of substance use among LGBTI+ populations when compared to demographically matched peers. Notably, in multiple cities, sexual minority men report higher rates of substance use (e.g., drug and alcohol use, smoking) compared with the general population, with extensive use of stimulants and other party drugs, including 3,4-methylenedioxymethamphetamine (commonly known as MDMA or ecstasy), γ -hydroxybutyric acid (commonly known as GHB), and ketamine. Alcohol use is also more common among sexual minority men in the 50 cities than among the general population. Similarly, across cities, lesbian and transgender women had higher rates of substance use compared with the general population. According to available literature, a major underlying reason for these disparities stems from the internalization of societal stigma as a result of growing up in non-affirming environments, leading to sexual and gender minority stress and suboptimal health outcomes in reaction to these adverse experiences.

How Big a Problem is Housing Access on a 1 to 4 Scale?*

Quezon City	1.8
Melbourne	2.4
Copenhagen	2.5
Tokyo	2.5
Bangkok	2.6
Kingston	2.8
Chicago	3
Miami	3
Kampala	3.1
London	3.2
Athens	3.2
Maputo	3.2
Lisbon	3.3
Mexico City	3.3
New Orleans	3.3
New York	3.4
Charleston	3.6
Phoenix	3.6
Dublin	3.8
Denver	3.9
San Francisco	4

* Scores on a scale of 1 ("not a problem") to 4 ("serious problem").

“An over-emphasis on the success story of affluent white gay men distorts perceptions of LGBTI+ reality.”

Key Informant, London

“Many are still expelled from their home or repress their sexuality or gender identity for fear of being expelled, which leads to several problems, especially in mental health.”

Key Informant, São Paulo

One issue contributing to mental health disparities among the population is the practice of conversion therapy, which is a term for harmful, non-evidence-based, and discredited practices that seek to “change” LGBTI+ people to have heterosexual and/or cisgender identities. Too often, LGBTI+ people receive such treatment in lieu of the evidence-based, affirming mental health support that they actually need. Most of the cities where this practice was banned were in the Americas.

Data on other health indicators among LGBTI+ populations — including diabetes, obesity, and mortality rate — are even more scarce, with only a handful of cities having disaggregated results based on sexual orientation or gender identity. LGBTI+ populations did show a higher prevalence of disability than their non-LGBTI+ counterparts. On average, across cities, data show the prevalence of disability to be about 36% among lesbians, 36% among bisexual women, 26% among gay men, and 40% among bisexual men. None of the cities had disaggregated data on the prevalence of disability by gender identity.

Socioeconomic Factors

In terms of socioeconomic factors, finding and maintaining housing was a major factor for LGBTI+ communities, with eight in 10 key informants (80%) saying that it was a serious or moderate challenge. A slightly smaller percentage (71%) said the same about finding and maintaining adequate employment. However, this trend was driven by results in the Americas and, to a lesser extent, Europe; in both of these regions, housing outranked employment as a concern, whereas in Africa and Asia-Pacific, that trend was reversed. A smaller percentage (50%) globally felt that access to sufficient and nutritious food was a serious or moderate challenge for LGBTI+ people. The ability of local governments, nonprofit organizations, the private sector, and other actors to respond to these challenges was rated highest with respect to food access (3.0 out of 5; mode: 3; SD: 1.16) and lowest with respect to housing (2.6 out of 5; mode: 2; SD: 1.05). This finding is concerning in that it indicates that the areas in which support is most badly needed, housing first and employment second, are also the areas in which the local response remains weakest.

With respect to the data assessments, there were no city-specific, population-based data on the indicators used herein — unemployment rate, homelessness rate, poverty rate, or food insecurity — that were disaggregated by sexual orientation and/or gender identity. However, national (or, in the United States, state-specific) rates on these topics for the selected cities were high, particularly with respect to poverty, where rates ranged from 9.1% (Colorado, USA)³⁵ to 55.5% (South Africa).³⁶ These high overall poverty rates, in and of themselves, are a public health concern, since a significant relationship between income inequality and HIV prevalence has been documented across many countries throughout the world.³⁷ Countries with greater inequality have higher HIV prevalence, particularly in sub-Saharan Africa but also to a lesser extent across Asia-Pacific, Europe, and the Americas.

Discrimination

Key informants identified discrimination against LGBTI+ people to be a major problem for their communities, and research supports that discrimination is a contributing factor to the health inequities LGBTI+ people face. Cities were mixed with respect to nondiscrimination laws pertaining to sexual orientation, gender identity, gender expression, and HIV status, as well as laws recognizing LGBTI+ related hate crimes. The majority of cities with LGBTI+ protections are in the Americas, Europe, and Asia-Pacific, whereas cities without protections were mostly among those selected from the Africa region, excluding Durban (eThekweni), South Africa. The African cities and, to a lesser extent, cities in Asia-Pacific were also less likely than those in the Americas and Europe to legally recognize same-sex relationships, an important if not primary legal step in combatting discrimination.

According to key informants, discrimination against LGBTI+ people with other marginalized identities (e.g., racial, ethnic minorities) was the most problematic form of discrimination facing their community. Thirty-five percent of key informants said discrimination was a “serious” problem, 39% said it was a “moderate” problem, 19% said it was a “minor” problem, and >7% said it was “not a problem” at all. “I think the main issue in Denver around this would be the intersections of LGBTI+ identity and race and gender,” said one key informant who works in public health. “For white, cisgender LGBTI+ individuals, Denver is [a] ‘safe’ place to live and one without much discrimination compared to other parts of our country. I think for individuals of color, this is not the case. And I do know that non-white LGBTI+ [people] consistently express their own experiences of racism within the larger LGBTI+ communities.”

“Migrants are particularly demonized under the current UK government,” said a key informant in London. “There is a serious risk here around refugees and asylum seeker and their access to adequate health and care, including support to manage sexual health and chronic conditions.”

Regarding the types of discrimination facing the LGBTI+ community, key informants cited gender identity-based discrimination as being more of a problem than discrimination based upon sexual orientation or HIV status. Only 6% of key informants said that gender identity-based discrimination was “not a problem” in their community, while one in three said it was a “serious” problem. Particularly in jurisdictions that have banned sexual orientation-based discrimination but not gender identity-based discrimination, this presents an urgent need for legal reform and other interventions. Sexual orientation-based discrimination was also found to be a concern among 90% of key informants, including 19% who found it to be a “serious” challenge. HIV-related discrimination was a concern for 91%, including 24% who said it was a “serious” concern in their local LGBTI+ community.

In open-ended responses, many key informants wrote that open discrimination against LGBTI+ people in healthcare settings or lack of inclusive care (e.g., intake forms not being sensitive to gender minorities, competent care not being available) had an impact on health. Other key informants discussed how stigma and minority stress take a toll on mental health, with one in Columbia, SC, USA, writing that LGBTI+ people are “not treated like humans, but almost as if they’re contaminated by something. Consequently, this encourages them to skip out on needed routine medical [and] preventive care, which drives STI and infectious disease rates.” Still other key informants described how discrimination has an impact on social determinants of health, especially housing and homelessness, which leads to ripple effects across various aspects of overall well-being.

How Big a Problem is Intersectional Discrimination on a 1 to 4 Scale?*

Quezon City	1.6
New York	2.2
San Francisco	2.4
Charleston	2.6
Bangkok	2.6
Copenhagen	2.7
Tokyo	2.7
Phoenix	2.8
Chicago	3
Denver	3.1
Melbourne	3.2
Miami	3.3
Mexico City	3.3
London	3.4
Lisbon	3.4
Athens	3.4
Maputo	3.4
Dublin	3.4
Kampala	3.6
Kingston	3.7
New Orleans	4

* Scores on a scale of 1 (“not a problem”) to 4 (“serious problem”).

Criminal Justice

Key informants rated criminal justice issues slightly less in terms of their significance than were housing and employment issues. Eighty-five percent of key informants said that mistreatment or abuse of LGBTI+ people by law enforcement was a problem in their city, including 24% who said it was a “serious” problem, 31% a “moderate problem,” and 30% a “minor” problem. A slightly smaller percentage (71%) said that targeting of LGBTI+ people in their city was a “serious,” “moderate,” or “minor” challenge, while slightly more than that percentage (77%) reported the same about criminalization of HIV exposure and/or nondisclosure of HIV status. Most cities for which this issue was raised are in countries with laws that criminalize transmission and non-disclosure of HIV status to sexual partners, and criminalization of HIV can still occur in places that do not have laws that specifically mention HIV; instead, laws against endangerment, physical or sexual assault, and even attempted homicide are often employed. In fact, more than half of the current cases worldwide criminalized HIV exposure and non-disclosure of HIV status to sexual partners using general criminal laws.^{38,39}

Criminalization of sex work and/or mistreatment of sex workers was ranked as more of a concern than treatment of the LGBTI+ community itself, with 90% of key informants saying it was a problem, including 34% who said it was a “serious” problem. Although sex work is reportedly widespread in every city included in this report, more than 40 of 50 cities have laws governing sex work as illegal. This statistic is particularly concerning given that the legal environment, including policy, law enforcement, and the judicial system, is a significant structural determinant of HIV acquisition and transmission risk in the context of transactional sex and should remain at the center of the HIV prevention agenda. Moreover, LGBTI+ people are disproportionately represented in the field of sex work due, in part, to limited economic opportunities elsewhere, and can be the targets of arrest and mistreatment when sex work criminalization laws are enforced.

Critically, the majority of key informants (90%) said that there was a disparate impact among racial and ethnic minorities with respect to these criminal justice issues, including 30% who said it was a “serious” problem and 32% who said it was a “moderate” problem. Therefore, while not all criminal justice issues were rated as being as problematic as socioeconomic and discrimination issues, nine in 10 key informants felt that they were problematic with respect to impact on racial and ethnic minorities in particular. This problem was ranked highest in the Americas, followed by Africa, Europe, and Asia-Pacific. This ranking may relate to recent attention in the Americas, and especially the United States, regarding the disproportionate impact of criminal justice systems on people of color in general, which would apply in this case to LGBTI+ people of color. The relatively weak ranking of this issue in Europe is slightly surprising given many key informants noted problems facing LGBTI+ people from racial and ethnic minorities in their cities, especially migrants, though it could reflect relatively liberal criminal justice systems compared to those found in, for example, the United States.

“There is no gender recognition law in Thailand. Transgender people are not allowed to change their gender marker on their ID. They often face stigma and discrimination going to the hospital as their appearance will usually not match with their gender marker. They often get questioned with unnecessary and irrelevant questions. This creates massive discomfort for transgender people and it drives [them away from] health services.”

Key Informant, Bangkok

Community Resilience

Community-based organizations, nonprofits, and informal social networks of other LGBTI+ people were most frequently named as major sources of community resilience in open responses from key informants. In terms of which sector did best at engaging in productive and respectful dialogue with the local LGBTI+ population, nonprofits scored best, with an average of 3.9 out of 5 (mode: 4; SD: .92). Healthcare providers, local government, and the private sector all scored lower and roughly equally, with averages of 3 (mode: 3; SD: 1.08), 3 (mean: 4; SD: 1.23), and 2.9 out of 5 (mode: 3; SD: 1.10), respectively. While nonprofits scored well, some key informants called on them to take more of a leadership role in influencing other actors and society at large. Nonprofit organizations “could influence change if they invest in evidence-based advocacy,” said the executive director of an organization serving transgender women in Kampala. “Capacity building of healthcare providers about transgender women and the need to support them to access services would also influence change.”

Many key informants also called for more funding for community-based organizations, health services, and social spaces, noting that good work was being done but that more support was needed. “Give us funding to work,” stated the director of an organization providing health services to sex workers in Lagos. Strategies proposed by the key informants included lowering barriers to accessing grants, reducing bureaucracy, and diversifying which organizations receive grants.

Other common themes regarding how institutions can improve LGBTI+ resilience included engaging in meaningful and formal dialogue; supporting socioeconomic opportunity for LGBTI+ individuals; increasing LGBTI+ inclusive data collection to better identify needs and demonstrate inclusivity; visible displays of LGBTI+ support, such as LGBTI+ flags in public spaces and the participation of political leaders in LGBTI+ community celebrations; and supporting changes to laws to eliminate criminalization of LGBTI+ identities and eliminate LGBTI+ discrimination.

In terms of the assessments, evidence varied from city to city, pointing to a major need that local, national, and international actors could support. Although most heavily concentrated in cities in the Americas and Europe, many of the 50 cities globally had one or more LGBTI+ community spaces, as well as public funding for LGBTI+ community resources (e.g., tourism association, pride events). Similarly, many cities had spaces identified — either via known areas that are open to the public or hidden but known via word of mouth — where LGBTI+ populations could socialize. Furthermore, many cities had a local LGBTI+ office, liaison, public report, or public plan on advancing LGBTI+ equity, although little evidence was found of such supports in the African cities, with the notable exception of Durban (eThekweni).

How Concerning are Issues Relating to Social Determinants of Health on a 1-4 Scale? *

Housing access	3.2
Gender identity discrimination	3
Intersectional discrimination	3
Employment access	2.9
Sex worker treatment	2.9
Criminal justice for people of color	2.8
Sexual orientation discrimination	2.7
Police mistreatment	2.6
HIV status discrimination	2.4
Food access	2.4
Police targeting	2.3

* Scores on a scale of 1 (“not a problem”) to 4 (“serious problem”).

How Well Do Actors Engage with the Local Community, on a 1-5 Scale? *

Nonprofits	3.9
Providers	3.0
Government	3.0
Private Sector	2.9

* Scores on a 1 (“poor”) to 5 (“excellent”) scale.

Conclusion

The global analysis of the LGBTI+ health equity survey and assessment reveal that LGBTI+ communities face wide-ranging and widespread health inequity and that access to health and other critical services is particularly poor for gender minorities. Discrimination was a concern among an overwhelming number of key informants, but laws addressing discrimination remained absent or incomplete in a majority of jurisdictions. Communities facing multiple forms of marginalization, including communities of racial and ethnic LGBTI+ people, were found to face higher levels of discrimination and criminal justice involvement. And, despite greater public attention to civil and political issues such as same-sex marriage and discrimination laws, key informants noted that socioeconomic issues — which are key social determinants of health — were among their chief concerns. The opinions of these key informants, each one a local LGBTI+ stakeholder, helped to fill in the many gaps in data that the assessments revealed, including limited information on health disparities beyond HIV and STIs, and almost no large-scale data on socioeconomic conditions among LGBTI+ populations. Much of the data that did exist were focused on sexual minority men, including relating to HIV, STIs, and rates of depression, and occasionally data relating to HIV among transgender women.

Despite the many alarming results it presented, the research outcomes also highlighted the remarkable resilience of LGBTI+ communities. Even where formal programming or spaces for LGBTI+ people were limited, key informants noted the presence of informal spaces and social networks as a source of strength. HIV services stood out as a clear leader in health services for LGBTI+ people and nonprofit organizations led the way as being a source of collaboration and respectful dialogue with the community. The study also demonstrated that LGBTI+ advocates, communities, resources, and spaces exist throughout diverse cities, and that even in places with harsh anti-LGBTI+ laws and limited public resources to support LGBTI+ communities, these communities have found ways to support each other and survive.



Africa



2.7
QUALITY OF
LIFE SCORE
REGIONAL

This study included 10 Fast-Track Cities in Africa: Bamako, Durban (eThekweni), Kampala, Kigali, Lagos, Lusaka, Maputo, Nairobi County, Yaoundé, and Windhoek. Three cities were selected from these to serve as examples with more detailed analyses, which follow this regional description; they are Durban (eThekweni), Kampala, and Maputo.

Among the lingering injustices of the colonial era in Africa are still-standing socioeconomic inequalities and anti-LGBTI+ legislation (particularly laws regarding same-sex male relations), both of which complicate progress for LGBTI+ communities. The continent also faces major inequities with respect to HIV that — while more widespread than elsewhere in the world — still disproportionately affect LGBTI+ people. Key informants in the 10 African cities also reported different priorities than those in the Americas and Europe, which often drive (financially, politically, and culturally) LGBTI+ movements elsewhere — a cautionary finding for those wishing to best support LGBTI+ health equity in Africa.

Quality of Life and Care

On average, key informants in Africa rated their local LGBTI+ quality of life at 2.7 (mode: 3; SD: .97), well below the global average of 3.2. Key informants also rated all health services worse than the global averages, with LGBTI+ affirming mental healthcare being rated worse of all, at only a 2.3 on a 1 to 5 scale (mode: 2; SD: 1.05) compared to a 3.2 score worldwide. Disturbingly, given the continent's disproportionate burden of the disease, HIV services were among those rated worse than the global average, at 3.3 out of 5 (mode: 3, SD: .98), compared to 3.8 across all cities.

Stigma was the most common barrier to health service access and utilization that was cited by the key informants, especially for transgender individuals. “The biggest challenge is the negative judgment,” said an HIV project manager in Bamako, “however you translate it: stigmatization, rejection, discrimination.”

Only one of the 10 African cities, Durban (eThekweni), had laws banning the practice of conversion therapy, or the nonscientific practice of attempting to change one's sexual orientation or gender identity. The persistence of such practices may contribute to the negative scores given to various types of care, and also contributes to mistrust of healthcare systems.⁴⁰

“People (including healthcare providers) lack information about LGBTI+ [health].”

Key Informant, Kigali



69%

of key informants in Africa said access to employment was a “serious” problem for LGBTI+ people, compared to just 27% of key informants globally

Health Outcomes

Data regarding HIV prevalence was relatively complete among the African cities and demonstrated a clear need for HIV to remain a priority among LGBTI+ populations, as well as for LGBTI+ populations to remain a key group for city stakeholders coordinating HIV responses. With the exception of Yaoundé, the nine other African cities had some city-specific data available on population-wide HIV prevalence and all but Nairobi County, Lusaka, Windhoek, and Yaoundé had some city-specific data specifically on prevalence among sexual minority men. Bamako had the largest disparity between MSM and the general population, with 13.7% of sexual minority men living with HIV compared to 1.1% of the overall population, a 12.5 times higher prevalence.⁴¹ Inequities in HIV burden were also found in Lagos (17.4%⁴² versus 1.4%⁴³), Durban (eThekweni) (48.2%⁴⁴ versus 27%⁴⁵ in Durban’s province of KwaZulu-Natal), Kampala (12.2%⁴⁶ versus 6.9%⁴⁷), Maputo (41.4% versus 10.4%⁴⁸), and Kigali (10%⁴⁹ versus 4.3%⁵⁰), when comparing sexual minority men to the overall population.

Regarding other aspects of sexual health, disaggregated data for sexual minority men exist in Kampala and Kigali with respect to chlamydia, gonorrhea, and syphilis, and with respect to chlamydia and gonorrhea in Lagos and Maputo. While prevalence of these conditions was generally lower than HIV, many of the rates were concerningly high. Kampala had relatively low rates of chlamydia and gonorrhea among sexual minority men than did the other cities, but a relatively high rate of syphilis at 10.3%.⁵¹ The highest rates of chlamydia and gonorrhea among sexual minority men and transgender women were found in Lagos (18.3% and 25.8%, respectively)⁵² and Kigali (9.1% and 8.8%, respectively).⁵³

Data on mental health were relatively limited among the African cities. No city had population-based, SOGI-disaggregated data on anxiety, PTSD, or suicide, nor was any national SOGI-disaggregated data identified. Data existed in one city, Bamako, regarding depression among MSM, with a reported rate of 8%.⁵⁴ Additionally, there were national data applicable to Durban (eThekweni) (44% of MSM in South Africa).⁵⁵ These numbers suggest that depression and other mental health problems among sexual and gender minorities throughout cities in the African region could be quite high but requires additional epidemiological research to document the prevalence of mental health disorders and determine an appropriate response that is informed by both the data and the science.

Data on other indicators included in the study — obesity, smoking, drug use, and mortality — were even more limited, with only a few cities or national population-based data available that disaggregated results based on sexual orientation or gender identity. In Lagos, 15.4% of sexual minority men were reported to be current smokers. In terms of alcohol consumption, 34.1% of MSM in Lagos were current drinkers, and half of the current drinkers were described to have a drinking problem using the CAGE assessment for alcohol dependence.⁵⁶ In terms of alcohol consumption, 43.7% of MSM in Maputo were classified as problem drinkers using the AUDIT-C scale. Cannabis use in the 12 months preceding the survey was reported by 12% of MSM in Maputo; less than 3% of MSM used other drugs.⁵⁷



Socioeconomic Factors

In terms of socioeconomic factors, perhaps not surprising given the longstanding socioeconomic injustices affecting African nations, key informants identified employment, housing, and food access for LGBTI+ individuals to be “serious” problems. For example, while globally, 27% of key informants said that LGBTI+ employment access was a “serious” concern, that number skyrocketed to 69% in Africa, where less than 3% said it was “not a problem.”

With respect to the assessments, no city population-level had relevant data on the indicators used herein — unemployment rate, homelessness rate, poverty rate, or food insecurity — that were disaggregated by sexual orientation and/or gender identity. However, national rates for the selected cities on these topics were high, particularly for poverty, where rates ranged from 17.4% for Windhoek (Namibian national data) to 55.5% for Durban (eThekweni) (South African national data).⁵⁸ These high overall poverty rates, combined with the survey data on socioeconomic inequities facing LGBTI+ populations, support the conclusion that this is a major issue in addressing LGBTI+ health equity in African cities, despite the lack of relevant LGBTI+ specific data.

Discrimination

Regarding discrimination, African key informants rated discrimination on the basis of gender identity, HIV status, and intersectional factors roughly the same as their global counterparts. However, key informants rated sexual orientation-based discrimination about 25% higher as a problem than did the average key informant worldwide. A majority (60%) said that sexual orientation-based discrimination was a “serious” problem, while less than 9% said it was “not a problem.” Many key informants said that discrimination facing LGBTI+ people prevented access to services, hindered HIV responses, and caused significant mental health problems in their local communities.

Only one out of the 10 African cities selected — Durban (eThekweni) — has nondiscrimination laws pertaining to sexual orientation, gender identity, gender expression, and HIV status.⁵⁹ A similar pattern emerged with respect to the legality of same-sex relationships, with LGBTI+ rights in African cities ranging from having the same legal protections as non-LGBTI+ people (again, Durban (eThekweni)) to punishments that start with fines to life imprisonment (i.e., Lagos).⁶⁰ There are many reasons for this, but homophobic colonial laws, religious morality, and the idea that homosexuality is imported by the West are among the most influential. Among the African cities that were selected, only Durban (eThekweni) had regulations and policies that protect transgender individuals; the Alteration of Sex Description and Sex Status Act allows people to apply to have their sex status changed in the population archive, and consequently to receive identity documents and passports indicating their gender identity. The law necessitates the person to have undergone medical or surgical treatment, such as hormone replacement therapy, but gender affirmation surgery is not required.⁶¹

Criminal Justice

African key informants found the problems of police mistreatment, police targeting, and criminal treatment of sex workers to be more severe than the average across all 50 cities. About half rated all three of these issues as being “serious,” with only a handful of key informants saying they were “not a problem.” This corresponds with the findings of the assessments, which demonstrated that African LGBTI+ communities faced more penalizing laws and fewer protective laws than did communities in other regions. Criminalization of HIV issues and the disproportionate impact on people with multiple marginalized identities both ranked closer in line with global averages.

Most African cities have laws that criminalize transmission and non-disclosure of HIV status to sexual partners. Even when laws do not explicitly mention HIV in this context, some African cities, such as Durban (eThekweni), have used existing laws to charge individuals in cases such as this

“Discrimination by health care workers acts as a barrier to accessing health services.”

Key Informant,
Nairobi County

“Stigma and discrimination [make] people living with HIV default from accessing antiretroviral therapy services at health facilities.”

Key Informant,
Nairobi County

with attempted homicide;⁶² in fact, more than half of the current cases worldwide criminalized transmission and non-disclosure of HIV status to sexual partners using general criminal laws.⁶³ Although sex work is widespread in African cities, each have laws governing sex work as illegal.

Community Resilience

Three trends emerged when key informants were asked about sources of resilience for their local communities: support from within the LGBTI+ community itself, including stemming from the resilience of individuals themselves; services from local organizations, including through support groups; and international donors, who funded many of these efforts (although organizational reliance on these sources caused some concerns about sustainability). When asked how local institutions can best support their community to grow its resilience, the most common requests were more collaboration with LGBTI+ individuals and organizations, public education about LGBTI+ identities, and advocacy to change negative laws and policies impacting the community.

“Even us at the frontline are feeling threatened and disempowered,” said the director of a nonprofit in Durban (eThekweni). “Visible partnerships towards advancing lives and promoting rights” would provide a boost to the community, they said, as would “more meaningful dialogues or community activities than these last-minute tick boxes we have been having.”

Key informants in Africa gave a lower score to how their local governments interact with LGBTI+ communities compared to the global averages, with an average score of 2.4 (mode: 2; SD: 1.19) compared to 3.0 worldwide. They ranked providers (3; mode: 3; SD: 1.15) and nonprofits (4; mode: 5; SD: 1.01) about equally to their global peers, and the private sector (2.7; mode: 2; SD: 1.19) just slightly behind the global average (2.9).

In terms of assessment factors used to gauge LGBTI+ community resilience, almost no evidence was found. This points to a major need that local, national, and international actors could support. In Durban (eThekweni), at least one LGBTI+ community space was identified, as was public funding for LGBTI+ community resources such as a tourism association and pride events.⁶⁴ Durban (eThekweni) also had other LGBTI+ spaces, and while all cities lacked any permanent social spaces (i.e., LGBTI+ bars), there have been places identified where gay men can socialize. Such spaces, community resources, and funding were not found in any of the other African cities included in the study. Furthermore, no cities had a local LGBTI+ office or liaison, or a public report or plan on advancing LGBTI+ equity.

Conclusion

The study's findings indicate a wide variety of challenges affecting LGBTI+ communities in African cities. Key informants in Africa scored their services and relationships with institutions as worse, and their challenges greater, than the global averages around most issues on which they were surveyed. The challenges facing these communities were reinforced by the findings of the assessments, which indicated fewer legal and political supports (as well as less visibility and data) than was available elsewhere in the world. Nevertheless, internal community strengths and support from nonprofits stood out as bright spots in reflections on community resilience, with nonprofits scoring slightly better in Africa than the global average, as a plurality gave nonprofit organizations a 5 out of 5 score on relationships with LGBTI+ people. Additionally, a comparison with other cities around the world demonstrates that while the challenges facing LGBTI+ people in Africa may be greater than those in some other parts of the world, the underlying issues — and solutions — also bear many similarities.

“The main sources of resilience of this group are civil society organizations that have done their work in defense of human rights and have been the only institutions to work with these groups.”

Key Informant, Maputo

Select Cities

Durban (eThekweni)

Situated in South Africa, the city of Durban (eThekweni) faces national contexts that includes one of the highest poverty rates among the cities included in this study as well as a high overall rate of HIV. At the same time, because of national and local LGBTI+ inclusive measures, Durban (eThekweni) stood out among the 10 African cities as a clear leader on LGBTI+ health equity.

In Durban (eThekweni) alone, same-sex marriage was legal, conversion therapy was banned, and transgender people were able to change their gender markers on their identification documents — a key means by which to access health services and avoid LGBTI+ violence and stigma.

Durban (eThekweni) also stood out for its community supports, including having a community space for LGBTI+ people and some public funding of LGBTI+ events. Nevertheless, key informants said these resources were limited and urged institutions to increase their support, especially given the violence that LGBTI+ individuals must still confront. “Organizing Durban Pride in Durban is a nightmare,” said the director of a local LGBTI+ organization, who says support for the event has dwindled. Pride is meant “to create an awareness, build bridges, showcase talent, and promote Durban and eThekweni as a Safer City.”

Another key informant who works as a psychotherapist in the community encouraged local actors to “create safe spaces, more support groups, and encourage more family building amongst their respective communities in order to spread awareness... Just allow [LGBTI+ individuals] to live as normal people. If they don’t want to change to suit anyone, they shouldn’t be killed for it.”

4.0
QUALITY OF
LIFE SCORE
CITY





2.3

QUALITY OF LIFE SCORE

CITY

Kampala

Kampala is one of the fastest growing cities in Africa and is situated in a country known throughout the world for its efforts to pass extreme anti-LGBTI+ legislation, the worst of which has so far been stymied. Sadly, but not surprisingly, key informants in Kampala gave their city one of the lowest quality of life scores (2.3; mean: 2; SD: .71) of the 50 cities included in the study.

Unlike the global trend, in Kampala, key informants rated sexual orientation-based discrimination as a greater problem than discrimination on the basis of gender identity, with all but one informant saying that sexual orientation-based discrimination was a “serious” problem. Still, many noted in their comments that the situation for transgender women in Kampala was particularly dire, indicating that perhaps homophobic attitudes driven by the higher visibility of that issue are also affecting transgender people, regardless of their sexual orientation.

“The existing laws and policies inhibit open provision of service [and] successful HIV treatment.”

Moreover, in Kampala, the mistreatment and targeting of LGBTI+ people by law enforcement were considered greater concerns than they were internationally. “Transgender people face the hardest hardships and queer sex workers, too, where they have been beaten up and jailed,” said a local activist working with LGBTI+ women. Additionally, the director of a local HIV organization said, “In my city, it’s still illegal to say you’re an LGBTI+ member. This makes it hard to even advertise the organizations that provide [services].”

Key Informant, Kampala

The biggest request from key informants was for more funding and support from local and international actors. The director of a local organization for people living with HIV said key to their success has been the “availability of caring non-state actors,” specifically naming the US President’s Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and diplomatic missions from countries such as the United States and Sweden.

Most key informants also noted the need for legal reform and some placed this above all other concerns. “First,” advised one key informant, “address the harsh policy.”

Maputo

Key informants in Maputo rated their socioeconomic, criminal justice, and discrimination issues as being more problematic than the global averages. The most significant concern raised by key informants was lack of access to employment, followed by mistreatment by the police and discrimination facing people with multiple marginalized identities. These issues are likely caused in part and exacerbated by the city's lack of legal protections for LGBTI+ people as well as laws recognizing and affirming their identities.

"Poor access to employment and employability" were among the top concerns of one key informant, along with "poor access to education due to stigma and discrimination" facing the LGBTI+ community. Other key informants concurred that stigma was a "serious" concern. One key informant noted that psychological violence may seem like less of a concern than physical violence, "but if we go deeper, we can see that this violence affects most people and has been the reason that people in this community even hang themselves or have mental disorders."

Healthcare services were rated more closely to the global average, with HIV services faring particularly well, with an average score of 4 on a 1 to 5 scale. Additionally, key informants gave better ratings to how local government, providers, and the private sector interact with their local LGBTI+ community than did the average key informant worldwide. While these scores (all averaging 3.6 on a 1 to 5 scale) still left significant room for improvement, they represented a potentially relevant strength for the LGBTI+ community in Maputo compared to others.

One local LGBTI+ activist who gave above-average scores to how local institutions interact with the community called for more support: "Not monetary, but visibility: having the right to walk without being discriminated against or stoned just for carrying the LGBT flag... Many of us need that support."



"Generally, effeminate gay men and the transgender community face additional challenges by the way these groups freely express their sexuality and gender, which is contrary to heterosexual expressions."

Key Informant, Maputo



The Americas

In the Americas, 20 cities participated in the study: Atlanta, Baton Rouge, Buenos Aires, Charleston, Chicago, Columbia, Dallas, Denver, District of Columbia, Kingston, Mexico City, Miami-Dade County, Montréal, New Orleans, New York City, Oakland, Phoenix, Rio de Janeiro, San Francisco, and São Paulo. Three of these cities — Kingston, New Orleans, and Mexico City — were selected to serve as examples with more detailed analyses, which appear after this regional description.

Together, these Fast-Track Cities span the entire Western hemisphere and represent a variety of cultures and political climates for LGBTI+ individuals. While the region has been making significant progress in recent years in recognizing same-sex marriages and banning certain forms of discrimination — and while many of these cities are known for their vibrant LGBTI+ communities — the results of this study show that there remain significant challenges.

Quality of Life and Care

Overall, key informants in the Americas gave their cities an average quality of life score that matched the global average: 3.2 on a 1-to-5 scale (mode: 3; SD: 0.95). Less than 6% gave their city a 5 out of 5, indicating that few believed that their city had no room for improvement.

Key informants from the Americas also rated access to LGBTI+ inclusive care roughly the same as did their global counterparts. As with the global trend, gender-affirming care (2.8 on a 1 to 5 scale; mode: 3; SD: 1.10) and mental health care (2.8; mode: 2; SD: 1.03) were rated lower than primary care (3.2; mode: 3; SD: 1.12) and HIV care (3.8; mode: 4; SD: 1.06), which was rated the best.

Even in cities known to be LGBTI+ friendly, many gave mediocre scores to the availability of inclusive and quality care. “In San Francisco, we are on the cutting edge of LGBTQ+ services, although there is always room for improvement,” said one local community advocate who specifically noted care for older adults as an area in which more attention was needed.



Many key informants pointed to nonprofit organizations and LGBTI+ leaders as driving LGBTI+ inclusive care. “Most of that work is being taken up by LGBTQI+ health providers, nonprofits, and advocates to push government and private sectors to be more inclusive and address LGBTQI+ disparities,” said a key informant in Chicago.

Health Outcomes

Compared to the other regions, data regarding HIV prevalence with respect to sexual and gender minority populations were the most complete among the cities in the Americas included in the study. Data were the most comprehensive among sexual minority men, with the highest HIV prevalence reported in Baton Rouge (44.7%),⁶⁵ followed by Miami-Dade County (42.8%) and New Orleans (36.9%).⁶⁶ Universally, across all cities in the Americas, extremely concerning racial and ethnic disparities exist for HIV prevalence data. In the United States, Black sexual minority men having the highest prevalence out of any racial group, followed closely by Latinx sexual minority men.⁶⁷ Similarly, across cities, transgender women represent a population that is most severely affected by HIV with an average estimated HIV prevalence of 42.2% across the cities in the Americas. Cities with the highest HIV prevalence among transgender women included Atlanta (58.4%), New York City (52.2%), New Orleans (44.6%), and San Francisco (41.2%). Among transgender women, similarities among racial and ethnic disparities exist for HIV prevalence data, with Black transgender women having the highest HIV prevalence out of any racial group.⁶⁸ The constant and unrelenting exposure to sexual and gender minority stigma compounded by the psychosocial challenges associated with social disadvantage and economic marginalization exacerbates disparities in HIV prevalence among these populations. Among sexual minority men and transgender women, this invalidates their sexual and gender identity and can lead to behaviors (e.g., substance use, sex work, healthcare avoidance) that potentiate HIV acquisition and transmission risk.

Disaggregated data for sexual minority men exist in nearly all of the selected cities with respect to chlamydia, gonorrhea, and syphilis. Overall, STI prevalence and incidence among sexual minority men — including primary and secondary syphilis and antimicrobial-resistant gonorrhea — is greater than that reported in sexual minority women and both heterosexual women (who have sex with men only) and men (who have sex with women only). There was a general lack of city-specific, population-level STI data available for transgender individuals. While the prevalence of these diseases is generally lower than HIV among sexual and gender minorities, many of the rates were still concerningly high. Furthermore, both chlamydia and gonorrhea differed in prevalence by anatomical site (e.g., urethral, rectal, pharyngeal) among sexual minority men. With respect to urethral chlamydia among sexual minority men, Miami-Dade County (5%) had the lowest prevalence and the highest was seen in San Francisco (5.9%); rectal chlamydia rates were much higher, ranging from 14.3% in Miami-Dade County to 18.4% in San Francisco.⁶⁹ As far as urethral gonorrhea rates among sexual minority men, Miami-Dade County (5.4%) had the lowest prevalence and the highest was seen in New York City (8.9%); rectal gonorrhea rates were much higher, ranging from 12.2% in Miami-Dade County to 14.8% in San Francisco. The prevalence of syphilis among sexual minority men ranged from 8.3% in Denver to 21.9% in San Francisco.⁷⁰

Population-level data on the prevalence of specific mental health disorders among sexual and gender minorities was robust for the cities in the Americas, but there remains plenty of room for strengthening these data. Rates of depression and anxiety among all sexual and gender minority groups are consistently higher than those among the general adult population. Among MSM, rates of depression range from 47.3% (San Francisco) to 47.8% (New York City) across cities as compared to 5-12% among the general adult population.^{71,72,73} For alcohol and drug use across cities in the Americas, on average 26.2% of sexual minority men reported drinking alcohol at least three days per week, and 10.6% were heavy drinkers (i.e., they consumed at least four drinks per day or consumed an amount equal to six drinks per occasion).⁷⁴ Furthermore, among sexual minority men, marijuana was the drug most likely to be used (average for New York City,

Chicago, San Francisco, and Denver, with negligible variation: 46.3%), followed by poppers (amyl nitrates) (36.6%); hallucinogens, including ecstasy (24%); cocaine (19.3%); amphetamines (12.9%); and injection drug use (10%).⁷⁵ Among the cities (New York City, San Francisco, Chicago) with population level data specific to transgender women, the average prevalence (differences by city are insignificant) of specific disorders was as follows: lifetime and current major depressive episode, 35.4% and 14.7%, respectively; suicidality, 20.2%; generalized anxiety disorder, 7.9%; and posttraumatic stress disorder, 9.8%. Among transgender women, the average prevalence (differences by city are insignificant) of alcohol dependence is 11.2% and substance use dependence is 15.2%.⁷⁶

Socioeconomic Factors

On socioeconomic issues, key informants from the Americas reported more significant problems regarding LGBTI+ access to adequate housing and food than the global average. In the Americas, 55% said that housing access was a “serious” concern, compared to 42% who said the same globally. Regarding food access, 92% of key informants in the Americas felt that this was at least somewhat of a problem, compared to 76% globally who felt the same. Most of the key informants from the Americas came from the United States, a country with ample resources to address these concerns, and yet the response by institutional actors to address socioeconomic concerns facing the LGBTI+ community were ranked worse in the Americas than globally. Latin America is also known to face rising socioeconomic disparities generally. These factors — combined with limited antidiscrimination laws (described below) — likely explain why the Americas fared poorly on these key social determinants of health.

With respect to the assessments, there was scant city-specific, population-level data on unemployment rates, homelessness rates, poverty rates, or food insecurity that were disaggregated by sexual orientation and/or gender identity. In the United States, there were limited state-specific and country-level population data; on average LGBTI+ people collectively have a poverty rate of 21.6%, which is much higher than the rate for cisgender heterosexual people of 15.7%. It is important to note that among LGBTI+ people, transgender people have an especially high rate of poverty (29.4%).⁷⁷ A major contributor to the high rate of poverty among transgender individuals is their high (15%) unemployment rate — three times higher than the unemployment rate in the U.S. population at the time of the survey (5%). On average, lesbian (17.9%) and heterosexual (17.8%) cisgender women have higher poverty rates than gay (12.1%) and heterosexual (13.4%) cisgender men. But cisgender lesbian women do not have significantly different poverty rates than cisgender heterosexual women. Finally, bisexual cisgender women (29.4%) and men (19.5%) had higher poverty rates than heterosexual straight women and men, respectively.⁷⁸ As far as population-level data on recent homelessness in the US, 8% of transgender and 3% of cisgender sexual minorities experienced this versus 1% of cisgender heterosexuals.⁷⁹

Discrimination

Key informants from the Americas rated discrimination relating to sexual orientation and HIV status about equally with respect to the global ratings. However, they rated the problems of discrimination on the basis of gender identity and intersectional discrimination facing LGBTI+ racial and ethnic minorities as more significant problems than the overall average of key informants surveyed.

In the United States, same-sex relations have been legal nationwide since 2003⁸⁰ and same-sex marriage has been legal in every state since 2015.⁸¹ In the Brazilian cities of Rio de Janeiro and São Paulo, LGBTI+ rights are among the most advanced in Latin America, including the right for same-sex couples to marry since 2013.⁸² Montréal, Mexico City, and Buenos Aires have also legalized same-sex relations and same-sex marriage since 2004,⁸³ 2009,⁸⁴ and 2010,⁸⁵ respectively.

Across all selected cities in the Americas, hate crime is recognized and punishable by law. In all selected United States cities, hate crimes based on sexual orientation or gender identity are punishable by federal law.⁸⁶ Universally, across the Americas, transgender people are allowed to access appropriate gender-based facilities and are able to change their gender marker on legal documents, although the requirements and therefore ease of doing so varies.^{87,88,89}

Criminal Justice

The Americas saw sharp disparities compared to their global neighbors with respect to criminal justice issues. For example, key informants in the Americas scored the problem of LGBTI+ people being targeted for arrests about 13% higher than the global average and scored about 16% higher than the global average the disproportionate impact of the criminal justice system on LGBTI+ racial and ethnic. Indeed, 41% of key informants in the Americas said that the disproportionate impact on LGBTI+ people of color was a “serious” problem, compared to 30% who said so globally.

As noted, LGBTI+ identities and relationships were not criminalized in any of the cities from the Americas included in the study. With respect to the legality of transactional sex in the Americas, all selected cities have laws making the practice of exchanging sex for money illegal, except for Buenos Aires, Mexico City, Rio de Janeiro, and São Paulo; however, it is illegal to operate a brothel in these cities, and vagrancy laws are routinely used against sex workers soliciting clients on the street. In Montréal, offering sexual services is not illegal; however, purchasing and using sexual services is illegal.⁹⁰ With respect to the exposure and non-disclosure of HIV status to sexual partners, only Montréal,⁹¹ Phoenix, District of Columbia, and Dallas have no criminalization laws, while Atlanta, Baton Rouge, Charleston, Chicago, Columbia, Miami-Dade County and New Orleans criminalize or control behaviors through HIV-specific statutes and regulations.⁹²

Community Resilience

Key informants in the Americas rated LGBTI+ community engagement by local government and healthcare providers about the same as did their peers globally, but rated nonprofits and businesses more poorly than did key informants worldwide. Still, as in other parts of the world, nonprofit organizations were the clear leaders, scoring an average of 3.8 on a 1-to-5 scale compared to a 3.0 score for local government and providers, and a 2.8 score for businesses.

According to the assessments, factors thought to support LGBTI+ community resilience across the selected cities in the Americas were robust. All cities in the Americas are appointed with LGBTI+ community spaces and community resources (e.g., tourism association, pride event) and have allocated funding for LGBTI+ specific service organizations. Similarly, in existence for all selected cities in this region, are publications on LGBTI+ scientific research, or reports or plans on advancing LGBTI+ health equity.⁹³⁻¹⁰⁹

Conclusion

Overall, there were no areas in which key informants from the Americas provided average ratings that were better than the global average, and in several areas (e.g., housing, criminal justice, racial impact) they rated their local conditions worse. Therefore, despite the progress that has been made on LGBTI+ issues in the Americas in recent decades, the participants from these cities reported worse overall conditions than did their colleagues around the globe. Many of these challenges seem related to factors connecting LGBTI+ identities to other social justice issues, namely poverty and racism.





2.7
QUALITY OF
LIFE SCORE
CITY

Select Cities

Kingston

"I would say nonprofit organizations in Jamaica are leading the way in providing services to LGBT+ people, such as free HIV/STI testing, HIV care/treatment, offering PrEP (especially [to those in] serodiscordant relationships), and psychosocial support for those that need it."

Key Informant, Kingston

Key informants in Kingston rated the quality of life for their LGBTI+ population at 2.7 on a 1 to 5 scale, well below the 3.2 global average. They also rated access to various types of care below global averages, although the difference was particularly stark with respect to mental health care (2.3 locally versus 2.8 globally) and gender-affirming care (2.3 locally versus 2.7 globally).

Every key informant noted that nonprofit organizations were doing the most to address inequities, while others needed to do more. LGBTI+ health "is mostly being addressed by nonprofit organizations and some clinical and service providers," said one key informant, "so these services [are] not adequate in relation to access and the quality of service." While the local government scored low on its interactions with the LGBTI+ community (1.5 on a 1 to 5 scale), the data assessment promisingly found numerous formal engagement mechanisms on LGBTI+ issues (such as an advisory group and inclusion in public reports), indicating that the basic infrastructure was in place for the government to work on these relationships.

Sexual orientation and gender identity-based discrimination were both rated equally in Kingston, with all but one key informant saying these were both "serious" problems. Notably, key informants pointed to widespread stigma and discrimination in different facets of life as impacting mental health, socioeconomic opportunity, and the willingness of LGBTI+ people to seek care.

One key informant called for more education "for the general population [and] especially healthcare workers for them to understand [the] LGBTI+ community, their gender identity/sexual orientation, etc. The community needs support — whether psychosocial or financial — to be sustainable in society."



3.3
QUALITY OF
LIFE SCORE
CITY

New Orleans

Overall, key informants in New Orleans gave their city a quality of life score for LGBTI+ people (3.3) roughly equal to the global average (3.2). However, with respect to healthcare access, key informants rated the city considerably worse on access to HIV services (3.3 compared to 3.8 globally) and gender-affirming care (2.3 versus 2.7).

Across the board, key informants scored socioeconomic challenges in New Orleans as being more severe than the global average, although the difference was particularly striking with respect to access to sufficient and nutritious food. While only 13% of global key informants said food access for LGBTI+ people is a “serious” problem, 58% of key informants in New Orleans reported this challenge as being “serious,” a stark reality for a city in one of the world’s wealthiest nations.

Similarly, key informants rated their LGBTI+ community as having much more significant criminal justice issues than the global average. Eighty-three percent of key informants said that criminal justice disparities among LGBTI+ people of color is a “serious” challenge, compared to just 30% of key informants globally.

“There are areas of our city that are very accepting and LGBTI+ friendly and some LGBTI+ persons in New Orleans have robust support systems of family and friends,” said one key informant, “but this is not universal.”

Many key informants noted the importance of community organizations as a source of resiliency but said that more was needed. “Local governments, healthcare providers, nonprofit organizations, and the private sector should seek out the advocates that are making efforts and trying to get something done,” said one key informant. Another recommended, in what was a common theme, “actually providing funding and resources to the organizations that can do this well” and “avoiding concentrating too much funding or resources in any particular organization.”

“Housing discrimination and employment discrimination are pretty rampant... We have a lot of hard-working people that can never get their head fully above water.”

Key Informant,
New Orleans



3.2

QUALITY OF LIFE SCORE

CITY

Mexico City

“Mexico City defines itself as being LGBTI+ friendly, but in fact, it is far from being so.”

Key Informant,
Mexico City

“Those with low education background face a lot of challenges to get easy access to health facilities due to the complexity of bureaucratic processes... There are few options for the transgender community.”

Key Informant,
Mexico City

Overall, key informants in Mexico City gave LGBTI+ conditions in their community lower marks than did key informants globally. On access to care, they gave their city worse scores on the availability of primary LGBTI+ inclusive care (2.8 versus 3.1 globally, on a 1 to 5 scale), mental health care (2.7 versus 2.8 globally), and HIV care (3.3 versus 3.8 globally). However, they rated access to gender-affirming care as marginally better (2.8 versus 2.7 globally). The differences in scores were mostly minor deviations from the global averages, with the exception of HIV care, which is concerning given the high burden of HIV among LGBTI+ people.

On socioeconomic issues, key informants rated both employment and housing access as bigger problems than did their peers worldwide. The exception was on food access, for which one-third said it was “not a problem” compared to one-quarter of key informants globally, while no key informants in Mexico City said it was a “serious” problem compared to 13% who did so globally.

Discrimination on the basis of sexual orientation was rated as slightly more problematic in Mexico City than globally, and intersectional discrimination was rated equally. However, discrimination on the basis of gender identity and regarding HIV status was rated as more of a problem. Most criminal justice issues were also rated as more problematic in Mexico City than globally, with the exception of issues relating to sex work, which (while still deemed a problem by most key informants) were rated as less of a problem than they were worldwide.

One key informant reported “arbitrary cases of detention of people who get found ‘cruising,’” or looking for other LGBTI+ people publicly. Another noted “greater police violence” facing the LGBTI+ community, including those who engage in sex work, compared to the general population.

When asked about resilience in the local community, key informants noted nonprofit organizations, bars, and informal social spaces as key areas of support, but they said more support was needed from the government. One key informant, who named bars and other venues as the current center of LGBTI+ community, called for “implementation of permanent campaigns [and] creation of community centers and kitchens that give priority attention to LGBTI+ people.”



Asia-Pacific



3.6
QUALITY OF
LIFE SCORE
REGIONAL

Five cities from the Asia-Pacific region were included in this study: Bangkok; Melbourne; Quezon City; Taipei; and Tokyo. Three of these — Bangkok, Melbourne, and Quezon City — were selected as examples for individual analyses, which follow this regional description.

While the number of cities in this region was smaller than that for the other regions, it is reflective of the fact that the Fast-Track Cities network in the region is relatively small, although expanding (i.e., Tokyo is a prospective Fast-Track City). The expansion of the Fast-Track Cities network in the region is important because Asia has experienced a surge in HIV rates, particularly among sexual minority men and transgender individuals, over the past several years.

Quality of Life and Care

Key informants in Asia-Pacific rated the quality of life for LGBTI+ individuals at a considerably higher rate than the global average, giving their cities a score of 3.6 on a 1 to 5 scale (mode: 4; SD: 0.91) compared to the worldwide average of 3.2. Tokyo received the lowest score of the cities included in the study, with an average rating of 2.2, while Quezon City received the highest score, with a rating of 4.0.

Access to all types of care were similarly rated better in Asia-Pacific than they were globally, though they followed the same trends as were observed worldwide, in which access to HIV-related care was rated best (4.2 on a 1 to 5 scale; mode: 5; SD: 0.99), followed by culturally competent primary care (3.6; mode: 4; SD: 0.91). Lowest-scoring types of care were gender-affirming care (3.1; mode: 3; SD: 1.30) and mental health care (3.3; mode: 4; SD: 1.20).

“LGBTI+ health disparities are addressed mainly by non-profit organizations working for LGBTI+ people,” said a key informant in Tokyo who rated healthcare access there to be fairly poor. “Women, transgender people, racial and ethnic minorities, and people with disabilities” all face additional barriers to accessing care.



Health Outcomes

Data on HIV prevalence with respect to sexual and gender minority populations is the most detailed among the selected cities in Asia. Disaggregated data were complete among sexual minority men with the highest HIV prevalence reported in Bangkok (19.5%)¹¹⁰ followed by Quezon City (8.8%),¹¹¹ Melbourne (4.9%),¹¹² Taipei (4.3%),¹¹³ and Tokyo (3%).¹¹⁴ Similarly, transgender women in Asia also are at considerable risk for HIV, with the highest estimated HIV prevalence seen in Bangkok (12%-13.5%).^{115,116} In Melbourne, the limited data show an approximate HIV prevalence among transgender women of 4.5% and 2.5% among transgender men.¹¹⁷ These groups experience higher rates of HIV in their communities due to varying social, demographic, and economic factors, including victimization, stigma, discrimination, and harassment, all of which leads to further socioeconomic marginalization and exacerbates disparities in HIV among these populations. The HIV rates experienced by LGBTI+ people, particularly sexual minority men and gender minority individuals, are concerning as HIV rates in the region have trended upward over the past decade.¹¹⁸

Despite effective treatments, lack of access to culturally competent and stigma-free health care for sexual and gender minorities in the cities in the Asia-Pacific region leads to higher STI rates. In addition, the high prevalence of STIs is facilitated by a sex industry fueled by tourism and

local consumption. Among the selected cities that had disaggregated data on the prevalence of chlamydia and gonorrhea among sexual minority men, the lowest rate was seen in Quezon City (0.7% and 3.5%, respectively)¹¹⁹ and the highest in Bangkok, with chlamydia prevalence at 16% and urethral, rectal, and oropharyngeal gonorrhea, 34.7%, 29%, and 27.9%, respectively.¹²⁰ Syphilis infection among sexual minority men in the selected cities in Asia was also relatively elevated with the highest prevalence seen in Bangkok (24.4%)¹²¹ and the lowest in Taipei (2.2%)¹²² followed by Quezon City (2.1%).¹²³ Across selected cities in the Asia-Pacific region, there is a general lack of city-specific, population-level STI data for both transgender women and men. However, data from Bangkok show that a high prevalence of syphilis (3.2%), chlamydia (22.9%), and gonorrhea (14.3%) among transgender women.¹²⁴

Across the globe, substantial evidence has shown that sexual and gender minorities experience overall poorer mental health outcomes compared to their heterosexual counterparts or the general adult population. Although the governments within the selected cities in Asia have increased legislation and provided more accessible mental health services recently, there remains a general taboo and stigma around mental health, particularly within families and the community in which people live. Hence, people often do not seek treatment for fear of being ostracized; instead, they turn to either traditional family care alternatives or religious alternatives that maintain a sense of pride within one's immediate family. Overall, there was a lack of disaggregated data at the population level across cities. Rates of depression and anxiety among sexual and gender minority groups remain significantly higher due to a combination of discrimination, victimization, and internationalization of stigma, among other factors. Concerningly, transgender women in Bangkok have an estimated 58.2% prevalence of depression,¹²⁵ and in Melbourne, depression rates range from 21.3% among intersex individuals¹²⁶ to 57.2% among transgender women and men.¹²⁷ In terms of suicidality, among gay and bisexual men in Taipei, 31% reported experiencing suicide ideation or attempting suicide, including 14.6% who reported having attempted suicide at some point in their lifetime.¹²⁸ In Melbourne, 30.3% of LGBTI+ individuals reported a suicide attempt at some point in their lives, including 5.2% who reported this within the past year.¹²⁹

Comparisons on drug and alcohol use were challenging because not every city had disaggregated data among sexual and gender minority groups at the population level and the way data were measured and reported varied in terms of quantity, frequency, and severity of use versus substance use disorder. Data that were available at the population level showed that 79.1% of transgender women and 75.1% of transgender men in Bangkok reported alcohol use in the past 12 months.¹³⁰ In terms of meeting diagnostic criteria for alcohol use disorder, the highest was seen in Quezon City with a prevalence of 24.7% among sexual minority men.¹³¹ Data on alcohol consumption in Melbourne grouped sexual minorities, including lesbian, gay and bisexual individuals, indicating that 22% reported drinking that exceeds lifetime risk guidelines and 38% reported drinking that exceeds single-occasion risk guidelines.¹³² Regarding other substance use, among transgender individuals in Bangkok, marijuana prevalence was the highest (12% compared to 5.5% among cisgender counterparts), followed by kratom (9%), amphetamine pills (3.0%), and crystal methamphetamine (2%).¹³³ Moreover, the prevalence of any substance use in Melbourne among lesbian, gay and bisexual individuals is 40%.¹³⁴

Tobacco use is also highly prevalent among gender minorities in Bangkok, with 67% of transgender women and 56.9% of transgender men having smoked tobacco in the past 12 months;¹³⁵ in Melbourne, 16% of sexual minority individuals reported daily smoking.¹³⁶ Sexual minority women in Quezon City have a 24.3% prevalence of smoking, whereas among sexual minority men, there is a 71.3% prevalence of smoking.¹³⁷ Finally, in Melbourne, research shows that 39% of LGBTI+ individuals identify as having some form of a disability or chronic health condition.¹³⁸

"It is difficult to be open as LGBTI+ and... live a normal, socially-acceptable life if sexual orientation is not disclosed."

Key Informant, Tokyo

Socioeconomic Factors

Key informants in these cities rated socioeconomic concerns of employment, housing, and food access below the global averages. Access to employment was the biggest socioeconomic concern, of which only 8% said it was not a concern at all, but only 14% said it was a “serious” concern, with a majority of the latter being from Bangkok. The remaining 78% of key informants rated employment as a minor or moderate concern. Access to food was the lowest of these concerns, with 61% saying that was “not at all a problem” for their local LGBTI+ population; again, Bangkok was the city in which this concern levels for this issue were highest. Overall, key informants in the Asia-Pacific region gave better ratings to the local response to these socioeconomic challenges than did key informants globally.

With respect to the assessments, there was a general lack of disaggregated population-level data among sexual and gender minorities with respect to the prevalence of unemployment, homelessness, poverty, and food insecurity. There exists little city-specific, but some country-level, population data on the prevalence of poverty among LGBTI+ individuals collectively, ranging from 9.9% in Bangkok to 12.6% in Melbourne and 16.6% in the Philippines. Regarding disaggregated population-level data on food insecurity, among LGBTI+ individuals, the prevalence of undernourishment ranged from 9.3% in Bangkok to 14.5% in the Philippines.¹³⁹

Discrimination

Overall, key informants in the Asia-Pacific region gave better scores on the problem of various types of discrimination than did the average key informant globally. However, unlike the global trend, HIV-based discrimination outranked intersectional discrimination as a concern in Asia-Pacific and roughly tied gender identity-based discrimination as a problem. Sixty-four percent of key informants said HIV-related discrimination was a “moderate” or “serious” problem, compared to 61% who said the same about gender identity-based discrimination, with fewer feeling the same about sexual orientation-based or intersectional discrimination. The relative strength of HIV discrimination as a concern should draw note as HIV advocates seek to address stigma as part of the global strategy to end the HIV pandemic.

In terms of the legal landscape explored in the assessments, neither same-sex marriage nor any other recognition of same-sex relationships are available in Bangkok, Quezon City, or Tokyo, while same-sex marriage is legal in Taipei and Melbourne.¹⁴⁰ Same-sex marriage has been legal in Taipei since 2019,¹⁴¹ and Taipei enacts legal protection against discrimination based on sexual orientation and gender identity in education,¹⁴² as well as protections against discrimination based on sexual orientation at work.^{143,144} Bangkok enacted broad anti-discrimination laws covering sexual orientation and gender identity and as of 2019; a civil partnership is being discussed by the Thai government which, if passed, would grant same-sex couples several rights of marriage, including property and inheritance rights.¹⁴⁵ Additionally, Melbourne has enacted legal protections to support the LGBTI+ community from discrimination.¹⁴⁶ In 2003, Quezon City approved an ordinance banning discrimination against sexual minorities¹⁴⁷ and the Tokyo Metropolitan Government has passed legislation banning discrimination based on sexual orientation and gender identity in workspaces.¹⁴⁸ Universally, across the selected cities of the Asia-Pacific region, transgender people are allowed to access appropriate gender-based organizations and are able to change their gender marker on legal documents; however, some key informants made comments to the contrary, indicating ongoing challenges facing transgender people in navigating legal systems.

Criminal Justice

As with problems related to socioeconomics and discrimination, key informants in the Asia-Pacific cities rated as less serious issues relating to criminal justice, when compared to global averages. As was the case globally, the legality of sex work and treatment of sex workers is the criminal justice issue rated most severely. Fifty percent of key informants said that this issue represented a “serious” or “moderate” problem for the LGBTI+ community in their city, while 31% said it was

“Many LGBTI+ people don’t come out to others. Some LGBTI+ people are not accepted by their family. LGBTI+ teenagers don’t get enough support in schools. Some LGBTI+ people are [unable] to find jobs.”

Key Informant, Taipei

a “minor” problem and 19% said it was “not a problem.” The next highest-rated problem was the treatment of racial and ethnic LGBTI+ minorities by the criminal justice system, followed by mistreatment of LGBTI+ people by police, the criminalization of HIV, and finally, the targeting of LGBTI+ people by law enforcement, which most said was “not a problem.”

The assessments found that same-sex relations and identities were legal throughout the cities selected for the study in Asia-Pacific. Bangkok, Melbourne, Quezon City, and Tokyo all criminalize and attempt to modulate behaviors through HIV specific statutes and regulations which penalize people who choose to not to disclose their HIV status and hold others liable for transmitting HIV to their sexual partners.¹⁴⁹ Regarding the legality of transactional sex in the selected cities, all have laws prohibiting the practice of exchanging sex for money.¹⁵⁰ However, in Bangkok and Quezon City, sex work is somewhat tolerated among the society with minimal law enforcement and legal action against sex workers.¹⁵¹ Furthermore, in Tokyo, the definition of “prostitution” is “intercourse with an unspecified person in exchange for payment,” and therefore fails to account for the sale of other sexual services which have become widespread and are considered legal.¹⁵²

Community Resilience

In written comments, key informants presented as common sources of resilience the work being done by nonprofit organizations and the social networks of LGBTI+ people themselves, including families of choice. Other key informants mentioned LGBTI+ community events, greater visibility in recent years in the media, and support from friendly business and government leaders as sources of resilience.

In terms of supporting community resilience, all four sectors included in the survey — local government, providers, nonprofits and the private sector — fared better across the six Asia-Pacific cities than they did globally. However, while nonprofits still received the best marks, local government and the private sector more significantly outperformed the global averages. Nonprofits received a 4.1 score on a 1 to 5 scale (mode: 4; SD: 1.00) compared to a 3.9 globally; the private sector received a 3.5 (mode: 3; SD: 1.08) compared to 2.9 globally; and local government received a 3.4 (mode: 4; SD: 1.25) compared to 3 globally. In a change from the global trend, providers — who came in second worldwide in terms of how well they engage with the local LGBTI+ communities — came in last in the Asia-Pacific region, with a 3.3 score (mode: 4; SD: 1.16), although they were only modestly behind local government and the private sector.

Factors thought to support LGBTI+ resilience were found in all the selected cities in the Asia-Pacific region, including community spaces and resources (e.g., tourism association, pride events). Additionally, in all cities, public funding has been allocated for LGBTI+ specific service organizations. Similarly, LGBTI+ scientific research was available for all selected cities in this region, including reports or plans on advancing health equity in the local and wider community.

Conclusion

The cities in the Asia-Pacific region that were included in this study demonstrated a variety of strengths relative to the average city globally, including higher ratings for healthcare services and public engagement, and lower levels of concern around socioeconomic, discrimination, and criminal justice-related problems. Concerns regarding HIV-related discrimination rated relatively highly as community concerns, and providers scored relatively poorly in terms of their relationships with LGBTI+ communities. In addition, of all the problems included in the survey, only two — food access and targeting of LGBTI+ individuals by police — were rated as “not a problem” by a majority of key informants, indicating that a wide variety of challenges still exist for these communities.

Additionally, data assessments showed HIV disparities facing LGBTI+ individuals in the Asia-Pacific region that were of increasing concern, as well as other health inequities where data were available, such as with respect to substance use and mental health. Legal protections and policies recognizing LGBTI+ identities and relationships were also limited.

Select Cities

Bangkok

Overall, key informants in Bangkok gave their city a higher quality of life score than the global average, 3.4 on a 1 to 5 scale compared to 3.2 globally. However, on three out of four types of care, they rated their city well below the global averages; this was especially true regarding mental health care, in which a majority of key informants gave the lowest available score of 1, and the average was just 1.7, compared to a 2.8 worldwide.

However, with respect to gender-affirming care, key informants gave Bangkok a better score than the global average: 3.1 versus 2.7 globally. "Gender-affirming surgery is readily available in Bangkok," a physician and researcher said. "In fact, more transgender women undergo surgery in Bangkok than in any other city in the world. However, the procedure is not covered by insurance [and] gender-affirming hormone treatment is less available."

"Transgender health services are not included in any national health plan or coverage," said another key informant, who gave a low score to gender-affirming care access. "This left transgender people a massive barrier to access to proper healthcare."

While key informants in Bangkok scored housing and food access as much less of problems than they were rated for LGBTI+ people globally, they rated employment access as a more serious problem than their global peers, with all key informants saying this was either a "serious" or "moderate" problem. "Transgender people still face massive stigma and discrimination on employment, which leaves them with very limited employment options," said one key informant. "For these reasons, many of them are forced to engage in sex work." Indeed, both discrimination on the basis of gender identity and the treatment of sex workers were rated as much more problematic in Bangkok than they were worldwide.

Given the wide variety of challenges facing Bangkok's LGBTI+ community, but its nonetheless above average quality of life score, community resilience is likely key. Even more so than with the global trends, nonprofits were rated quite well in how they support local LGBTI+ individuals compared to other actors, and most key informants named community organizations and the community itself as sources of strength.

3.4
QUALITY OF
LIFE SCORE
CITY



"There are few LGBTI+ specific services available in Thailand. Due to stigmatization and the fear of discrimination, most LGBTI+ people do not reveal their sexual orientation or behavior when accessing health services and therefore do not receive appropriate care or counselling when accessing HIV/STI screening and prevention services."

Key Informant, Bangkok





3.8

QUALITY OF
LIFE SCORE
CITY

Melbourne

Key informants in Melbourne rated their city above average in terms of quality of life for LGBTI+ people, with a 3.8 on a 1 to 5 scale, compared to 3.2 worldwide. Similarly, they rated access to LGBTI+ inclusive primary care, mental health care, and HIV services better than the global averages. With respect to gender-affirming care, the city was rated slightly below the global average, with a 2.6 average and no informant scoring said care above a three.

Across the board on socioeconomic and criminal justice issues, key informants in Melbourne rated these as being lesser problems than did key informants worldwide. The one exception was on the problem of a disproportionate impact of the criminal justice system on LGBTI+ people of color, where Melbourne key informants scored their city the same as the global average.

Melbourne also scored better in relation to discrimination on the basis of sexual orientation and HIV status, as well as intersectional discrimination, although the city received the same “moderate” problem average score as did the rest of the world on the issue of gender identity-based discrimination.

Key informants in Melbourne gave strong marks to how local actors engage with LGBTI+ individuals, and the local government in particular scored much better than the global average, receiving a 4.2 on a 1 to 5 scale, compared to 3.0 globally. Additionally, unlike global responses, Melbourne’s key informants singled out LGBTI+ community events (e.g., pride events, fundraisers, festivals) as a major source of resilience, while calling for increased institutional participation in such activities.

The situation for LGBTI+ people “has improved enormously over the last 20 years with consistent state government support, increasing policy initiatives,” said a clinician and researcher. “We are the envy of all other states in Australia.”

“There seems to be a strong and committed focus on LGBTI+ health and wellbeing in our state government that is reflected in high levels of consultation with LGBTI+ communities and the distribution of some funding to address critical issues. The nonprofits seem to be addressing the impacts of intersectionality within our LGBTI+ communities and are starting to focus on the issues impacting a broader cross section of the community beyond the traditional gay white male focus.”

Key Informant, Melbourne





4.0

QUALITY OF
LIFE SCORE
CITY

Quezon City

Overall, key informants in Quezon City rated LGBTI+ quality of life in their city at 4 on a 1 to 5 scale, better than the global 3.2 average. They also rated access to care above the global averages, and followed the same trend as did ratings worldwide, in which HIV care was rated best, followed by primary care, with gender-affirming care and mental health care lagging.

While services were better rated in Quezon City than elsewhere, and many of the challenges facing LGBTI+ people were rated as less problematic, most key informants noted the persistent stigma and discrimination facing the community. “Although it has lessened, discrimination and lack of information regarding LGBTI+ and everything about it still serve as the major problem in the city,” said one key informant.

Some key informants noted that the challenges facing the LGBTI+ community are particularly pronounced in the poorest sections of the city, where opportunity in general is lower, access to services is more limited, and knowledge about LGBTI+ individuals is low.

In terms of building resilience, some key informants praised the work being done by nonprofit organizations and the city government, while others suggested initiatives be more grassroots-oriented and participatory. “In order for a policy to be effective, it should be participatory,” said one key informant. “In other words, let the LGBTI+ people create the policy they need and make sure that it is implemented down to the smallest community.”

“The LGBTI+ community has been working hard... to prove to others that they are also capable of doing the same things as everyone else, or even more.”

Key Informant,
Quezon City





Europe

This study included 15 cities from across Europe: Amsterdam, Athens, Berlin, Brussels, Copenhagen, Dublin, Glasgow, Kyiv, Lisbon, London, Madrid, Milan, Paris, Prague, and Vienna. Three of these cities — Athens, Kyiv, and London — were selected to serve as examples with individual analyses following this regional description.

Even among the majority of these cities that are part of the European Union, the cities face a variety of legal and policy landscapes that underpin LGBTI+ issues, as well as diverse LGBTI+ community histories and cultural backdrops that inform LGBTI+ health equity in each.

Quality of Life and Care

Overall, key informants in Europe gave their cities an average quality of life score of 3.3 (mode: 4; SD: 0.85) on a 1 to 5 scale, just slightly above the global average of 3.2. A plurality of key informants (40%) gave their city a score of 4.

Regarding quality of care, key informants scored each facet of care roughly the same as their global counterparts. As was the trend globally, HIV care scored best, with a 3.8 on a 1 to 5 scale (mode: 4; SD: 1.04) followed by general care with a score of a 3 (mode: 3; SD: 1.03), mental health care with a score of 2.8 (mode: 2; SD: 1.01), and finally gender-affirming care with a score of 2.6 (mode: 2; SD: 1.13).

Many key informants noted the work of nonprofits as being key to addressing health inequities, and many noted the need for additional resources to build on what services do exist. “LGBTI+ health concerns are largely addressed through symbolic gestures (speeches, pamphlet launches), and rarely through commitment of substantial resources,” said an anthropologist and sexuality expert in Dublin. “Specialist clinics have been at capacity for years.”



Health Outcomes

Data on HIV prevalence with respect to sexual and gender minority populations is the most detailed assessment area among the selected cities in Europe. Disaggregated data were complete among sexual minority men, with the highest HIV prevalence in Amsterdam (19.9%), followed by Berlin (19.7%), Lisbon (17.6%), Copenhagen (17.1%), Paris (16.3%), Kyiv (15.3%), London (14.6%), Brussels (14.5%), Athens (14.2%), Madrid (14%), Milan (12.3%), Prague (10.9%), Vienna (10.1%), Dublin (8.4%), and Glasgow (4.4%).¹⁵³ Although much of Europe has access to cutting-edge HIV treatment options and preventative strategies, sexual and gender minorities experience higher rates of HIV despite comprising a small percentage of Europe's population. As noted in HIV prevention literature in European cities, discrimination on the basis of sexual orientation or gender identity including for employment, public accommodations, housing, or healthcare can lead to mental health problems, such as anxiety and depression, which can then contribute to behaviors that place individuals at risk for HIV acquisition. The potential real-life consequences of bias, victimization, and discrimination with respect to social, cultural, demographic, and economic factors modulate the spread of HIV and exacerbate disparities in HIV prevalence and treatment among these populations. Furthermore, social determinants related to discrimination and oppression, including institutional discrimination in healthcare access and treatment, as well as a shortage of healthcare providers who are culturally competent and knowledgeable in LGBTI+ health modulates higher rates of STDs among sexual and gender minority populations in the majority of the selected cities in Europe.

Chlamydia infection among sexual minority men is relatively high compared to heterosexual counterparts or the general adult population with the highest prevalence rate reported in London (29.6%), followed by Athens (26%), Paris (11.7%), Amsterdam (10%), Glasgow (7.1%), Copenhagen (6.4%), Berlin (3.8%), Madrid (3.7%), Vienna (3.5%), Lisbon (2.9%), Kyiv (1.9%), Milan (1.5%), and Prague (1.2%). Disaggregated data among the selected cities in Europe reveal the highest Gonorrhea prevalence in London (44.3%), followed by Athens (18.3%), Amsterdam (11.8%), Paris (10.8%), Glasgow (8.0%), Lisbon (7.8%), Brussels (6.8%), Copenhagen (6.9%), Madrid (6.1%), Berlin (4.3%), Vienna (4%), Prague (2.4%), Milan (2.3%), and Kyiv (1.9%). The highest syphilis prevalence was reported in Athens (37.9%), followed by Paris (13%), Milan (9.1%), London (8.54%), Berlin (8.1%), Prague (5.6%), Madrid (5.4%), Lisbon (5.3%), Brussels (7.3%), Copenhagen (3.1%), Glasgow (3.1%), Vienna (3%), Kyiv (2.4%), and Amsterdam (2.3%).¹⁵⁴

Across the cities in Europe, evidence revealed that sexual and gender minorities experience higher rates of mental health issues when compared to the general population. Disaggregated data regarding anxiety are the most complete among sexual minority men, with the highest anxiety prevalence Dublin (41.7%), Kyiv (12.1%), London (10.7%), Athens (9.1%), Prague (9%), Copenhagen (7%), Lisbon (6.9%), Paris and Brussels (6.5%), Madrid (5.9%), Berlin and Amsterdam (5.1%), and Vienna (3.6%).¹⁵⁵ Strikingly, the prevalence of anxiety is 60% among lesbian, gay and bisexual individuals in Glasgow and 72% and 47% among transgender women and men in Glasgow and Milan, respectively.^{156,157} Data regarding depression rates that were available at the population level reveal, on average, 46.8% of sexual and gender minorities in Dublin reported some level of depression.¹⁵⁸ Additionally, the prevalence of depression is 49% among sexual minority individuals and 72% among transgender people in Glasgow,¹⁵⁹ 52% among LGBTI+ individuals in London,¹⁶⁰ and 63.1% among transgender individuals in Milan.¹⁶¹ With respect to suicide prevalence, 21.4% of all LGBTI+ participants in Dublin had ever seriously attempted suicide,¹⁶² whereas 46% of transgender individuals and 31% of sexual minority individuals in London attempted suicide.¹⁶³ Finally, the highest prevalence of attempted suicide (51.7%) was seen among transgender individuals in Milan.¹⁶⁴

There is an overall general lack of disaggregated population-level data among sexual and gender minorities with respect to diabetes and obesity. Glasgow registered on the high end of diabetes prevalence, which was at 2% among sexual minority individuals there,¹⁶⁵ while London had the highest prevalence of being overweight or obese, which was true of 44% of sexual minority men.¹⁶⁶

"Despite efforts to combat discrimination and stigma, there are still a number of obstacles in accessing certain services (i.e., housing). In this sense, the Lisbon City Council created a plan that seeks to provide specific responses to the LGBTI+ community and to fight transphobia and homophobia, integrating vulnerable populations such as migrants, refugees, [and] people who use drugs."

Key Informant, Lisbon

“These disparities are largely overlooked. No data are being collected on citizen’s sexual orientation or gender identity [and] community surveys are largely missing in this area. The city has so far not addressed these disparities because they have so far not developed an interest and a sense of care for citizens who are not heterosexuals.”

Key Informant, Prague

Comparisons regarding alcohol and drug use across the selected cities in Europe were challenging because not every city has disaggregated data among sexual and gender minorities and the data that was measured and reported varies in terms of quantity, frequency, and severity of use versus a diagnosis of substance use disorder. Data that were available at the population level reveal that 35.4% of sexual minority men in Dublin report current smoking¹⁶⁷ and in Copenhagen, one in five LGBTI+ individuals smoke daily and one in four bisexual women smoke cannabis.¹⁶⁸ In Glasgow and London, 15% of LGBTI+ individuals report smoking every day,^{169,170} whereas 43.1% of sexual minority men in Paris report using cigarettes or e-cigarettes daily.¹⁷¹ Furthermore, 54.5% and 35% of sexual minority men in Paris¹⁷² and Dublin,¹⁷³ respectively, have a prevalence of any current illicit substance use. Importantly, in terms of active use, 11% and 13% of LGBTI+ individuals aged 18 to 24 in Glasgow¹⁷⁴ and London,¹⁷⁵ respectively, report using drugs at least once a month. In terms of meeting diagnostic criteria for potential alcohol dependency, the highest was seen in Kyiv with a prevalence of 30.6% among sexual minority men, followed by Berlin (22.1%), Vienna (21.8%), Lisbon (14.8%), Madrid (14.9%), Prague (14.4%), Amsterdam (13.5%), Milan (10.8%), and Athens (10.1%).¹⁷⁶ In Copenhagen, 16.0% of gay men exceed the high-risk limit (21 units of alcohol per week) and 17% of transgender individuals drink more than 17.5 units per week.¹⁷⁷ Among LGBTI+ individuals in London¹⁷⁸ and Glasgow,¹⁷⁹ 16% and 14% reported daily drinking, respectively. Among sexual minority men in Dublin, 58% reported binge-drinking in the last twelve months,¹⁸⁰ whereas 46.7% of sexual minority men in Paris reported alcohol use (five or more drinks in one sitting).¹⁸¹

Finally, no population level data on the prevalence of disability was available with disaggregation by sexual or gender minority status.

Socioeconomic Factors

On two socioeconomic questions — access to employment and housing — European key informants were almost exactly in line with key informants globally. Four percent said that employment access was “not a problem” (compared to 5% worldwide), 28% said it was a “minor” problem (25% worldwide), 43% said it was a “moderate” problem (43% worldwide), and 26% said it was a “major” problem (27% worldwide). A similar trend held for access to housing, which was considered more of a challenge, with 38% finding it to be a serious problem (compared to 42% worldwide).

However, the European cities did perform better than the global average when it came to access to sufficient and nutritious food for LGBTI+ individuals. Here, a third of key informants (33%) said it was “not a problem” (compared to 24% globally) while only 4% said it was a “serious” problem (compared to 13% globally), with the rest rating it a “moderate” or “minor” problem.

With respect to the data assessments, there is a lack of disaggregated population-level data among sexual and gender minorities relating to the prevalence of homelessness and food insecurity. There exists some city-specific and country-level, population data on the prevalence of unemployment with the highest rates in Greece (15.9%)¹⁸² followed by Italy (10.7%),¹⁸³ Madrid (10.3%),¹⁸⁴ Portugal (6.9%),¹⁸⁵ London (6.5%),¹⁸⁶ Ireland (5.8%),¹⁸⁷ Belgium (5.6%),¹⁸⁸ Copenhagen (5.3%),¹⁸⁹ Scotland (4.3%),¹⁹⁰ Germany and Netherlands (3.8%),¹⁹¹ and Czech Republic (3.4%).¹⁹² As far as disaggregated country-level population-level data on poverty rates, the highest rates exist in Greece (31.8%)¹⁹³ followed by Spain (20.7%), Italy (20.1%), Portugal (17.2%), Switzerland (16%), Belgium and Germany (15.8%), France (13.6%), Austria (13.3%), Ireland (13.1%), Denmark (12.5%), and Czech Republic (10.1%).¹⁹⁴

Discrimination

Key informants for the European cities scored sexual orientation and gender identity-based discrimination as being slightly less of a problem in their communities than the global average. HIV-related discrimination scored equally problematic, while discrimination against people with multiple forms of marginalization (i.e., LGBTI+ racial and ethnic minorities) scored as a bigger problem than it did worldwide.

On sexual orientation-based discrimination, while 87% of key informants said that it was a problem, only 12% said that it was a “serious” problem, compared to 19% globally who said the same. Regarding gender identity-based discrimination, a larger 92% share felt that it was a problem, and a more significant 29% said it was a “serious” problem — but, again, this was better than the 33% who said it was a “serious” problem globally.

Intersectional discrimination was noted as a serious problem by 36% of key informants in Europe, almost identical to the 35% who said so globally. This is in keeping with the fact that 66% of key informants specifically named migrants, refugees, and/or asylees as individuals facing particular hardships when asked if any groups within the LGBTI+ population face inequities.

The assessments found that discrimination on the basis of sexual orientation and, to a lesser extent, gender identity was banned in most of the selected cities in Europe. For example, only Milan does not have a regional or national ban on gender identity-based discrimination in employment settings. Across all selected cities in Europe, same-sex relations are legal and, in most cities, recognized. However, same-sex marriage is still not available in four of the cities included from Europe: Athens, Kyiv, Milan, and Prague.¹⁹⁵ Across all selected cities in Europe, hate crimes are recognized and punishable by law. Universally, across the European Union, transgender people are allowed to access appropriate gender-based facilities and are able to change their gender marker on legal documents.

Criminal Justice

Key informants in Europe scored criminal justice issues as being less of a problem for LGBTI+ individuals than did the average key informant worldwide, specifically in the areas of mistreatment or targeting by police, criminalization of sex work and treatment of sex workers, and a disproportionate impact on racial and ethnic minorities. However, the European cities did not score better than the global average on criminal justice issues relating to HIV status and disclosure, instead rating that problem equally with their global peers.

While key informants rated criminal justice issues as slightly less problematic in Europe than elsewhere in the world, most still believed they were at least a “minor” a problem for their community. Seventy-five percent said that mistreatment by the police was a “minor,” “moderate,” or “serious” problem; 56% said that targeting of LGBTI+ people for arrests was a problem; 94% said criminalization of sex work and/or treatment of sex workers was a problem; 78% said that criminalization of HIV exposure and/or nondisclosure of status was a problem; and 81% said a disproportionate impact on LGBTI+ racial and ethnic minorities was a problem. This was consistent with the global trend in which issues relating to sex workers were deemed the most problematic.

66%

of key informants
in Europe volunteered
“migrants,” “asylees,”
or “refugees” when
asked if any LGBTI+
subgroups face
particular hardship

AND

96%

said that **intersectional
discrimination** was a
problem in their city

Regarding the assessments, LGBTI+ identities and relationships are not criminalized in any of the European cities included in the report. With respect to the transmission and non-disclosure of HIV status to sexual partners, all European countries criminalize or control behaviors through HIV-specific statutes and regulations; however, in Amsterdam, only intentional HIV exposure or transmission are criminalized, making it one of the most advanced cities in the world when it comes to laws seeking to criminalize transmission and non-disclosure of HIV status to sexual partners. With respect to the legality of transactional sex in Europe, nine of the selected cities have laws making the practice of exchanging sex for money illegal, while Amsterdam, Athens, Berlin, Copenhagen, Brussels, and Vienna do not. However, in most of the latter group of cities, there are regulations in place surrounding activities such as operating brothels, receiving money from or facilitating exchanges of sex and money between other parties, and soliciting money in exchange for sex. In Dublin and Paris, it is illegal to pay for sex, but not to be a sex worker (the client commits a crime, but not the sex worker).

“Copenhagen isn’t a paradise for LGBT+ people just because we offer LGBT+ people extensive rights; the culture needs to change.”

Key Informant,
Copenhagen

Community Resilience

As with other parts of the world, key informants in Europe were most likely to name community organizations and the community’s internal strength as the two main source of resilience. Key informants in Europe were, however, more likely than those elsewhere to name local LGBTI+ bars, cafes, and social establishments as a source of community strength.

European key informants gave their cities slightly better scores than the global averages in terms of how local governments, nonprofit organizations, and the private sector engage with their community, while giving the same score to providers as did key informants worldwide. Still, the scores showed much room for improvement. As with the global trend, nonprofit organizations received the best score for their community engagement, with a 4.1 on a 1 to 5 scale (mode: 4; SD: 0.78). Local governments scored a 3.1 (mode: 4; SD: 1.19), as did providers (mode: 4; SD: 1.05), while the private sector was only slightly behind with a 3 (mode: 3; SD: 1.01).

In all of the selected cities of Europe, assessment factors thought to enhance and support LGBTI+ resilience are available, including community spaces and resources (e.g., tourism association, pride events) and allocated funding for LGBTI+ specific service organizations. In an effort to overcome intersecting dynamics of discrimination, societal harassment, and stigma, community-building models of social work practice help alleviate feelings of alienation and oppression by creating a family-like community based on empathy and relatability which promotes perseverance and adaptability in the face of adversities. Among the selected cities of Europe, Kyiv is the only city that does not have an LGBTI+ office or liaison and does not offer or promote publications on sexual and gender minority scientific research, which includes reports or plans on advancing health equity in the local and wider LGBTI+ community.¹⁹⁶⁻²⁰⁴

Conclusion

Overall, Europe performed better than the global average in many areas of the assessment (e.g., having positive policies in place, having available community resources), as well as in the key informant surveys (e.g., discrimination, criminal justice, food access, relationships with local institutions). However, the key informants in European cities gave their local LGBTI+ quality of life only a slightly better score than the global average, with a 3.3 on a 1 to 5 scale compared to a 3.2 globally. Additionally, LGBTI+ inclusive health services were not rated much better than the global average. These results suggest that while LGBTI+ people in European Fast-Track Cities enjoy better policies, more visibility, and greater inclusion than the average LGBTI+ person worldwide, there is still much room for improvement, particularly with respect to health services. Additionally, the assessment results reveal missing data on LGBTI+ issues in Europe, despite the communities’ relatively high visibility and political support.



2.8
 QUALITY OF
 LIFE SCORE
 CITY

Select Cities

Athens

Key informants from Athens reported a quality-of-life score of 2.8 on a 1-to-5 scale — well below the global average of 3.2. Access to quality, inclusive types of care were also ranked more poorly than international averages, with access to gender-affirming care rated just 2.2 out of 5.

In a reverse of the global trend, key informants in Athens rated access to employment as an even bigger challenge than access to housing. Ninety-one percent of key informants said access to employment was a serious or moderate challenge, compared to 81% who said the same of housing.

Key informants in Athens were far more likely than their global counterparts to name all types of discrimination (based on sexual orientation, gender identity, HIV status, and intersectional factors) as being a “serious” problem for their community. While LGBTI+ Athenians enjoy strong nondiscrimination protections, a lack of other legal recognitions — such as same-sex marriage and adoption, as well as easier policies to change gender identity documents — may prevent the underlying stigma facing LGBTI+ people to be addressed.

“There is not gender-affirming care in my city and also no planning in doing so in the future. There is no education about healthy sex practices not only for the LGBTI+ people but also for cisgender/heterosexual people. Most of the progress that has been made is due to the work of non-profit organizations but there is still a long way ahead.”

Key Informant, Athens



“Same-sex marriage is not legalized (apart from civil unions). Adoption by same sex couples is still a taboo issue. Homophobia and transphobia are rampant in Greek society and often enforced by the Orthodox Church and right-wing politicians.”

Key Informant, Athens



2.7

QUALITY OF LIFE SCORE
CITY

Kyiv

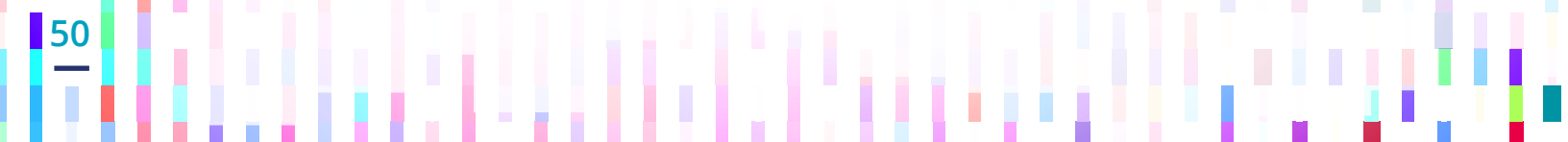
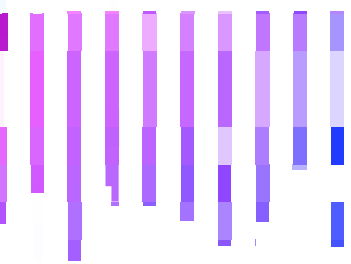
Kyiv was in the minority of European cities with respect to several legal and policy factors, including in that it does not yet have legal recognition of same-sex couples. There was also no evidence found when completing the city's assessment of a formal LGBTI+ advisory group or a public LGBTI+ equity report.

A small sample of key informants in Kyiv reported that progress had been made but was incomplete. "The situation has been changing for the better in recent years," said one key informant working in public health. "LGBTI+ representatives hold public events, the local authorities allow and protect them. Doctors and society as a whole have become tolerant of LGBTI+ people, although it should be noted that there are problems... I would like more participation of local governments in support of the LGBTI+ movement." Intolerance, violence, and stigma, especially from certain political and cultural groups, were also identified as challenges by key informants.

Additionally, HIV remains a major issue for LGBTI+ people in Kyiv, with 15.3% of sexual minority men self-reporting that they are living with HIV; the same survey also found that 12.6% of sexual minority men in the city had recently experienced severe anxiety or depression.^{205,206} However, Kyiv has made progress on HIV issues since joining the Fast-Track Cities initiative: between 2015 and 2019, the number of people living with HIV who were on ART jumped from less than 50% to over 80%, and the percentage of those individuals who were virally suppressed reached 96% in 2018.^{207,208}

"In general, the basic human rights remain a non-achieved dream for LGBTI+ [people]: equality in marriage and child adoption; be yourself in public openly; to take your partner's hand, kiss, hug without fear of attack."

Key Informant, Kyiv





3.4
QUALITY OF
LIFE SCORE
CITY

London

London's key informants gave their city a higher LGBTI+ equality of life score than the global average, with a 3.4 on a 1 to 5 scale, compared to 3.2 worldwide. They also gave above-average marks on primary, mental health, and HIV related care; for example, every key informant gave their city a four or five score on the availability of affordable, quality HIV services. On the other hand, key informants rated their city's availability of gender-affirming care at slightly below the global average, with a majority of key informants giving such care a score of a two.

Key informants in London identified problems facing LGBTI+ racial and ethnic minorities. Disparate impact on this particular population by the criminal justice system was considered the most problematic of criminal justice issues on which they were surveyed, and intersectional discrimination was rated the most problematic form of discrimination, with all key informants saying it was a "moderate" or "serious" challenge. In contrast, just one key informant said that discrimination facing sexual minorities in general was a "moderate" or "serious" problem in the city.

Local government, providers, and nonprofits all scored above the global average for their work on engaging the community, while the private sector scored slightly worse than the global average. The assessment conducted for London also found a wide array of public supports thought to build community resilience, and the city has a favorable policy landscape, including nondiscrimination protections and same-sex marriage.

Still, several key informants called for engagement with a wider and more diverse segment of the LGBTI+ population. "Representation is not enough," said one key informant. "It needs to be supported by an evidenced, long-term commitment to challenging issues of poverty that have the biggest impact on all aspects of health and wellbeing."

"Regrettably, LGBTQIA+ health is overly pathologized — looking for things to 'fix' rather than taking a more holistic approach to overall health and wellbeing. However, considering the austere environment to funding and resource allocation, this is not surprising."

Key Informant, London



"Disruptions in education, employment, and housing are common issues, particularly for transgender people and migrants."

Key Informant, London

Recommendations

Overcoming LGBTI+ Health Equity Barriers

Based on the findings of this report, the following recommendations are being issued to advance LGBTI+ health equity in Fast-Track Cities and beyond. The overarching and cross-cutting recommendations include principles that are broadly applicable to a variety of actors who impact LGBTI+ health equity. These are followed by specific recommendations for local governments, providers and health systems, community-based organizations, national governments, and international actors.

OVERARCHING & CROSS-CUTTING

- 1. PRIORITIZE THE ELIMINATION OF INEQUITIES WITHIN LGBTI+ COMMUNITIES.** The results of this report demonstrate that, while each local context is different, inequities are present *within* LGBTI+ communities around the world. These inequities affect racial and ethnic minorities, gender minorities, women, and other groups. LGBTI+ health equity cannot be addressed without identifying, engaging with, and prioritizing these disparately impacted subpopulations.
- 2. ADDRESS UNDERLYING SOCIOECONOMIC FACTORS.** While data on social determinants of health rarely included disaggregated data on LGBTI+ populations, key informants shared many concerns with respect to access to employment, housing, and food. These issues are all key to achieving health equity and can be addressed through nondiscrimination laws, which were lacking or incomplete in most cities, as well as socioeconomic development policies and programs designed for LGBTI+ populations, such as enhancing inclusive labor policies and educational environments and providing LGBTI+ specific employment opportunities and academic scholarships.
- 3. IMPROVE INCLUSIVE DATA COLLECTION.** Even in cities that were relatively highly resourced and LGBTI+ inclusive, data regarding LGBTI+ health equity were lacking, especially outside of the topic of HIV (such as with respect to noncommunicable diseases). Additionally, data on social determinants of health were lacking in most places. Surveillance systems and research must include sexual orientation and gender identity questions to fully define and understand the needs of these populations. For surveillance systems to effectively do so, LGBTI+ individuals must feel safe and comfortable in self-identifying as LGBTI+.
- 4. ADDRESS CRIMINAL JUSTICE DISPARITIES.** While only a few cities were in countries that outright discriminate against LGBTI+ people through laws criminalizing same-sex relationships, many criminalized sex work and/or HIV exposure, which likely have a disparate impact on LGBTI+ populations. Additionally, key informants indicated an overall discriminatory impact of criminal justice systems, especially for LGBTI+ racial and ethnic minorities. Both criminal law and the practices of the criminal justice system must be reformed to protect and strengthen LGBTI+ civil rights and to ensure that LGBTI+ people can safely live their lives, enjoy socioeconomic opportunities, and access health services.
- 5. ENSURE NONDISCRIMINATION.** Data assessments revealed that few jurisdictions had comprehensive nondiscrimination protections in place that guaranteed equitable access

to health services and insurance benefits, especially for transgender individuals, as well as to socioeconomic opportunities such as employment and housing. Furthermore, key informants indicated that access to these services and opportunities was limited and that discrimination was common. Nondiscrimination laws with proper enforcement are the first step on the path to full social inclusion.

6.

ENGAGE COMMUNITIES AT ALL LEVELS. Key informants indicated that while nonprofits did relatively well at engaging with local LGBTI+ communities, far more work was needed with respect to healthcare providers, government entities, and the private sector. Assessments revealed that many local governments in Europe and the Americas had local LGBTI+ advisory groups and some funding for LGBTI+ organizations or events, but fewer cities had formal LGBTI+ liaisons, offices, or public reports on advancing equity. LGBTI+ communities in Africa and, to a lesser extent, Asia-Pacific were particularly in need of such formal support and engagement. While local responses to housing, food, and employment issues all left much room for improvement according to key informants, responses to the issue of housing were particularly rated as low, suggesting this could be an important area to increase engagement.

7.

RECOGNIZE GENDER MINORITIES AND THEIR HEALTH NEEDS. Gender minorities in many cities lacked even a basic recognition of their gender identity, with many not having access to identity documents that reflect their name and gender or being able to access gender-based facilities that correspond with their identities. Transgender people also did not have equal access under the law to gender-affirming care in many jurisdictions, and actual access in practice was a need indicated across regions by key informants. This basic legal recognition and access to gender-affirming care is essential for meeting all other health

8.

equity goals among gender minority populations.

IMPROVE HEALTH SYSTEMS. Access to culturally competent care was noted as a significant need among key informants, with mental health and gender-affirming care options said to be particularly lacking. Cultural competency education should be encouraged or mandated to improve health systems' basic ability to respond to LGBTI+ health needs. Without such improvements, health systems themselves will be a barrier to rather than a partner in ending LGBTI+ health inequities.

9.

FOSTER MULTILATERAL COLLABORATION. Advancing LGBTI+ health equity in cities around the world will require innovative collaboration between local, national, and international actors, including governments, nonprofits, and the private sector. The Fast-Track Cities network is an example of city multilateralism, in which cities augment traditional health diplomacy and engage with other cities as well as national and international actors to advance shared goals. This dynamic is especially important given the shared dependence between national governments (which set relevant laws, issue funding, and collect data) and local governments (which are more closely connected to communities and lead public health responses).

10.

SUPPORT HIV SERVICE PROVIDERS AS LGBTI+ CARE LEADERS. Globally, access to low-cost, low-barrier HIV services was rated higher than other types of healthcare services. Those working in the field of HIV can help foster connections to other types of care, build trusted networks, and train other providers on engaging with LGBTI+ communities.

CITY AND MUNICIPAL GOVERNMENTS

Cities and municipal governments around the world have been leaders in advancing LGBTI+ equity and must continue to lead the way. In addition to offering the overarching recommendations above, this report is making the following recommendations specifically to city and municipal governments:

- 1. ENACT LOCAL NONDISCRIMINATION ORDINANCES OR POLICIES.** While national nondiscrimination laws or constitutional provisions often offer the strongest protection for LGBTI+ individuals, local ordinances or policies could fill in many of the gaps identified in this report. Such actions, even if relatively limited, can also send a symbolic message of inclusion, make local LGBTI+ communities feel seen, and open a larger dialogue.
- 2. ESTABLISH FORMAL COLLABORATIONS WITH LOCAL STAKEHOLDERS.** Many cities in Europe and the Americas, and a few cities in Asia-Pacific and Africa, have established formal collaborations with local stakeholders, such as LGBTI+ advisory groups, liaisons, or public plans, as well as funding for LGBTI+ organizations and events. This type of collaboration is an of what cities can often do better than countries, given their proximity and close ties to local populations. This is also an area in which local governments can generally act unilaterally, without the need for national policy changes or support.
- 3. SUPPORT AND IMPLEMENT LGBTI+ SPECIFIC RESEARCH.** This report revealed a dearth of data that can be disaggregated based on sexual orientation and gender identity. While much of the relevant data is collected primarily at the regional or national levels, local governments gather data or support research that could be invaluable in informing local LGBTI+ health needs; this includes advancing comprehension of current health inequities and learning how to better implement policy and funding solutions. While this type of research can be challenging — especially when data collection follows national guidance or templates — increasing data whenever possible is a worthwhile step in the right direction. Local governments should avoid seeing the relative newness and scarcity of sexual orientation and gender identity questions as a reason for inaction.
- 4. PROMOTE COMPREHENSIVE LGBTI+ CULTURAL COMPETENCY TRAINING.** Local governments can provide LGBTI+ cultural competency trainings to their staffs, as well as offer (and in some cases require) such training of local contractors and grantees. Regardless of how advanced LGBTI+ rights are in a given jurisdiction, training is important because it helps bring about the cultural change that is equally as important as legal change. Training of public-facing staff and contractors helps ensure that interactions with LGBTI+ individuals are respectful and inclusive, while training of staff such as administrators and managers can ensure that LGBTI+ populations are properly considered when policy and funding decisions are made.
- 5. ADVOCATE FOR NATIONAL AND GLOBAL CHANGE.** The Fast-Track Cities initiative has proven that city governments can successfully engage in multilateralism and advance health goals through advocacy with national governments as well as through engaging with other cities and international actors. While cities may not always have the direct authority to act on all of the overarching recommendations noted above, they can be powerful forces in advancing change at home and abroad. This can be accomplished through direct advocacy as well as by serving as an incubator for change and providing an example of positive policies and strategies that can be more broadly applied.

PROVIDERS AND HEALTH SYSTEMS

Providers and health systems have an important role to play in addressing LGBTI+ health equity, both through the services that they provide to patients and the role they can play in advocating for systemic change. Following are recommendations for providers and health systems to take to strengthen local LGBTI+ health equity:

- 1. IMPLEMENT NONDISCRIMINATION POLICIES.** Even in settings that do not have local or national nondiscrimination laws applying to LGBTI+ individuals, providers and actors within health systems can often add these to their practices. This type of policy — as well as other actions, such as LGBTI+ inclusive messaging and imagery in medical offices — sends the message that it is a safe and welcoming place for LGBTI+ populations. Where outward support of LGBTI+ patients is not legally permissible, general nondiscrimination and inclusion policies could be effective.
- 2. CONDUCT LGBTI+ HEALTH EQUITY TRAINING.** Key informants indicated a dearth of LGBTI+ competent healthcare providers, particularly in the areas of mental health and gender-affirming care. Healthcare providers have an ethical responsibility to educate themselves about the needs of vulnerable populations. While systemic changes, such as the inclusion of LGBTI+ issues in health education curricula and licensing requirements, are needed, systems and providers can also take individual action, including through free or low-cost resources available online.
- 3. COLLECT SOGI DATA.** The data assessments for this report demonstrated major gaps in knowledge on LGBTI+ health issues, particularly at the local level. Healthcare settings collect a wide range of data that could be invaluable to better understand and address LGBTI+ health equity, were it possible to disaggregate such data based on sexual orientation and gender identity. Collecting such data (when the local context is one in which it is

safe to do so) also sends a welcoming and inclusive message to LGBTI+ patients and can serve as a catalyst for healthcare staff to learn more about LGBTI+ communities and their needs.

- 4. CREATE A LOCAL REFERRAL NETWORK.** Social determinants of health for LGBTI+ people are equally important to healthcare access in addressing inequities. Providers and health systems can play a crucial role in helping to connect LGBTI+ patients to culturally competent legal, housing, employment, food, and other services. These referral networks also ensure the reverse — that LGBTI+ individuals seeking services from community resources are connected to LGBTI+ inclusive care. Participation in community events and developing medical-legal partnerships are other methods of developing connections to LGBTI+ serving organizations.

- 5. ADVOCATE FOR CHANGE.** Policymakers should and often do take seriously the expert opinion of local healthcare entities and professionals. Individual providers can take action at the local level by advocating with decision-making bodies (i.e., submitting oral or written testimony at relevant proceedings), communicating with the public (i.e., writing an opinion piece on relevant policies), or advocating for change within their own clinic or hospital. Healthcare organizations can play a similar role, especially as many already engage regularly with local decision-makers. The healthcare sector can help bring a science-driven, evidence-based perspective to LGBTI+ issues that are often clouded by stigma and are over politicized.

COMMUNITY-BASED ORGANIZATIONS

Community-based organizations are key to the resilience of local LGBTI+ populations and must continue to expand their work on behalf of these communities in the pursuit of health equity. Following are recommendations for an enhanced role for community-based organizations to promote LGBTI+ health equity:

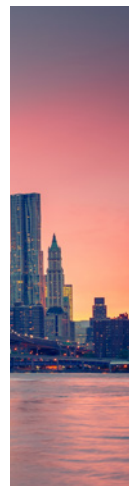
- 1. LEAD THE WAY ON LGBTI+ ENGAGEMENT.** Key informants indicated that community-based organizations outperformed local government, providers, and the private sector in respectfully engaging local LGBTI+ communities. Community-based organizations should continue to play this vital role and use their strong connections to LGBTI+ individuals to lift up their voices and concerns among other stakeholders.
- 2. PRIORITIZE LGBTI+ PEOPLE WITH MULTIPLE FORMS OF MARGINALIZATION.** This report indicates higher levels of unmet needs among subpopulations such as gender minorities and LGBTI+ racial and ethnic minorities. Given the critical role that community-based organizations play in supporting LGBTI+ communities, it is critical that they prioritize these disparately impacted groups, who historically have been left behind by many mainstream LGBTI+ serving organizations. Building connections with organizations that serve these populations could be a successful and mutually beneficial strategy.
- 3. BUILD MULTISECTORAL PARTNERSHIPS.** As trusted gatekeepers among LGBTI+ populations, community-based organizations can serve a powerful role in connecting LGBTI+ people to other services. This report demonstrates that LGBTI+ health equity requires increased attention to issues such as housing, employment, criminal justice, and more, in addition to traditional health services. Local organizations can build LGBTI+ inclusive referral networks to help LGBTI+ people connect with the wide scope of services they may need in order to advance their wellbeing.
- 4. EMPOWER COMMUNITIES TO ACT.** Community-based organizations can play a vital role in helping local LGBTI+ people advance justice, both within the LGBTI+ population (i.e., working to address racism or transphobia within the LGBTI+ community itself) and externally in their city, country, and beyond (i.e., providing community members with advocacy tools).



NATIONAL GOVERNMENTS

While this report focuses on LGBTI+ health equity in Fast-Track Cities, national governments play a critical and at times determinative role in addressing LGBTI+ health equity issues. Following are recommendations for the role that national governments can play in supporting cities and municipalities to achieve LGBTI+ health equity:

- 1. ADOPT NATIONAL NONDISCRIMINATION LAWS.** The strongest protections against LGBTI+ discrimination — be it in healthcare access, employment, housing, or other areas — are generally national. Cities often have limited power to ban LGBTI+ discrimination and ensure inclusion through local ordinances and policies, placing the responsibility on national governments to ensure these critical measures come into effect. National governments should, at a minimum, not prohibit local governments from enacting their own nondiscrimination measures.
- 2. IMPLEMENT INCLUSIVE DATA COLLECTION STANDARDS.** Even when data are being collected at subnational levels, said collection is often done in connection with national rules, standards, and guidelines. National governments should ensure that their own data collection is inclusive of sexual orientation and gender identity measures, and should also promote standardized, inclusive data collection by local governments, nongovernmental entities, and other relevant stakeholders.
- 3. FUND LOCAL LGBTI+ SERVICES.** A great deal of funding for local health and other essential services is derived from national governments. Funding should be prioritized for organizations that explicitly serve local LGBTI+ populations and especially priority subpopulations (e.g., gender minorities, LGBTI+ racial and ethnic minorities). National governments can also require grantees to adhere to LGBTI+ nondiscrimination and inclusion policies.
- 4. ENGAGE IN LGBTI+ HEALTH EQUITY DIPLOMACY.** National governments can use relationships with public and private entities to advance LGBTI+ health equity on the world stage. This engagement should be conducted in partnership with cities, which are often leaders in LGBTI+ issues, by supporting city multinationalism on issues relating to LGBTI+ health.



INTERNATIONAL ACTORS

International actors — including intergovernmental organizations, donors, and private entities — can all play a supportive role in advancing LGBTBI+ health equity. Following are recommendations for the ways in which international actors can collaborate with cities to advance LGBTBI+ health equity:

- 1. SUPPORT RESEARCH AND PROGRAMMING RELATING TO LGBTBI+ EQUITY.** Particularly when governmental entities fail to support LGBTBI+ equity, either due to opposition to LGBTBI+ rights or because of resource constraints, international actors have a responsibility to consider LGBTBI+ populations in their work. International actors can help cities to better understand their local LGBTBI+ communities and can support services for these individuals. Similar to the role of national governments, international entities can fund city-specific work to advance LGBTBI+ equity and encourage or require nondiscrimination and inclusion among local partners and grantees.
- 2. ADDRESS LGBTBI+ HEALTH HOLISTICALLY.** International actors should avoid contributing to siloed responses that narrowly address LGBTBI+ health issues. This report makes clear that social determinants of health, including socioeconomic opportunity, are critical to addressing LGBTBI+ health and other inequities. Significant social change is needed to reject aspects of the status quo that have imbedded stigma and inequality into health and other systems.
- 3. BUILD COLLABORATIVE NETWORKS.** The Fast-Track Cities initiative is an example of international nonprofits and intergovernmental organizations uniting with local partners to engage in innovative collaboration with respect to HIV. A similar model can be used to build novel partnerships to address LGBTBI+ issues. Local actors could use such networks to access global support and solidarity, which is especially useful when local or national political climates hamper efforts to advance LGBTBI+ health equity.
- 4. LISTEN LOCALLY.** LGBTBI+ communities are diverse, and as this report demonstrates, so are their strengths and needs. The issues facing one community or region should not be interpreted as representing the priorities of all LGBTBI+ communities. All institutions working to effect change globally would benefit from letting people on the ground take the lead on LGBTBI+ issues, including those related to health.



Conclusion

An Urgent Call to Action

This study demonstrates a dire need to improve the health and wellbeing of LGBTI+ people around the world — from cities in which LGBTI+ communities are visible and enjoy strong political support, to cities in which LGBTI+ identities are ignored or even punished. Data assessments of the 50 cities that were selected for this study reveal both significant disparities where data does exist, as well as many areas in which population-wide data are severely lacking. A survey of 275 key informants across the 50 cities further demonstrated that access to health and socioeconomic resources is limited, even in affluent cities, and that stigma and discrimination is relentlessly pervasive. Furthermore, both the assessments and the key informant surveys showed that meaningful engagement with LGBTI+ communities was limited, especially outside of community-based organizations.

There was a high degree of variability on the severity of challenges and the quality of services and institutional relationships relevant to LGBTI+ health, both across and within regions. The cities in the Asia-Pacific region scored best overall; the cities selected from Africa scored worst, on average; and the cities from the Americas and Europe fell in between. Within each region, cities with better policies on LGBTI+ issues tended to score better. Nonetheless, there was overall a great deal of consistency in how different challenges were ranked. For example, gender identity-related discrimination was rated as a more significant problem than sexual orientation-related discrimination nearly universally, and gender-affirming care was similarly rated as less available than general LGBTI+ inclusive care. Additionally, while the severity of the problems varied, most key informants said that access to housing and employment was a challenge for their local LGBTI+ population regardless of the overall socioeconomic strength of their city. In sum, the results of the study showed that LGBTI+ issues do indeed vary locally, but also that LGBTI+ populations around the world — even in “LGBTI+ friendly” cities with vast resources — face myriad challenges with respect to equity.

The recommendations made in this report call for broad changes to local and national laws and policies, improved data collection, increased LGBTI+ health training, and more robust community engagement. However, underlying these recommendations is a need for social transformation that holistically addresses topics such as equity and stigma, and that sees topics such as socioeconomic opportunity and criminal justice as being integral to improved health and well-being. Moreover, these recommendations cannot be meaningfully accomplished and, in fact, could serve to exacerbate inequities — if the most marginalized subpopulations within LGBTI+ communities are not prioritized. These populations include transgender and other gender minority individuals, racial and ethnic minorities, and people who face multiple forms of marginalization and social isolation.

Most of all, if health equity is to be achieved, stakeholders must leverage the profound resilience that LGBTI+ communities from around the world have consistently demonstrated. Despite the health inequities they face on a day-to-day basis, LGBTI+ people are not victims. They are community activists, essential workers, healthcare providers, artists, scientists, family members, neighbors, and much more. Undoubtedly, LGBTI+ people are the most powerful resource in undoing the inequalities that they themselves face. But that aspiration can be realized much sooner, and many lives can be saved, if more of the myriad actors with the power to change systems join in the march towards equity.

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