HEALTH ETHICS AND THE ERADICATION OF CONVERSION PRACTICES IN AFRICA

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OUTRIGHT INTERNATIONAL

About Outright International

Outright International works together for better LGBTIQ lives. Outright is dedicated to working with partners around the globe to strengthen the capacity of the LGBTIQ human rights movement, document and amplify human rights violations against LGBTIQ people, and advocate for inclusion and equality. Founded in 1990, with staff in over a dozen countries, Outright works with the United Nations, regional human rights monitoring bodies, and civil society partners. Outright holds consultative status at the United Nations, where it serves as the secretariat of the UN LGBTI Core Group.

OutrightInternational.org
hello@OutrightInternational.org
facebook.com/Outrightintl
twitter.com/Outrightintl
youtube.com/@OutrightIntl

Outright International
216 E 45th Street 17th Floor
New York, NY 10017, USA
P: +1 (212) 430.6054

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Contents

Glossary of Terms

ACHPR: African Charter for Human and Peoples' Rights.

Affirmative Therapy: A set of therapeutic approaches designed to help gender and sexual minority persons develop self-acceptance, build community, and acquire resilience.

Cisgender: Denoting or relating to a person whose sense of personal identity and gender corresponds with their sex assigned at birth.

Cisheteronormativity: A pervasive belief system that centers and naturalizes heterosexuality and the binary female-male sexes to the extent that it is assumed that the only two "normal" ways of being are cisgender, heterosexual masculine men and cisgender, heterosexual feminine women.

Cisnormativity: A pervasive belief system based on the assumption that every person's gender identity aligns with the sex they were assigned at birth and that those whose gender identities do not align with their sex assigned at birth are "abnormal."

Conversion Practices: Practices intended to suppress or change a person's sexual orientation, gender identity, or gender expression based on cisgender, heteronormative indoctrination and the incorrect assumption that such persons' orientation, identity, or expression is not normal.

CSOs: Civil society organizations.

Gay: A synonym for homosexual in many parts of the world; in this report, used specifically to refer to the sexual orientation of a man whose primary sexual and romantic attraction is toward other men.

Gender: Gender is socially constructed and denotes the characteristics, norms, behaviors, and roles of women, men, girls, and boys, as well as relationships with each other.

Gender-Affirming Health Care: Affirmative health care that may involve a range of psychological, behavioral, medical, and surgical interventions aimed at affirming an individual's gender identity when such is not in alignment with the assigned sex at birth. Gender-affirming health care can be used interchangeably with "trans-affirming health care" or "trans-specific health care" and refers to a broad range of physical and mental health services, including but not limited to hormone therapy, voice therapy, surgeries, and puberty blockers. For more details, refer to the World Professional Association for Transgender Health, Standards of Care.[1]

1 Eli Coleman et al., Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, The World Professional Association for Transgender Health (WPATH), 2012, https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?_t=1613669341.

Gender Identity: A person's internal, deeply felt sense of being female or male, both, or something other than female or male.

Gender Nonconforming: Behaving or appearing in ways that do not fully conform to socially prescribed gender roles and norms.

Heteroerotic: Concerning or arousing sexual desire centered on a person of a different sex.

Heterosexual: The sexual orientation of a person whose primary sexual and romantic attraction is toward people of another sex.

Homoerotic: Concerning or arousing sexual desire centered on a person of the same sex.

Homophobia: Fear of, contempt of, and/or discrimination against homosexuals or homosexuality, usually based on negative stereotypes of homosexuality. Homophobia can be both individual and institutional: entrenched damaging opinions about same-sex attraction may influence the enactment of discriminatory laws and policies and the manner in which individuals, the government, organizations, the media, and society in general behave towards people perceived as lesbian, gay, bisexual, or queer.

Homosexual: The sexual orientation of a person whose primary sexual and romantic attractions are toward people of the same sex.

Intersex: An umbrella term that refers to a range of biological traits and conditions that cause individuals to be born with chromosomes, gonads, and/or genitals that vary from what is considered typical for female or male bodies.

LGBTQ: Lesbian, gay, bisexual, transgender, and queer; an inclusive term for groups and identities sometimes also grouped as "sexual and gender minorities." Because this document does not cover conversion practices against intersex people, this report does not primarily use the intersex-inclusive acronym LGBTIQ.

Nonbinary: A term to describe the gender identity of people who do not identify exclusively as female or male or as women or men. This term is sometimes used interchangeably with the term "genderqueer."

Outing: Revealing the sexual orientation and/or gender identity of a lesbian, gay, bisexual, transgender, intersex, or queer person without their consent or permission.

Queer: An inclusive umbrella term covering multiple identities, sometimes used interchangeably with "LGBTIQ." Also used to describe divergence from heterosexual and cisgender norms without specifying new identity categories.

Sexual Orientation: The way or ways in which a person's sexual and romantic desires are directed. The term describes whether a person is attracted primarily to people of the same or different sex or to both or others.

Sexual Violence: Any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person, regardless of their relationship to the victim, in any setting.

Sexual and Gender Minority Person: Person whose sexual orientation, gender identity, or gender expression are outside the majority hetero- or cisnormative social norms.

Transgender: The gender identity of people whose sex assigned at birth does not conform to their identified or lived gender. A transgender person usually adopts, or would prefer to adopt, a gender expression in consonance with their gender identity but may or may not desire to permanently alter their physical characteristics to conform to their gender identity.

Transgender Men: Persons designated female at birth but who identify and may present themselves as men. Transgender men are generally referred to with male pronouns.

Transgender Women: Persons designated male at birth but who identify and may present themselves as women. Transgender women are generally referred to with female pronouns.

Transphobia: Fear of, contempt of, and/or discrimination against transgender, nonbinary, or gender nonconforming people, usually based on negative stereotypes. Transphobia can be both individual and institutional: entrenched damaging opinions about transgender identities may influence the enactment of discriminatory laws and policies and the manner in which individuals, the government, organizations, the media, and society in general behave toward people whose identities do not conform to mainstream gender roles.

Summary

Conversion practices – attempts to change or suppress a person's sexual orientation, gender identity, or gender expression to align with heterosexual, cisgender norms – are widespread in Africa and cause measurable harm. No comprehensive resource compiles and analyzes national, regional, and international healthcare codes that hold sway in Africa, alongside the positions of regional and international professional bodies with regard to conversion practices and other harmful, degrading, and discriminatory practices against sexual and gender minority persons in Africa. Healthcare workers themselves sometimes grapple with sourcing accurate information about gender and sexual minority issues and how to navigate the balance between learned biases, unfavorable local legislation and policies around sexual and gender diversity, and global healthcare standards and codes.

This report intends to bridge this resource gap by providing a tool for both advocates and practitioners in Africa that can be leveraged to eradicate conversion practices. The objective of this text is two-fold. First, it seeks to provide African healthcare workers with current thinking and guidance on conversion practices and sexual and gender diversity. The medically trained reader will be exposed to a compendium of local and international declarations and codes of healthcare standards related to conversion practices. This can facilitate a more nuanced engagement with sexual and gender minority persons during everyday healthcare practice. Second, the document provides quality material that civil society organizations and other advocates can utilize for informed engagement during advocacy for the eradication of conversion practices, the enforcement of the rights of sexual and gender minority persons within the healthcare space in the region, and the adoption of affirmative healthcare models of delivery.

The report begins with an assessment of the global and regional burden of conversion practices, presenting international and African literature on conversion practices and their harms, including those perpetrated within the healthcare space. This is followed with a brief foray into the historical context of the evolution of knowledge around the nature of human sexual and gender diversity, a transition underpinned by scientific research that developed from understanding sexual and gender diversity first as a mental disorder, later as a form of immaturity, to the present status as a normal variant. This historical background provides context for the origin of conversion practices and how, over time, the erroneous beliefs underpinning the practice were debunked.

The next section of the report reviews existing legal, policy, and regulatory documents related to healthcare ethics standards globally and in Africa, with a view to identifying sections that proscribe, or may be construed to proscribe, healthcare workers from carrying out conversion practices and other discriminatory and harmful practices against sexual and gender minority persons. Conversion practices violate national and international codes of ethical practice and

place the perpetrator – in this case, the healthcare worker – in potential professional jeopardy. Drawing from the lessons learned, the section closes with a highlight of the responsibilities of individual healthcare workers, health professional bodies, civil society organizations, and state governments in Africa to ensure that healthcare practitioners refrain from conversion and other harmful and discriminatory practices and provide affirming care for sexual and gender minority persons in the region.

Finally, the report provides practical suggestions on how mental health and other healthcare practitioners can contribute to the eradication of conversion practices and promote the delivery of needed affirmative therapy. It is hoped that advocates against conversion practices in the healthcare environment and African healthcare workers who wish to uphold high standards of ethical practice when dealing with sexual and gender minority persons will find the report a useful companion.

I. Conversion Practices Violate the Rights of Sexual and Gender Minority Persons in Africa

Prevalence of Conversion Practices Around the World and in Africa

Conversion practices are attempts to repress, change, or alter a person's sexual orientation or gender identity from lesbian, gay, bisexual, transgender, or queer (LGBTQ) to heterosexual and cisgender, based on the incorrect assumption that LGBTQ identities represent a social, religious, or biological aberration of which the individual needs to be relieved.[2] These practices have also been referred to as "conversion therapy," or, by practitioners, as "reparative therapy."[3]We adopt the term "conversion practices" to avoid legitimizing such practices as therapy.

Conversion practices stem from the medicalization of minority sexual and gender identities dating back to the mid-19th century, which entailed efforts to find medical interventions to "correct" people with an LGBTQ orientation or identity, as discussed in more detail in section II. Religious groups also joined the fray, seeking to provide "spiritual cleansing" centered on their own conceptualization of homosexuality and gender nonconformity as sin, depravity, or evil possession.

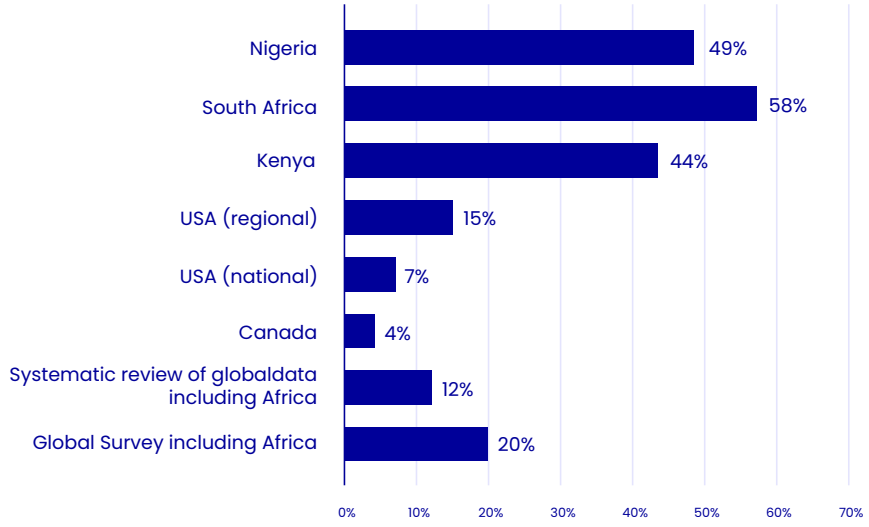
It is now clear that conversion practice is a global phenomenon that sexual and gender minority persons have had to endure across all regions of the world.[4] But there is a paucity of data on how common conversion practices are worldwide. Conversion practices have only come to the attention of human rights and health researchers in recent years as a problem meriting data collection. Further, LGBTQ persons often hide their identity and experiences and, as such, are not easily accessible during research.[5] Among the recent available evidence on the prevalence of conversion practices, a report pooling more than 8,000 participants from over 100 countries showed that more than 20% of respondents indicated that either they or someone they knew had been subjected to conversion practices.[6] In Africa, research supported by Outright International in Nigeria, Kenya, and South Africa found that, on average, close to half of a tota of 2,891 LGBTQ persons surveyed reported that they had been subjected to conversion practices in their lifetime (49%, 44%, and 58% of respondents sampled from these countries, respectively).[7]

2 Jessica N. Fish and Stephen T. Russell, "Sexual Orientation and Gender Identity Change Efforts are Unethical and Harmful," American Journal of Public Health 110, no. 8 (2020): 1113-1114, doi:10.2105/AJPH.2020.305765.
3 United Nations Office of the High Commissioner for Human Rights (OHCHR), "Independent Expert Report on Sexual Orientation and Gender Identity," accessed 29 August, 2023, https://www.ohchr.org/en/special-procedures/ie-sexual-orientation-and-gender-identity.
4 Ibid. See also Outright International (Outright), Harmful Treatments: The Global Reach of So-Called Conversion Therapy, September 2023, https://outrightinternational.org/sites/default/files/2023-08/082123_Outright_Conversion2023.pdf.
5 This is true even in non-criminalizing countries like the United Kingdom. Adam Jowett et al., Conversion Therapy: An Evidence Assessment and Qualitative Study, Government Equalities Office, 2020, https://pure.coventry.ac.uk/ws/portalfiles/portal/44880617/2020_12_15_Conversion_Therapy_Reserach_Report_AJ_edited_clean_4_.pdf.
6 Tyler Adamson et al., "The Global State of Conversion Therapy - A Preliminary Report and Current Evidence Brief," Center for Open Science, May 2020, doi:10.31235/osf.io/9ew78.
7 Outright, *Converting Mindsets, Not Our Identities*, 2022, https://outrightinternational.org/our-work/human-rights-research/converting-mindsets-not-our-identities, 8.

Conversion practices are likely common in other parts of Africa due to high levels of stigma and criminalization.[8] No country in Africa has any form of legislative or policy protection that specifically protects sexual and gender minority persons against conversion practices.[9]

Figure 1

PREVALENCE OF CONVERSION PRACTICES AS REPORTED IN SELECT COUNTRIES[10]



Nature and Harms of Conversion Practices in Africa

Outright's research finds that in Kenya, Nigeria, and South Africa, forms of conversion practices include prayers, exorcism, torture, false imprisonment in camps or religious centers, and sexual violence, including through forced or coerced marriage.[11]

The research demonstrates that respondents who were subjected to conversion practices did not find them helpful and reported negative impacts on their mental health and well-being.

Many survivors of conversion practices said they suffer from depression, social anxiety, substance abuse, and thoughts of or attempts of suicide. For instance, a gay male respondent from Nigeria said:

> **"[Conversion practices] affected me psychologically, and I had to cut all my friends off, apart from my best friend. … I stayed in my room all day, not going out**

8 Augustine Edobor Arimoro, "Interrogating the Criminalisation of Same-Sex Sexual Activity: A Study of Commonwealth Africa," *Liverpool Law Review* 42, 3 (2021), https://link.springer.com/article/10.1007/s10991-021-09280-5
9 Outright, *Converting Mindsets.*
10 Adamson et al., "The Global State of Conversion Therapy;" Travis Salway et al., "Prevalence of Exposure to Sexual Orientation Change Efforts and Associated Sociodemographic Characteristics and Psychosocial Health Outcomes among Canadian Sexual Minority Men," Canadian Journal of Psychiatry 65, no. 7, doi:10.1177/0706743720902629; John R. Blosnich, et al., "Sexual Orientation Change Efforts, Adverse Childhood Experiences, and Suicide Ideation and Attempt Among Sexual Minority Adults, United States, 2016-2018," American Journal of Public Health 110, no. 7 (2020), doi:10.2105/AJPH.2020.305637; Steven Meanley et al., "Lifetime Exposure to Conversion Therapy and Psychosocial Health Among Midlife and Older Adult Men Who Have Sex With Men," The Gerontologist 60, no. 7, doi:10.1093/geront/gnaa069.
11 Outright, *Converting Mindsets.*

> **or socializing with people. My pastor kept saying that I needed to pray and fast, but I kept trying, and nothing worked. I self-harmed too. "[12]**

Another respondent from South Africa said that they were subjected to conversion practices in high school:

> **"I thought I was dirty and cursed. I believed I needed to change. I attempted suicide several times."[13]**

A transmasculine respondent from South Africa who was subjected to conversion practices said:

> **"I have always felt like a guy and still feel like a guy. Conversion hasn't changed anything. I just felt impure."[14]**

The most common perpetrators identified in Outright's research in Africa are cultural and religious figures such as pastors, priests, and traditional healers. The second most commonly identified perpetrators of conversion practices identified in the three African countries are healthcare workers.[15]

Conversion Practices and Discriminatory Treatment in the African Health Sector

Outright's research found that psychiatrists, psychologists, and professional counselors are implicated in cases of conversion practices in Kenya, Nigeria, and South Africa, usually in the form of counseling and talk therapy. An investigation by openDemocracy published in 2021 also identified other forms of conversion practice in the healthcare sector in East Africa, including the prescription of hormones intended to "masculinize" a gay male patient and to suppress the gender expression of a trans person.[16]

These overt forms of conversion practice are accompanied by other manifestations of conversion ideology by healthcare practitioners. In one qualitative study of lesbian, gay, and bisexual people in South Africa who sought counseling services with psychologists for unrelated psycho-social issues, respondents reported that some counselors told them that they were "sick" or "doing the wrong thing" and were advised to seek out sexual activities with a person of a different sex for the sole purpose of hetero- or cisnormative conversion.[17]

12 Ibid, 17.
13 Ibid, 23.
14 Ibid, 25.
15 Ibid.
16 Lydia Namubiru, Khatondi Soita Wepukhulu, and Rael Ombuor, "Hospitals across East Africa Offer Controversial Anti-Gay Counselling," *openDemocracy*, 2 July 2021, https://www.opendemocracy.net/en/5050/hospitals-east-africa-controversial-anti-gay-counselling/.
17 Cornelius J. Victor and Juan A. Nel, "Lesbian, Gay, and Bisexual Clients' Experience with Counselling and Psychotherapy in South Africa: Implications for Affirmative Practice," *South African Journal of Psychology* 46, no. 3 (2016),

Discriminatory behaviors of healthcare workers towards gender and sexual minority persons, while not necessarily in themselves a form of conversion practice, may cause sexual and gender minority persons to internalize stigma and consider seeking out conversion practices. Qualitative research in numerous countries has documented lived experiences of discrimination perpetrated by healthcare workers in Africa. In South Africa,[18] Tanzania,[19] and Mozambique,[20] sexual and gender minority persons have reported personal experiences of denial of access to needed health services and breach of confidentiality through healthcare workers' open gossip about respondents' sexuality and gender identity. A qualitative study conducted among sexual and gender minority adolescents sampled from Malawi, Mozambique, Namibia, Zambia, and Zimbabwe reported that such adolescents experienced exclusion from public sexual and reproductive health services due to the coercive enforcement of hetero- and cisnormative ideals within the service environment.[21] Such adolescents were also simultaneously excluded from non-governmental reproductive health services because the service providers did not want to run the legal risk of being tagged as "homosexuality recruiters" in countries where same-sex intimacy is criminalized.[22]

Conversion Ideology and Its Psychosocial Impact on LGBTQ People in Africa

There is a well-established mental health disparity among sexual and gender minority populations globally compared to the general population. Systematic reviews of available data worldwide have shown three- or four-fold higher prevalence rates of mental health problems such as anxiety, depression, suicidality, and alcohol/drug abuse among sexual and gender minority populations worldwide.[23] Mental health disparities experienced by LGBTQ persons have been linked with experiences of social exclusion, discrimination, prejudice, homo- or transphobic teasing and outright persecution (see Figure 2 below).[24] This observation aligns with current understanding in that the observed mental health disparity among sexual and gender minority groups is not because of an inherent abnormality within such identities or expressions but because of systemic prejudices.

In the specific context of Africa, though there is no indication that they were solely a result of lived experiences of conversion practices, a large-scale survey involving more than 2,300 sexual and gender minority persons in Kenya, Lesotho, South Africa, and Eswatini revealed that 46-57% of respondents had significant depressive symptoms, 55-66% had major anxiety, and 12% had evidence of alcohol or drug dependence, while 22-27% had attempted suicide in the

doi:10.1177/0081246315620774.

18 Alex Müller, "Scrambling for Access: Availability, Accessibility, Acceptability and Quality of Healthcare for Lesbian, Gay, Bisexual and Transgender People in South Africa," *BMC International Health and Human Rights* 17, no. 1 (2017): 16, doi:10.1186/s12914-017-0124-4.

19 "Tanzania: Obstructions to LGBT Health, Rights," Human Rights Watch, 3 February 2020, https://www.hrw.org/news/2020/02/03/tanzania-obstructions-lgbt-health-rights.

20 Farisai Gamariel et al., "Access to Health Services for Men Who Have Sex with Men and Transgender Women in Beira, Mozambique: A Qualitative Study," *PLoS One* 15, no. 1 (2020), doi:10.1371/journal.pone.0228307.

21 Alex Müller et al., "The No-Go Zone: A Qualitative Study of Access to Sexual and Reproductive Health Services for Sexual and Gender Minority Adolescents in Southern Africa," *Reproductive Health* 15, no. 1, doi:10.1186/s12978-018-0462-2.

22 Ibid.

23 Ibid. See also Mattia Marchi et al., "Self-Harm and Suicidality among LGBTIQ People: A Systematic Review and Meta-Analysis," *International Review of Psychiatry* 34 no. 3-4, doi:10.1080/09540261.2022.2053070; Miriam M. Moagi et al., "Mental Health Challenges of Lesbian, Gay, Bisexual and Transgender People: An Integrated Literature Review," *Health SA* 26, 2021, doi:10.4102/hsag.v26i0.1487; Clare Wilson and Laura A. Cariola, "LGBTQI+ Youth and Mental Health: A Systematic Review of Qualitative Research," *Adolescent Research Review* 5, no. 2 (2020), doi:10.1007/s40894-019-00118-w; Mathijs Lucassen et al., "Sexual Minority Youth and Depressive Symptoms or Depressive Disorder: A Systematic Review and Meta-Analysis of Population-Based Studies," *Australian and New Zealand Journal of Psychiatry* 51, no. 8, doi:10.1177/0004867417713664.

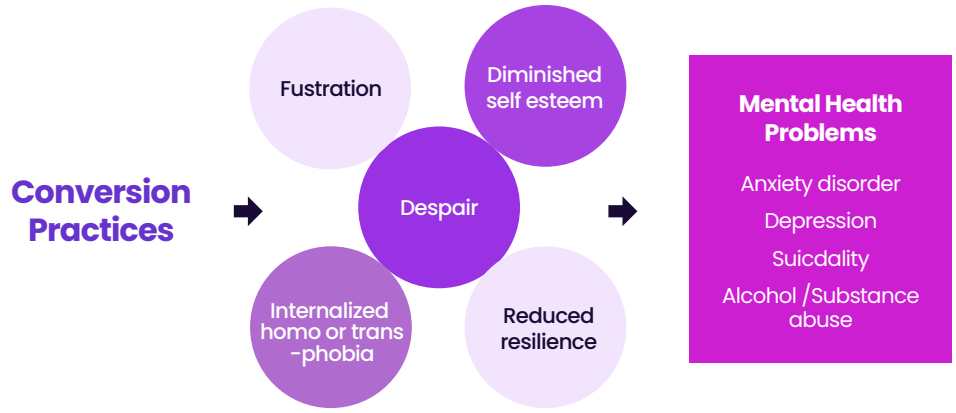
24 Wilson and Cariola, "LGBTQI+ Youth and Mental Health." See also Kate L. Collier et al., "Sexual Orientation and Gender Identity/Expression Related Peer Victimization in Adolescence: A Systematic Review of Associated Psychosocial and Health Outcomes," *The Journal of Sex Research* 50, no. 3-4 (2013), doi:10.1080/00224499.2012.750639; Carolyn Brown et al., "Mental Health Needs of Transgender Women, Gay Men, and Other Men Who Have Sex with Men across Sub-Saharan Africa," In *LGBTQ Mental Health: International Perspectives and Experiences*, eds. N. Nakamura & C. H. Logie (Washington, DC: American Psychological Association, 2020).

past year.[25] A similar but single-site study conducted in Kenya reported clinically significant levels of post-traumatic stress and depressive symptoms, at 53% and 26%, respectively, among sexual and gender minority persons.[26] Both studies concluded that the reported prevalence rates of mental health problems among sexual and gender minority populations were significantly higher than the national average.

The understanding that mental health disparities stem from stigma, social exclusion, and conversion ideology underpins the concept of affirmative therapy, a set of approaches in which therapists and other mental health practitioners help LGBTQ persons to develop self-acceptance by strengthening them against negative feelings, such as shame and guilt; supporting them to build pride and to acquire resilience-enhancing skills in the face of prejudice; and building community.[27]

Figure 2

THE PATHWAY FROM CONVERSION PRACTICES TO MENTAL HEALTH PROBLEMS



Affirmative therapy has been demonstrated to have positive effects on mental health, coping, and resilience among sexual and gender minority persons during the course of clinical trials.[28] In contrast, conversion practices have failed, at the population level and across multiple contexts, to have any demonstrable benefits in terms of any change to a person's sexual orientation or gender identity or to improve their well-being.[29] Table 1 compares conversion practices with affirmative therapy.

25 Alex Müller, and Kristen Daskilewicz, "Mental Health among Lesbian, Gay, Bisexual, Transgender and Intersex People in East and Southern Africa," *European Journal of Public Health* 1, no. 28 (2018): 794, doi:10.1093/eurpub/cky212.794.
26 Gary W. Harper et al., "Mental Health Challenges and Needs among Sexual and Gender Minority People in Western Kenya," *International Journal of Environmental Research & Public Health* 18, no. 3 (2021): 1311, doi:10.3390/ijerph18031311.
27 Suntosh R. Pillay et al., "The Psychological Society of South Africa's Guidelines for Psychology Professionals Working with Sexually and Gender-Diverse People: Towards Inclusive and Affirmative Practice." *South African Journal of Psychology* 49, no. 3 (2019), doi:10.1177/0081246319853423.
28 Shelley L. Craig et al., "Efficacy of Affirmative Cognitive Behavioural Group Therapy for Sexual and Gender Minority Adolescents and Young Adults in Community Settings in Ontario, Canada," *BMC Psychology* 9, no. 1 (2021): 94, doi:10.1186/s40359-021-00595-6.
29 See, for instance, Jowett et al., *Conversion Therapy*; Julianne M. Serovich et al., "A Systematic Review of the Research Base on Sexual Reorientation Therapies," *Journal of Marital and Family Therapy* 34, no. 2 (2008), doi:10.1111/j.1752-0606.2008.00065.x.

Table 1
CONVERSION PRACTICES VS. AFFIRMATIVE THERAPY

CONVERSION PRACTICES	AFFIRMATIVE THERAPY
Have no proven benefits at population level.[30]	Has been shown in controlled clinical trials to have positive effects on mental health, well-being, and quality of life.[31]
Are associated with frustration and despair.	Helps to build a sense of pride.
Can lead to internalized homophobia.[32]	Builds a sense of self- acceptance.
Are associated with diminished resilience.	Helps to build resilience.
Have been associated with increased risk of mental health problems, including depression and suicidality.[33]	Promotes mental health.
Are associated with a diminished, poorer quality of life.[34]	Invariably improves quality of life.

This section has presented the nature, extent, and negative social and mental health impact of conversion practices among sexual and gender minority persons. Section II will discuss some of the factors that fuel conversion practices in Africa and all over the world. Section III will highlight the ethical standards for healthcare practitioners concerning conversion practices, including within local and international codes of healthcare practice. Finally, we will discuss how a practitioner who continues to engage in these harmful practices may place themselves in ethical, professional, and legal jeopardy.

How Common Is Sexual and Gender Diversity in Africa and Around the World?

Conversion practices stem partly from the idea that LGBTQ identities are uncommon or "abnormal." Yet diversity in sexual orientation, gender identity, and expression is well-established to have existed around the world dating as far back as human history. Sexual orientation and gender identity and expression are increasingly being seen on a continuum. While heterosexual orientation is on one end of a spectrum and may represent the experience of the majority, minority sexual orientations such as lesbian, gay, and bisexual are well represented across the human population.[35] The same applies to cisgender identities compared with transgender identities.[36]

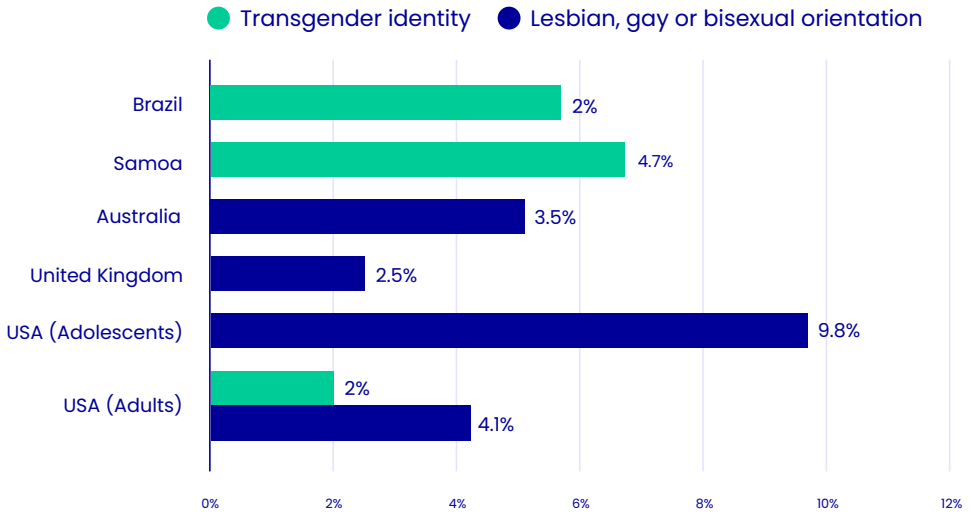
Although an accurate estimation of the exact size of the global population of LGBTQ persons is elusive, epidemiological evidence demonstrates that the proportion of the population of individuals on the sexual and gender minority spectrum is large enough

30 Ibid
31 Shelley L. Craig et al., "Efficacy of Affirmative Cognitive Behavioural Group Therapy."
32 Meanley et al., "Lifetime Exposure to Conversion Therapy;" See also Ariel Shidlo and Michael Schroeder, "Changing Sexual Orientation: A Consumers' Report, Professional Psychology: Research & Practice 33, no. 3 (2002), doi:10.1037/0735-7028.33.3.249. John P. Dehlin et al., "Sexual Orientation Change Efforts among Current or Former LDS Church Members," Journal of Counseling Psychology 62, no. 2 (2015), doi:10.1037/cou0000011.
33 Blosnich et al., "Sexual Orientation Change Efforts."
34 Anna Forsythe et al., "Humanistic and Economic Burden of Conversion Therapy Among LGBTQ Youths in the United States," JAMA Pediatrics 176, no. 5 (2022), doi:10.1001/jamapediatrics.2022.0042.
35 Ritch C. Savin-Williams, "An Exploratory Study of the Categorical versus Spectrum Nature of Sexual Orientation," *Journal of Sex Research* 51, no. 4 (2014), doi:10.1080/00224499.2013.871691.
36 Claire Ainsworth, "Sex Redefined," *Nature (London)*, no. 7539 (2015), doi:10.1038/518288a.

to warrant attention, focus, and protection from discriminatory practices and social exclusion. The following chart demonstrates several size estimates of lesbian, gay, and bisexual adults, ranging from 2.5% to 4.1%.[37] Similar data from several countries reveals that a minority but significant proportion of the population identifies as transgender or expresses other non-binary gender identities, ranging from 2% to 4.7%.[38]

Figure 3

PROPORTION OF THE GENERAL POPULATION WITH MINORITY SEXUAL AND GENDER EXPRESSION AND IDENTITIES AS REPORTED FROM DIFFERENT COUNTRIES



[Adapted from research data published by Wilson et al. (2020), von Kampen et al. (2017), Vanderlaan et al. (2013), Depa et al. (2022), and Goodman et al. (2019) as cited in the footnotes]

37 Tom Wilson et al., "What is the Size of Australia's Sexual Minority Population?" *BMC Research Notes* 13, no. 1 (2020): 535, doi:10.1186/s13104-020-05383-w; Sanne Christine van Kampen et al., "The Proportion of the Population of England that Self-Identifies as Lesbian, Gay or Bisexual: Producing Modelled Estimates Based on National Social Surveys," *BMC Research Notes* 10, no. 1 (2017): 594, doi:10.1186/s13104-017-2921-1; "Adult LGBT Population in the United States," Williams Institute, July 2020, https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Adult-US-Pop-Jul-2020.pdf. The figure of 4.1% is extrapolated from the fact sheet using the total number LGB adults (cis or trans) as compared to the total number of LGBT adults in the United States. An even larger number of adolescents may openly identify themselves as lesbian, gay, or bisexual: 9.8% of adolescents in one US study. Nishitha Depa et al., "Mental Health Disparities amongst Sexual Minority Adolescents of the US: A National Survey Study of YRBSS-CDC," *Psychiatry Research* 314 (2022): 114635, doi:10.1016/j.psychres.2022.114635.

38 Michael Goodman et al., "Size and Distribution of Transgender and Gender Nonconforming Populations: A Narrative Review," *Endocrinology and Metabolism Clinics of North America* 48, no. 2 (2019), doi:10.1016/j.ecl.2019.01.001. See also Giancarlo Spizzirri et al., "Proportion of People Identified as Transgender and Non-Binary Gender in Brazil," *Scientific Reports* 11, no. 1 (2021): 2240, doi:10.1038/s41598-021-81411-4; Esther L. Meerwijk and Jae M. Sevelius, "Transgender Population Size in the United States: A Meta-Regression of Population-Based Probability Samples," *American Journal Public Health* 107, no. 2 (2017): e8, doi:10.2105/AJPH.2016.303578; Doug P. Vanderlaan, "The Prevalence of Fa'afafine Relatives among Samoan Gynephilic Men and Fa'afafine," *Archives of Sexual Behavior* 42, no. 3 (2013), doi:10.1007/s10508-012-0015-7.

Though these estimates of sexual and gender minority persons are significant enough to command attention on their own, the figures in many countries are believed to be gross underestimations given that fear of stigma, discrimination, possible prosecution, and violations of confidentiality force many individuals to conceal their sexual orientations and gender identities in regions where sexual and gender minority status is criminalized. Disparities in conceptual definitions of sexual and gender minority status in different cultural contexts may also impact reporting.[39] One analysis put the under-estimation rate for sexual and gender minority expression and identities in national surveys as high as 83% globally; for every 100 sexual and gender minority persons identified in such surveys, at least 83 others are missed.[40]

The underestimation rate may be even higher in regions such as Africa, where sexual and gender minority persons confront widespread criminalization, social stigma, and institutional discrimination.[41] It is therefore not surprising that few readily available, accurate LGBTQ population size estimates exist in Africa. There is, however, no evidence that the proportion of sexual and gender minority persons is significantly less in the African region than elsewhere, and ethnographic studies show enduring evidence of sexual and gender diversity in African precolonial cultures.[42]

Despite the commonality of LGBTQ identities, these identities have long been pathologized in many parts of the world, including Africa. Only in recent years have LGBTQ advocates and their allies made progress in depathologizing them.

39 Mitchell R. Lunn, Juno Obedin-Maliver, and Kirsten Bibbins-Domingo, "Estimating the Prevalence of Sexual Minority Adolescents," *JAMA: the Journal of the American Medical Association* 317, no. 16 (2017), doi:10.1001/jama.2017.2918. See also John E. Pachankis, Richard Bränström, and Cheng-Shi Shiu, "How Many Sexual Minorities are Hidden? Projecting the Size of the Global Closet with Implications for Policy and Public Health," *PLOS ONE* 16, no. 6 (2019), doi:10.1371/journal.pone.0218084.
40 Pachankis, Bränström, and Shiu, "How Many Sexual Minorities are Hidden?" 6.
41 Ibid.
42 Busangokwakhe Dlamini, "Homosexuality in the African Context," *Agenda (Durban)* 67 (2006); see also George Olusola Ajibade, "Same-Sex Relationships in Yorùbá Culture and Orature," *Journal of Homosexuality* 60, no. 7 (2013), doi:10.1080/00918369.2013.774876.

II. Conversion Practices Arise From Debunked Beliefs in Diversity as Pathology

Historical Transition in Understanding Sexual Diversity Within the Psychiatric Community

For most of the late 19th and 20th centuries, psychiatrists classified minority sexual expressions or identities as mental disorders requiring treatment. Before the advent of the first edition of the early diagnostic schedules such as the Statistical Manual for the Use of Institutions of the Insane (1918),[43] atypical sexual and gender expressions/identities were featured as a pathology under categories such as "constitutional psychopathic inferiority (without psychosis)" which described a "large group of pathological personalities including sexual perversions." Later, Standard Classified Nomenclature of Disease (1935)[44] also featured "pathological sexuality" under the category of "psychopathic personality."

Based on these understandings, medical and psychological practitioners made concerted, albeit futile, efforts to evolve approaches and techniques to change minority sexual orientation or gender identity and expression based on the notion that these persons were inherently of heterosexual orientation or cisgender identity, which they refused to express due to a brain disease.[45] There were many such interventions, with "reparative therapy"[46] being the most widely practiced. "Reparative therapy" was founded on the now-discredited notion of Bieber and colleagues (1962) that homosexuality results from unconscious anxiety stemming from childhood conflicts, ostensibly needing resolution.[47]

Other historical conversion practices ranged from bed rest, prayers and exorcism, exercise, and brothel visits to behavioral conditioning by pairing exposure to homoerotic content with nausea-inducing drugs or encouraging masturbation during exposure to heteroerotic content. Some conversion practices included overt violence and could amount to torture and cruel, inhuman, and degrading treatment. These reportedly included electroshock, castration, lobotomy, and testicular transplantation. [48]

Diagnostic schedules used by psychiatrists in the second half of the 20th century, including

43 *Statistical Manual for the Use of Institutions for the Insane* (New York: The National Committee for Mental Hygiene, Bureau of Statistics, 1918), *American Journal of Psychiatry* 75, no. 2 (2006): 301, doi:10.1176/ajp.75.2.301.
44 "A Standard Classified Nomenclature of Disease." *Nature* 133, 551 (1934), doi:10.1038/133551b0.
45 Douglas C. Haldeman, "Introduction: A History of Conversion Therapy, from Accepted Practice to Condemnation," in *The Case against Conversion "Therapy": Evidence, Ethics, and Alternatives*, ed. Douglas C. Haldeman, American Psychological Association (2022), doi:10.1037/0000266-001.
46 Joseph Nicolosi, *Reparative Therapy of Male Homosexuality: A New Clinical Approach* (Northvale, NJ: Aronson 1991).
47 This theory was advanced most prominently by: Irving Bieber et al., *Homosexuality: A Psychoanalytic Study* (New York, NY: Basic Books 1962), 358.
48 Timothy F. Murphy, "Redirecting Sexual Orientation: Techniques and Justifications," *Journal of Sex Research,* 29, no. 4 (1992): doi:10.1080/00224499209551664; Rachel Savage, "LGBT+ Conversion Therapy Thrives Even as Bans Gather Pace," *Reuters*, 15 September 2021, https://www.reuters.com/article/global-lgbt-conversion-idUSL8N2Q83I8; United Nations Office of the High Commissioner for Human Rights (OHCHR), "Practices of So-Called 'Conversion Therapy' – Report of the Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity," A/HRC/44/53, 1 May 2020, https://www.ohchr.org/en/documents/thematic-reports/ahrc4453-practices-so-called-conversion-therapy-report-independent.

the American Psychological Association's Diagnostic and Statistical Manual (DSM) and the International Classification of Diseases (ICD), gradually transitioned in their understanding of the nature of homosexuality from an initial misperception of same-sex attraction as a mental disorder to a more nuanced understanding of it as a normal variant. Table 2 uses the DSM as a prototype to demonstrate this transition.

Table 2

THE TRANSITION IN THE DIAGNOSTIC STATUS OF HOMOSEXUALITY IN THE DSM

DSM Edition	Year	Diagnostic Label and Notes
DSM-I	1952	Without expressly mentioning homosexuality or any other forms of non-heterosexual sexual attraction or behaviors, the diagnostic schedule listed "sociopathic personality disturbances." This was described as illness characterized by non-psychotic behaviors or dispositions that are non-conforming to the prevailing cultural milieu. Sexual minority persons were generally codified under this category even when the document did not make any reference to homosexuality or any other variant of human sexual identity or behavior.
DSM-II	1968	A diagnostic category called "certain nonpsychotic mental disorders" was introduced with a subset of "sexual deviations" which included people with sexual interests that were directed "toward objects other than people of the opposite sex" including "homosexuality."
DSM-II-Text Revision	1974	A diagnostic category called "Sexual Orientation Disturbance" was added. The diagnosis of sexual orientation disturbance was only to be made when an individual with same-sex attractions found them distressing and wanted to change. The revision explicitly noted that the category was to be distinguished from "homosexuality, which by itself does not constitute a psychiatric disorder." This development depathologized sexual minority persons who were well-adjusted to their sexual orientation.
DSM-III	1980	The sexual orientation disorder category was changed to "ego-dystonic homosexuality" which was described as a "sustained pattern of homosexual arousal that the individual explicitly states has been unwanted and constitutes a persistent source of distress."
DSM-III-Text Revision and DSM-IV	1987 and 1994	The diagnostic group was reclassified as "sexual disorder not otherwise specified" which included a category of "persistent and marked distress about one's sexual orientation."
DSM-V	2013	No disorder category included that could be applied to people based on their sexual orientation.

Research and Other Efforts Leading to the Depathologizing of Sexual Minority Expressions

The classification of homosexuality as a normal variant rather than a mental disorder was the result of a joint effort of gay rights activists, open-minded psychiatrists who advocated for change (including within the American Psychological Association (APA)), and researchers who presented ground-breaking findings that reshaped the predominant understanding of

homosexuality in the mental health profession.[49]

Notable among the research findings is the work of Alfred Kinsey, who conducted the first large-scale survey of homosexuality in the United States in the late 1940s and documented that up to 37% of male adults reported having had homosexual attraction or behaviors in their lifetime.[50] Kinsey's demonstration of the widespread nature of same-sex sexual attractions and practices reduced the plausibility of homosexuality being a disorder, a finding that jolted the psychiatric community that had pathologized homosexuality.

Equally influential scientific findings contained within the reports from the works of Ford and Beach (1951),[51] later corroborated by Goldfoot et al. (1980),[52] showed that same-sex attractions and sexual behaviors are not unique to humans but also seen in other primates such as mountain gorillas, bonobos, and macaques. In addition, Evelyn Hooker (1957)[53] compared 30 homosexual males with an equal number of heterosexual males on psychological and well-being profiles and concluded that the happiness and well-adjusted nature of homosexual men was not different from that of heterosexual men. Hooker argued that earlier thinking which linked homosexuality and mental disorders came from hospital-based studies conducted among sexual minority persons who were already seeking or receiving mental health services. Hooker further concluded that earlier research that had linked homosexuality with mental maladjustment relied on false correlations driven by selection bias. Table 3 below summarizes the findings and implications of some landmark research studies that led to depathologizing LGBTQ expressions and identities.

Table 3

SOME LANDMARK RESEARCH FINDINGS THAT LED TO THE DEPATHOLOGIZING OF HOMOSEXUALITY

Landmark Study	Key Findings	Implications
Alfred Kinsey (1948)	Up to 37% of male adults in the general US population reported having had homosexual attraction or behaviors in their lifetime.	Homosexual attractions are much more common than is typically acknowledged.
Ford and Beach (1951) and later Goldfoot and others (1980)	Same sex attractions and sexual behaviors are not unique to humans but are also seen in other primates such as mountain gorillas, bonobos, and macaques.	Homosexual sexual attractions are not a form of human perversion but a biological variant present in both humans and other animals.
Evelyn Hooker (1957)	When objectively measured, the happiness and psycho-social adjustment of homosexual men are not significantly different from heterosexual men.	The initial link between homosexuality and behavioral disturbances was a result of selection bias inherent in the hospital-based samples of homosexual men used in previous studies.

49 Ronald Bayer R. *Homosexuality and American Psychiatry: The Politics of Diagnosis* (New York, NY: Basic Books 1981).
50 Alfred C. Kinsey, Wardell B. Pomeroy, Clyde E. Martin. *Sexual Behavior in the Human Male* (Philadelphia, PA: WB Saunders 1948).
51 Clellan Stearns Ford and Frank A. Beach, *Patterns of Sexual Behavior* (New York, NY: Harper 1951).
52 D.A. Goldfoot et al., "Behavioral and Physiological Evidence of Sexual Climax in the Female Stump-Tailed Macaque (Macaca Arctoides), *Science* 208, no. 4,451 (1980), doi:10.1126/science.7384791.
53 Evelyn Hooker, "The Adjustment of the Male Overt Homosexual," *Journal of Projective Techniques* 21 (1957), doi:10.1080/08853126.1957.10380742.

The notable efforts of gay rights activists, some influential practitioners within the APA, and the early scientific findings described above would later lead to the depathologizing of sexual minority status. As shown in Table 1, from 1974, when the text revision of the DSM-II was released, through 1980, when the DSM-III was released, to the era of DSM-IV released in 1994, homosexuality as a form of sexual attraction moved from what was seen as unequivocal psychopathology to a condition perceived as a disorder *only if the individual with same-sex attractions found them distressing and wanted to change.* The view that distress about one's sexual identity and behaviors connotes evidence of an illness was later challenged by scholars as not being grounded in science but a mere political compromise within the APA. Such scholars based their arguments on the factual premise that there are several other human variations, such as skin color, height, weight, and human physiological drives, such as appetite, with which people may be unhappy but which were not categorized as illnesses.[54]

In later years, the scientific working groups of both the DSM and the International Classification of Diseases (ICD), working independently, reviewed the utility of the continued pathologizing of the distress associated with homosexuality and concluded that such a position is not scientifically sound. They argued that if a disease label is attached to a psychosocial entity, such as an individual's sexual identity, preference, or behavior, it is essential that the condition have demonstrable public health and clinical utility, be associated with a verifiable and legitimate mental health service-need, and have an appreciable negative public health impact for which treatment is indicated.[55] In other words, private sexual behavior without demonstrable negative health consequences to the individual should not be a legitimate focus of health classification. These arguments would later contribute to the complete removal of any form of classification for sexual orientation in the present-day diagnostic schedules for mental disorders, that is, the DSM-V and the ICD-11.

The History of the Depathologizing of Minority Gender Expressions

The history of how transgender identities became pathologized and later depathologized in the diagnostic schedules has parallels with that of sexual orientation. In both cases, the initial pathologizing had roots in the writings of influential psychoanalysts, who erroneously viewed sexual and gender diversity as psycho-biological deviations from the norm and in need of fixing, and in interpretations of religious texts as condemning diversity.[56] Influential psychoanalysts used terms such as "psychopathia transexualis" and "transexual phenomenon" to describe transgender people before the category was listed in the DSM or ICD.[57] The medicalization of gender nonconformity began in the 19th century and was erroneously formalized as a mental disorder in the early 20th century, as with homosexuality.[58]

The first official appearance of gender identity issues in DSM was in 1980, with the inclusion of "gender identity disorder of childhood" and "transsexualism" for adolescents and adults. Table 4 below shows the transition in the understanding of the nature of minority gender identity from the DSM-III to the present. The transition in the ICD was also similar, if not parallel.

54 Lawrence Mass, *Homosexuality and Sexuality: Dialogues of the Sexual Revolution* (New York: Harrington Park Press 1990).
55 Geoffrey M. Reed et al., "Disorders Related to Sexuality and Gender Identity in the ICD-11: Revising the ICD-10 Classification Based on Current Scientific Evidence, Best Clinical Practices, and Human Rights Considerations," *World Psychiatry* 15, no. 3 (2016), doi:10.1002/wps.20354.
56 Jack Drescher, "Queer Diagnoses: Parallels and Contrasts in the History of Homosexuality, Gender Variance, and the Diagnostic and Statistical Manual," *Archives of Sexual Behavior* 39, no. 2 (2010), doi:10.1007/s10508-009-9531-5.
57 Ibid.
58 Ibid.

Table 4

THE TRANSITION IN THE DIAGNOSTIC STATUS OF HOMOSEXUALITY IN THE DSM

DSM Edition	Year	Diagnostic Label and Notes
DSM-III	1980	This was the first time gender identity issues were listed in the DSM. The category called "gender identity disorder of childhood" (GIDC) for children and "transsexualism" for adolescents and adults was introduced to denote the experience of disparity between anatomical sex and gender identity.
DSM-III Text Revision	1987	A third diagnosis was added: "gender identity disorder of adolescence and adulthood, non-transsexual type."
DSM-IV	1994	The diagnosis of gender identity disorder of adolescence and adulthood, non-transsexual type was jettisoned while GIDC and transsexualism were subsumed into a single category labelled "gender identity disorder" (GID), but with different criteria for diagnosis in children and adolescents/adults.
DSM-V	2018	The use of the word "disorder" was eliminated and, as such, the DSM IV diagnostic categories were changed to "Gender Dysphoria in Children" and "Gender Dysphoria in Adolescents or Adults."

Between the Stigma of Mental Illness and Access to Affirming Care for Gender Minority Persons: A Dilemma

The combined efforts of activists and scientific evidence influenced the process of depathologizing gender diversity in the diagnostic schedules.[59] However, outcomes of the push to depathologize gender identity variance slightly diverge, at present, from that of sexual minority expression and identity.

Mental health professionals and activists agreed that removing minority gender identities from the diagnostic schedules would reduce stigma and free transgender people to live life unencumbered by pathologized identities.[60] But it produced the risk of an unintended, adverse consequence. In most countries, the organization of health services, including the provision of medical insurance, is premised on the diagnosis of a relevant health condition. The removal of minority gender expression from the diagnostic schedule risks putting in jeopardy transgender persons who need transition-related health services. A dilemma ensued as to how to find a balance between concerns related to the stigmatization of mental disorders and the need for diagnostic categories that facilitate access to gender-affirming healthcare.[61]

59 Ibid.
60 Ibid.
61 Jack Drescher J, Peggy Cohen-Kettenis, and Sam Winter, "Minding the Body: Situating Gender Identity Diagnoses in the ICD-11," *International Review of Psychiatry (Abingdon, England)* 24, no. 6 (2012), doi:10.3109/09540261.2012.741575.

How the Gender Minority Dilemma Was Resolved Differently in DSM-V and ICD-11

The DSM-V and ICD-11 working groups adopted different approaches to resolving this dilemma. The ICD-11 resolved the dilemma by removing all gender-related diagnoses from any mental or behavioral disorder classification and creating a new chapter on "conditions related to sexual health"—a chapter that also includes experiences such as pregnancy—to provide a non-pathologizing basis for accessing care. The DSM-V, in contrast, changed the name of gender identity conditions by eliminating the word "disorder" and adopting "gender dysphoria."[62] Unlike the ICD, which has different chapters for different health conditions and, as such, could introduce a new chapter, the DSM is exclusively for mental and behavioral disorders. Therefore, although gender dysphoria is still technically listed in DSM-V as a mental and behavioral disorder, its inclusion was not intended to presuppose that it constituted a mental disorder in need of psychiatric care but rather a proxy to facilitate access to gender-affirming care.

In closing this section, it must be emphasized that psychiatry-linked professional bodies' overwhelming consensus today is that people have a wide range of sexual expressions and gender identities and that variations other than cisgender and heterosexual should be embraced as aspects of human diversity. The following section will highlight the ethical standards applicable to health practitioners that require them to refrain from implementing conversion practices.

62 Rebeca Robles, Tania Real, and Geoffrey M. Reed, "Depathologizing Sexual Orientation and Transgender Identities in Psychiatric Classifications," *Consortium Psychiatricum* 2, no. 2 (2021), doi:10.17816/CP61.

III. African and International Healthcare Codes Oppose Conversion Practices

How Ethical (or Unethical) Are Conversion Practices Within the Remit of Local and International Codes of Medical Practice?

Table 5, below, sets forth a glossary of some international and African codes of medical practice with bearing on the unethical status of conversion practices and other mistreatment of sexual and gender minority persons. The most fundamental and obvious ethical issue involved is the fact that being a person of sexual or gender minority does not constitute a disorder in need of a cure.

The current global consensus, based on the combined resolutions of the American Psychiatric Association and the World Health Assembly through the latest versions of their respective disease codification documents (the DSM-5 and the ICD-11), does not recognize sexual and gender minority expressions or identities as disease states in need of correction, which is the sole aim of conversion practices. In line with and echoing the extant state of knowledge, the American Psychiatric Association, in its position paper on issues related to sexual minority persons, is clear that "same-sex attraction, whether expressed in action, fantasy, or identity, implies no impairment per se in judgment, stability, reliability, or general social or vocational capabilities." By extension, the professional body states that "same-sex orientation need not be changed, and efforts to do so represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated."[63] The World Psychiatric Association (WPA) also declared in a similar position paper that it "considers same-sex attraction, orientation, and behavior as normal variants of human sexuality" and that "same-sex sexual orientation per se does not imply objective psychological dysfunction or impairment in judgment, stability or vocational capabilities."[64]

Conversion practices are unethical not only because they purport to "treat" something that is not a disorder but also because they are not evidence-based, do not represent the patient's best interests, and are not based on informed consent.[65]

Ethical Treatment Must Be in the Best Interests of the Patient

International codes of medical practice, by implication of both their letter and spirit, dictate that every physician, and by extension, every other healthcare worker, has a duty to offer medically proven treatment that is in the patient's best interest. For example, the World Medical Association Declaration of Lisbon states that "the patient shall always be treated in accordance with his/her best interests," and its Declaration of Tokyo affirms that a medical professional must "alleviate the distress of his or her fellow human beings, and no motive,

63 American Psychiatric Association, Position Statement on Issues Related to Sexual Orientation and Gender Minority Status, 2020, https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Sexual-Orientation-Gender-Minority-Status.pdf (accessed 17 September 2023)
64 Dinesh Bhugra et al., "WPA Position Statement on Gender Identity and Same-Sex Orientation, Attraction and Behaviours," *World Psychiatry* 15, no. 3 (2016), doi:10.1002/wps.20340.
65 Ibid.

whether personal, collective or political, shall prevail against this higher purpose.", and UNESCO's Universal Declaration on Bioethics and Human Rights states that the interests of the patient shall "have priority over the sole interest of science or society," and its Declaration of Tokyo affirms that medical professional must "alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this higher purpose." [66] In South Africa, the national ethical guidelines for health professionals state that "a practitioner shall at all times act in the best interests of his or her patients."[67] Conversion practices are not in the best interests of the patient, but rather a tool to enforce and promote hetero- and cisnormative social norms.

As mentioned earlier, conversion practices are associated with significant physical and psychological harm. For instance, a systematic review of global evidence showed that compared with LGBTIQ individuals who did not undergo conversion practices, those who did had a significantly higher prevalence of serious psychological consequences, including depression, sleep disturbances, chronic gastrointestinal diseases, problematic substance use, and suicidality.[68]

Ethical Treatment Is Evidence-Based

Evidence-based medicine, defined as "the conscientious, explicit, judicious and reasonable use of modern, best evidence in making decisions about the care of individual patients,"[69] is a cornerstone ethical principle to which medical practitioners must strive to adhere. For instance, the World Medical Association Declaration of Tokyo dictates that a patient is "entitled to relief of his/her suffering according to the current state of knowledge."[70]

Aside from the fact that current evidence firmly suggests that minority sexual and gender expression and identity does not constitute suffering from which an individual should be relieved, there is no systematic evidence that conversion practices could and do effect such cure that the practices purport to provide. Rather, the current state of knowledge is that the distress that some sexual and gender minority persons experience regarding their identities is because of societal prejudices and persecution. The appropriate intervention is affirmative therapy aimed at reducing the internalization of such biases and improving mental health and well-being.

Ethical Treatment Is Based on Informed Consent

Outright's global research found that respondents said they were forced to undergo conversion practice in nearly half of the cases documented.[71]

66 World Medical Association, "WMA Declaration of Lisbon on the Rights of the Patient," adopted by the World Medical Assembly, Lisbon, Portugal, September/October 1981, amended and later reaffirmed by the 200th WMA Council Session, Oslo, Norway, April 2015, https://www.wma.net/policies-post/wma-declaration-of-lisbon-on-the-rights-of-the-patient/; World Medical Association, WMA Declaration of Tokyo - Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment," June 1976, https://www.wma.net/policies-post/wma-declaration-of-tokyo-guidelines-for-physicians-concerning-torture-and-other-cruel-inhuman-or-degrading-treatment-or-punishment-in-relation-to-detention-and-imprisonment/; UNESCO, *The UNESCO Universal Declaration on Bioethics and Human Rights: Background, Principles and Application* (Paris: UNESCO 2009), https://unesdoc.unesco.org/ark:/48223/pf0000179844.

67 Health Professionals Council of South Africa, "Guidelines for Good Practice in Healthcare Professions: General Ethical Guidelines For the Healthcare Professions," December 2021, https://www.hpcsa.co.za/Uploads/professional_practice/ethics/Booklet_1_Guidelines_for_Good_Practice_vDec_2021.pdf.

68 Blosnich et al., "Sexual Orientation Change Efforts;" Jack L. Turban et al., "Association between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts among Transgender Adults, *JAMA Psychiatry* 77, no. 1 (2020), doi:10.1001/jamapsychiatry.2019.2285.

69 Gordon Guyatt et al., Evidence-Based Medicine: A New Approach to Teaching the Practice of Medicine," *JAMA* 268, no. 17 (1992), doi:10.1001/jama.1992.03490170092032.

70 Ibid.

71 Outright, *Harmful Treatment: The Global Reach of So-Called Conversion Therapy, 2019,* https://outrightinternational.org/sites/default/files/2023-08/082123_Outright_Conversion2023.pdf.

A certain proportion of sexual and gender minority persons seek conversion practices of their own accord, yet they do not provide informed consent. The very purpose of informed consent in medical practice includes protecting the patient from unwarranted bodily harm, promoting autonomous decision-making, and supporting a patient-centered and well-defined goal.[72] To achieve this, informed consent must involve an accurate description of the intended procedure or treatment, the risks and discomforts associated with it, the benefits, and alternative treatments. In addition, the consent must be given in an environment free from coercion. Consent for conversion practices that does not follow an explanation of the well-known risks and dangers, the lack of evidence for effectiveness, and information about the availability of affirmative therapy as the more evidence-based and effective alternative intervention cannot be deemed to be valid.

Medical treatment of children, like that of adults, should be based on informed consent in accordance with the principle of the evolving capacity of the child. Surveys of sexual and gender minority persons in Nigeria, Kenya, and South Africa found that parents were the most common initiators of the search for conversion practices for their children.[73] In Kenya and South Africa, more than half of respondents said that they were first subjected to conversion practices when they were under 18.[74]

Table 5

GLOSSARY OF INTERNATIONAL AND LOCAL CODES OF MEDICAL PRACTICE WITH BEARING ON CONVERSION PRACTICES AND OTHER MISTREATMENT OF SEXUAL AND GENDER MINORITY PERSONS

Ethical Issue	Relevant International and National Codes of Medical Practice	How Conversion Practices Contravene the Ethical Standard
The duty to provide evidence-based treatment	**World Medical Association (WMA) Declaration of Tokyo** (originally 1975)[75] ➢ A patient is "entitled to relief of his/her suffering according to the current state of knowledge."	The current state of knowledge is that LGBTQ identities and orientations are normal human variants and are not pathologies. There is no systematic evidence that conversion practices effectively change a person's sexual orientation or gender identity.

72 Daniel E. Hall, Allan V. Prochazka, and Aaron S. Fink, "Informed Consent for Clinical Treatment," *Canadian Medical Association Journal* 184, no. 5 (2012), doi:10.1503/cmaj.112120.
73 Outright, *Converting Mindsets*, 8.
74 galck+, *Shame is Not a Cure: So-Called Conversion "Therapy" Practices in Kenya*, 2022, https://outrightinternational.org/sites/default/files/2022-08/galck%2BConversion_Practices_in_Kenya.pdf, 22; Access Chapter 2 and Inxebalam', *"Conversion Practices" and Implications in the South African Context*, 2022, https://outrightinternational.org/sites/default/files/2022-08/AC2-conversion-report.pdf, 26.
75 World Medical Association, "WMA Declaration of Tokyo," adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975 and revised by the 67th WMA General Assembly, Taipei, Taiwan, October 2016.

Ethical Issue	Relevant International and National Codes of Medical Practice	How Conversion Practices Contravene the Ethical Standard
The duty to act in the *best interest* of the patient	**UNESCO Universal Declaration on Bioethics and Human Rights** (2005)[76] ➢ "The interests and welfare of the individual should have priority over the sole interest of science or society" (art. 3). **WMA Declaration of Lisbon** (originally 1981)[77] ➢ "The patient shall always be treated in accordance with his/her best interests. The treatment applied shall be in accordance with generally approved medical principles" (principle 1c). ➢ "The patient is entitled to relief of his/her suffering according to the current state of knowledge" (principle 10c). **WMA International Code of Medical Ethics** (originally 1949)[78] ➢ A physician shall act in the patient's best interest when providing medical care. **MDCN Code of Medical Ethics in Nigeria** (2004)[79] ➢ "Practitioners … must desist from compulsory treatment of a patient in the absence of illness and must not collaborate with other agencies to label somebody ill in the absence of any illness" (rule 7m).	Conversion practices cause demonstratable harm. Conversion practices are often seen as being in the interests of the society but are not in the best interests of the patient.

76 UNESCO, *The UNESCO Universal Declaration on Bioethics and Human Rights*.
77 World Medical Association, "WMA Declaration of Lisbon on the Rights of the Patient," Adopted by the World Medical Assembly, Lisbon, Portugal, September/October 1981, amended and later reaffirmed by the 200th WMA Council Session, Oslo, Norway, April 2015, https://www.wma.net/policies-post/wma-declaration-of-lisbon-on-the-rights-of-the-patient/.
78 World Medical Association, "WMA International Code of Medical Ethics," last revised by the 73rd WMA General Assembly, Berlin, Germany, October 2022, https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/.
79 Medical and Dental Council of Nigeria (MDCN), *Codes of Medical Ethics in Nigeria*, 2004, https://www.mdcnigeria.org/downloads/code-of-conducts.pdf (accessed 31 August 2023).

Ethical Issue	Relevant International and National Codes of Medical Practice	How Conversion Practices Contravene the Ethical Standard
The duty to act in the *best interest* of the patient	**HPCSA General Ethical Guidelines for the Healthcare Professions** (South Africa, 2021)[80] ➢ "Health care practitioners must act in the best interests of patients even when the interests of the latter conflict with their own personal self-interest" (art. 2.3.2.1). **HPCSA Ethical and Professional Rules of the Health Professions Council of South Africa** (2016)[81] "A practitioner shall at all times … act in the best interests of his or her patients" (art.27A(a)).	Conversion practices cause demonstratable harm. Conversion practices are often seen as being in the interests of the society but are not in the best interests of the patient.
The duty to uphold patients' dignity and not to offer or carry out a cruel, inhuman, or degrading medical intervention	**UNESCO Universal Declaration on Bioethics and Human Rights** (2005)[82] ➢ "Human dignity, human rights and fundamental freedoms are to be fully respected" (art. 3(1)). **WMA Declaration of Tokyo** (originally 1975)[83] ➢ "The doctor shall not countenance, condone, or participate in the practice of torture or other forms of cruel, inhuman, or degrading procedures…" (declaration 1). **MDCN Code of Medical Ethics in Nigeria** (2004)[84] ➢ "It is obligatory that practitioners are not drawn into the application of torture on any citizen. They shall not countenance, condone or participate in the practice of torture or any form of cruel, inhuman or degrading procedures…." (preamble, rule 67).	Conversion practices are physically and psychologically harmful and can constitute degrading treatment. In some cases, conversion practices can rise to the level of torture.

80 Health Professionals Council of South Africa, *Guidelines for Good Practice in Healthcare Professions*, 2021.
81 Health Professions Council of South Africa, *Guidelines for Good Practice in Healthcare Professions. Ethical and Professional Rules of the Health Professions Council of South Africa*, September 2016, https://www.hpcsa.co.za/Uploads/professional_practice/ethics/Booklet_2_Generic_Ethical_Rules_with_anexures.pdf (accessed 31 August 2023).
82 UNESCO, *The UNESCO Universal Declaration on Bioethics and Human Rights*.
83 World Medical Association, "WMA Declaration of Tokyo," revised 2016.
84 Medical and Dental Association of Nigeria, *Codes of Medical Ethics in Nigeria*.

Ethical Issue	Relevant International and National Codes of Medical Practice	How Conversion Practices Contravene the Ethical Standard
The duty to uphold patients' dignity and not to offer or carry out a cruel, inhuman, or degrading medical intervention	**HPCSA General Ethical Guidelines for the Healthcare Professions** (South Africa, 2021)[85] ➢ "Health care practitioners must respect patients as persons, and acknowledge their intrinsic worth, dignity, and sense of value" (art. 2.3.1). ➢ "Health care practitioners must honour the right of patients to self-determination or to make their own informed choices, and to live their lives by their own beliefs, values and preferences" (art. 2.3.4).	Conversion practices are physically and psychologically harmful and can constitute degrading treatment. In some cases, conversion practices can rise to the level of torture.
Duty not to discriminate or deny access to needed health services on the grounds of prejudice	**WMA Declaration of Lisbon** (originally 1981)[86] ➢ "Every person is entitled without discrimination to appropriate medical care" (Principle 1a). **WMA Declaration of Geneva** (originally 1948)[87] ➢ "As a member of the medical profession … I will not permit considerations of age, disease or disability, creed, ethnic origin, **gender**, nationality, political affiliation, race, **sexual orientation**, social standing or any other factor to intervene between my duty and my patient."	

As demonstrated in Table 5 above, conversion practices fail to meet key ethical requirements and codes of medical practice.

Ethical Treatment Eschews Torture and Cruel, Inhuman, and Degrading Treatment

International and national codes of medical practice demand of a practitioner the duty to respect human dignity and not to "countenance, condone, or participate in the practice of torture or other forms of cruel, inhuman, or degrading procedures." [88] The Medical and Dental Council of Nigeria (MDCN)'s Codes of Medical Ethics explicitly prohibits torture, defined to include efforts to "deliberate systematic or wanton infliction of physical or mental injury or both, occasioning harm" … or any other action or procedure which can be "considered to

85 Health Professionals Council of South Africa, *Guidelines for Good Practice in Healthcare Professions*, 2021.
86 World Medical Association, "WMA Declaration of Lisbon on the Rights of the Patient," amended April 2015.
87 World Medical Association, "WMA Declaration of Geneva," adopted by the 2nd General Assembly of the WMA, Geneva, Switzerland, September 1948, amended and revised severally with the latest version adopted by the 68th WMA General Assembly, Chicago, United States, October 2017, https://www.wma.net/policies-post/wma-declaration-of-geneva/.
88 World Medical Association, "Declaration of Tokyo."

constitute forms of torture or are contrary to the promotion of good health and maintenance of life."[89]

Conversion practices may sometimes rise to the level of torture or cruel, degrading, and inhuman treatment. Some of the cases documented by Outright involve physical violence that may constitute torture: for instance, in Nigeria, 5.78% of the over 1,000 respondents who had experienced conversion practices reported that they "were institutionalised at live-in 'treatment' facilities and/or locked in a facility, in isolation." [90] Methods of treatment in such a facility and forced confinement therein may constitute torture or cruel, inhuman, and degrading treatment. In addition, some scholars argue that conversion practices may inherently constitute cruel, inhuman, and degrading treatment because they are associated with the risk of long-lasting physical and psychological damage and are carried out based on the demeaning and disempowering assumptions that sexual and gender minority persons are inferior and sick and that heterosexual and cisgender identities are inherently preferable.[91]

This publication does not discuss in detail all of the international and regional legal standards that apply to conversion practices, but it is noteworthy that the Universal Declaration of Human Rights and derivatives such as the African Charter on Human and Peoples' Rights (ACHPR) recognize the equality of all human beings and the inviolability of human dignity. Article 5 of the ACHPR states that "every individual shall have the right to the respect of the dignity inherent in a human being" and that "all forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited." [92]

Ethical Treatment Requires Non-Discrimination

The Physician's Pledge, adopted by the World Medical Association and based on the Hippocratic Oath, which is usually the very first oath that a medical practitioner swears to on the day of their induction into medical practice, states that:

> **"As a member of the medical profession: I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient.[93] (Emphasis added)."**

Furthermore, the first principle of the WMA's Declaration of Lisbon states that "every person is

89 Medical and Dental Council of Nigeria (MDCN), *Codes of Medical Ethics in Nigeria*, sec. d.
90 The Initiative for Equal Rights, *The Nature, Extent and Impact of Conversion Practices in Nigeria,* (2022), https://outrightinternational.org/sites/default/files/2022-08/TIERS_Conversion_Practices_in_Nigeria.pdf, p. 43.
91 Ilias Trispiotis and Craig Purshouse, "'Conversion Therapy' As Degrading Treatment," *Oxford Journal of Legal Studies* 42, no. 1 (2022), doi:10.1093/ojls/gqab024.
92 African Charter on Human and Peoples' Rights, adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force October 21, 1986, https://au.int/sites/default/files/treaties/36390-treaty-0011_-_african_charter_on_human_and_peoples_rights_e.pdf (accessed 31 August 2023).
93 World Medical Association, "WMA Declaration of Geneva," September 1948, https://www.wma.net/policies-post/wma-declaration-of-geneva/.

entitled without discrimination to appropriate medical care."[94]

Yet one of the key drivers of health disparities among sexual and gender minority persons worldwide is unequal access to healthcare services, as noted in the previous section. Sexual and gender minority persons' experiences in trying to access healthcare in Africa have included denial of care, stigmatization, discrimination, breaches of confidentiality, and confronting cisheteronormative health systems that do not account for the existence of LGBTQ patients and their specific needs.[95] Conversion practices are also, in themselves, discriminatory: they specifically attempt to change the basic characteristics of minority persons to meet a majority standard. These experiences run counter to international and national codes of medical practice.

Steps to Report Harmful or Degrading Treatment and Other Unethical Practices by a Health Worker

While there might be slight differences in wording, national codes of medical ethics worldwide are drawn from the international codes as summarized in Table 5 above. The WMA's Declaration of Geneva, for instance, which is the Physician Oath that every practitioner of medicine globally must swear to before they can be registered as a practitioner, is reproduced verbatim on page 7 of Nigeria's MDCN Code of Medical Ethics. The Medical Practitioner and Dentist Board of Kenya's Code of Professional Conduct and Discipline also lists, as its guiding principles, many of the international codes of medical practice identified in Table 5 above.[96]

Violating these codes constitutes professional misconduct for which a practitioner may be sanctioned. There are medical and health worker's Disciplinary Tribunals all over Africa charged with the responsibility of receiving, investigating, and meting out appropriate sanctions for any form of violation of these codes of ethics. Healthcare practitioners must be mindful of the fact that they have an ethical responsibility to protect members of the public by reporting any form of objectionable practice, including foray into conversion practices among their own colleagues.[97]

When violations of ethical codes occur, there are guidelines for reportage either by the victim directly or other interested parties. For instance, in Nigeria, a citizen or a group of people can initiate a petition against a registered practitioner by filing a notarized affidavit addressed to the Registrar, Medical and Dental Council of Nigeria, and submitting it either to the physical address of the Council in Abuja, Nigeria or via an online platform.[98]

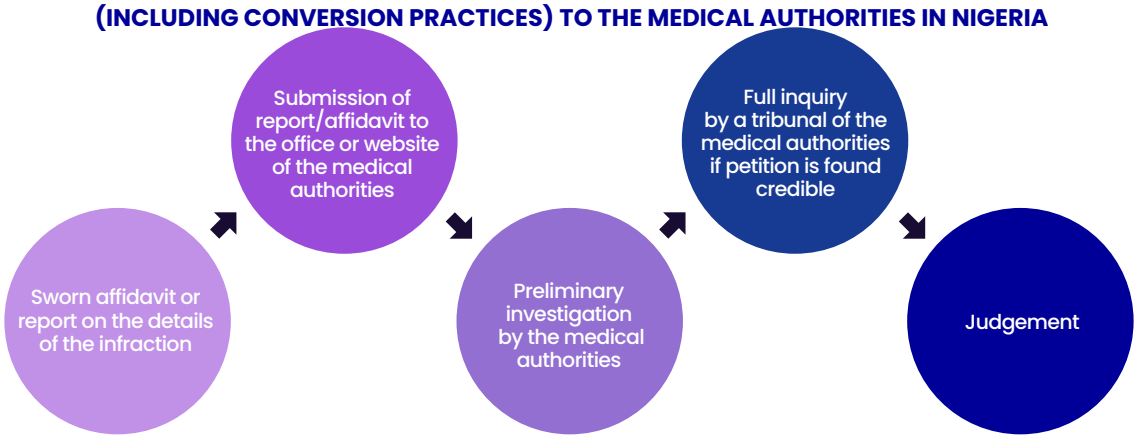
In accordance with the Medical and Dental Practitioners Act of Nigeria, when such a petition is received, it will be passed to the Medical and Dental Practitioners Investigation Panel whose duty is to first conduct a preliminary investigation into the petition and determine if there is sufficient grounds to refer the matter to the substantive Disciplinary Tribunal for full

94 World Medical Association, "WMA Declaration of Lisbon."
95 Müller, "Scrambling for Access," 16; Alex Müller et al., "The No-Go Zone;" Alex Müller, "Health for All? Sexual Orientation, Gender Identity, and the Implementation of the Right to Access to Health Care in South Africa," *Health and Human Rights* 18, no. 2 (2016).
96 Republic of Kenya, *The Code of Professional Conduct and Discipline,* 6th ed., https://kmpdc.go.ke/resources/Code-of-Professional-Conduct-and-Discipline-6th-Edition.pdf (accessed 31 August 2023), ch. 5.
97 According to the World Medical Association International Code of Medical Ethics, "The physician should avoid acting in such a way as to weaken public trust in the medical profession. To maintain that trust, individual physicians must hold themselves and fellow physicians to the highest standards of professional conduct and be prepared to report behaviour that conflicts with the principles of this Code to the appropriate authorities." World Medical Association, "WMA International Code of Medical Ethics," last revised by the 73rd WMA General Assembly, Berlin, Germany, October 2022, https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/; see also American Medical Association (AMA), Code of Medical Ethics, "9.4.2 Reporting Incompetent or Unethical Behaviors by Colleagues," August 2022, https://code-medical-ethics.ama-assn.org/ethics-opinions/reporting-incompetent-or-unethical-behaviors-colleagues.
98 Homepage, Medical and Dental Council of Nigeria, https://www.mdcn.gov.ng (accessed 31 August 2023).

adjudication (see Figure 3).[99] To Outright's knowledge, there has not been any report of any doctor to the relevant medical regulatory bodies for engaging in conversion practices in Nigeria. This is probably due to lack of information about the unethical nature of conversion practices and to the social, political, and legal context of minority sexual and gender expressions in Nigeria.

Figure 3

STEPS TO REPORT VIOLATIONS OF MEDICAL ETHICS (INCLUDING CONVERSION PRACTICES) TO THE MEDICAL AUTHORITIES IN NIGERIA



The procedure under the Health Professions Act of South Africa is similar.[100] The few differences are that in the case of South Africa, a complainant must submit a downloadable petition form accompanied with a copy of the complainant's means of identification. A sworn affidavit is only required if the complainant was a third-party and not the patient involved. An alternative dispute resolution system, through the Ombuds office, is also available in South Africa to resolve "minor transgressions." Penalties against a practitioner who appears before the Tribunals and is found culpable of professional misconduct (violation of the codes of medical ethics) can range from warnings, through temporary suspension, to delisting from the register of practitioners.

99 Federation of Nigeria, "Medical and Dental Practitioners Act, CAP M8," Laws of Federation of Nigeria, 2004, https://www.mdcn.gov.ng/public/storage/ckeditor/upload_7405511.pdf (accessed 31 August 2023).
100 Homepage, Health Professions Council of South Africa, https://www.hpcsa.co.za (accessed 31 August 2023).

IV. Eradicating Conversion Practices and Discriminatory Attitudes Towards Sexual and Gender Minority Persons in the Healthcare Space in Africa

Drawing from the lessons in the first three sections of the document, this section will focus on practical suggestions for how individual practitioners and their respective professional bodies (mental health and allied disciplines), civil society organizations, and governments can contribute to the eradication of conversion practices and promote the delivery of needed affirmative therapy in Africa. Table 6 below summarizes the suggested roles and responsibilities of different agencies in eradicating conversion practices in the healthcare space in Africa.

Role of the Individual Mental Health Practitioners

Embedded within international and national codes of medical ethics is the fundamental assumption that every healthcare practitioner has a responsibility to contribute to the maintenance and enhancement of the standard of healthcare service and to preserve the noble traditions of the profession. This responsibility includes a duty to attain the highest level of professionalism, in terms of knowledge and skill, and to deliver services in the most professional and honorable way. Therefore, one of the duties of healthcare practitioners is to keep abreast of knowledge and developments within their field of practice and how such developments have impacted or ought to impact practice. The ideal of continued medical education for health workers is echoed in article 27A[e] of South Africa's HPCSA codes, which states that: "a (healthcare) practitioner shall at all times keep his or her professional knowledge and skills up to date."[101] Similarly, article 9 (I) of Nigeria's Codes of Medical Ethics states that "practitioners must always strive to improve their medical knowledge and skill, and practise according to accepted scientific principles in rendering care to patients."[102] However, research conducted by Outright and The Initiative for Equal Rights in Nigeria finds that medical schools and other academic institutions involved in the training of mental health practitioners in Nigeria still do not teach about sexual orientation and gender identity, and when they do, these teachings still reflect the incorrect assumption that conversion practices are acceptable practice.[103]

The implication is that, beyond personal prejudices, every healthcare practitioner has an enforceable ethical duty to keep abreast of the current state of evidence on the status of minority sexual and gender expressions and identities in the medical literature, including

101 Health Professions Council of South Africa, *Ethical and Professional Rules of the Health Professions Council of South Africa.*
102 Medical and Dental Council of Nigeria, *Codes of Medical Ethics in Nigeria*, 17.
103 Outright, *Converting Mindsets*; The Initiative for Equal Rights, The Nature, Extent and Impact of Conversion Practices In Nigeria, August 2022, https://outrightinternational.org/sites/default/files/2022-08/TIERS_Conversion_Practices_in_Nigeria.pdf.

professional practice guidelines on issues surrounding the subject. Failure to do so will not only mean that the practitioner is not adhering to the dictates of evidence-based practice, but it can put the practitioner at risk of violating an important code of ethical practice and being guilty of professional misconduct.

The current evidence, as documented in systematic research and reflected in position statements and resolutions of international medical and mental health professional bodies, includes that sexual and gender minority expressions and identities are normal variants;[104] that conversion practices are not only futile but harmful;[105] and that affirmative therapy can help reduce the impact of societal prejudices and promote wellbeing of sexual and gender minority persons.[106]

Therefore, one of the first steps towards eradicating conversion practices in Africa is for local practitioners to acquaint themselves with the current state of evidence. This can be achieved through personal familiarization with extant literature and attendance of workshops and webinars. The next step is to acquire some basic training on affirmative therapy techniques, or at least identify a local practitioner with such skills to whom the practitioner in question can refer clients.

Mental health practitioners have a unique responsibility in the quest to eradicate conversion practices in Africa and entrench affirmative therapy. This is because despite several position statements that have denounced the erroneous pathologizing of minority gender and sexual expressions and identities, the search for conversion practices still often leads to the mental health practitioner's consulting room. In this regard, mental health practitioners will be confronted with the responsibility of acting in the best interests of the client.

If confronted with a client seeking conversion "therapy," medical ethics, as outlined above, requires that the practitioner decline to carry out a practice that is not evidence-based and is known to cause harm. The ethical obligation of a healthcare practitioner to withhold conversion "therapy" outweighs the need to respect the autonomy of the patient or any benefit that the patient believes they may derive from the practice.[107] In addition, for the majority of sexual and gender minority persons, the reason why conversion "therapies" are sought is not necessarily because of intra-psychic conflict, which is what psychotherapy seeks to resolve, but because of internalized homophobia and transphobia resulting from societal and religious pressures.[108]

Adolescents and children present a unique scenario as they are often brought to the mental health practitioner by parents requesting conversion practices. A case commentary published in the *American Medical Association Journal of Ethics* offers practical steps that a practitioner may follow when approached by parents of an adolescent for conversion practices.[109]
A mental health practitioner, confronted with a parent seeking conversion "therapy" for their adolescent child, should first seek to speak with the adolescent privately. In the course of this private discussion, the practitioner should listen empathically, show and express unconditional

104 David Scasta and Philip Bialer, "Position Statement on Issues Related to Homosexuality," American Psychiatric Association, 2013, https://www.psychiatry.org/getattachment/4ed6298d-e24c-4b8e-a0dd-3a3035e2e216/Position-2013-Homosexuality.pdf; Bhugra et al., "WPA Position Statement."
105 Jowett et al., *Conversion Therapy*; Serovich et al., "A Systematic Review."
106 Craig et al., "Efficacy of Affirmative Cognitive Behavioural Group Therapy."
107 Jack Drescher, "Ethical Concerns Raised When Patients Seek to Change Same-Sex Attractions," *Journal of Gay & Lesbian Psychotherapy* 5, no. 3-4 (2002), doi:10.1300/J236v05n03_11.
108 Erinn E. Tozer and Jeffrey A. Hayes, "Why Do Individuals Seek Conversion Therapy? The Role of Religiosity, Internalized Homonegativity, and Identity Development," *The Counseling Psychologist* 32, no. 5 (2004), doi:10.1177/0011000004267563.
109 Philip Zachariah, Gregory S. Blaschke, and Melissa Weddle, "A Request for 'Conversion Therapy,'" *AMA Journal of Ethics* 16, no. 11 (2014), doi:10.1001/virtualmentor.2014.16.11.ecas2-1411.

positive regard, and reassure the adolescent. In addition, the practitioner should conduct a full mental health assessment of the adolescent, with a particular focus on suicidal behaviors. The adolescent should be provided with information about and links to relevant support groups and helplines.

Furthermore, the practitioner must endeavor to manage the conflicting role of providing affirming care for the adolescent while not alienating the adolescent from their parents or guardians. This is because there is evidence that sexual and gender minority adolescents without parental support are several times more likely to be depressed, suicidal, or become involved in risky sexual behaviors and drug abuse.[110] Therefore, the mental health practitioner should initiate a conversation with the parents of the adolescent after providing the adolescent with affirming support in private. Therapists must strive to understand the plurality of parental opinions about sexuality and gender and establish each parent's unique understanding and perspective. The conversation with parents should be mindful of not opposing the parents' views overtly. It is better that the conversation with parents is geared towards acknowledging their beliefs and providing them with accurate and current scientific understanding, while encouraging them to support their child.[111] It may also be useful to link them up with parental support groups (see Information Box below).

PRACTICAL STEPS FOR A PRACTITIONER WHEN CONFRONTED WITH A PARENT'S OR CAREGIVER'S REQUEST FOR CONVERSION PRACTICES FOR AN ADOLESCENT

- Seek to speak with the adolescent privately as a first step.
- Listen empathically, show and express unconditional positive regard, and reassure the adolescent.
- Conduct full mental health assessment with particular focus on suicidal behaviors.
- Offer affirmative therapy, including links to support groups and helplines.
- Seek audience with caregivers to understand their perspectives and provide them with accurate and current scientific understanding while encouraging them to support their child.

Responsibilities of Professional Mental Health Bodies

The historical link between psychology and psychiatry and the initial pathologizing of sexual and gender minority expressions and identities places a unique burden of responsibility on mental health professional bodies in the effort to eradicate conversion practices.

One of the ways to pursue this responsibility is to empower their members, through workshops, seminars, and webinars on topical issues such as the state-of-the art science of sexual and gender diversity, the dangers inherent in conversion practices, and the evidence-based approaches to affirmative therapy among sexual and gender minority persons. This step will ensure that practitioners who genuinely lack access to information can obtain accurate information and become advocates of good ethical practice themselves.

Another way that mental health professional bodies can exercise responsibility is to issue

110 Caitlin Ryan, David Huebner, Rafael M. Diaz, and Jorge Sanchez, "Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults," *Pediatric,*123, no. 1 (2009), doi:10.1542/peds.2007-3524.

111 Zachariah, Blaschke, and Weddle, "A Request for 'Conversion Therapy.'"

statements denouncing the pathologizing of sexual and gender minority expressions and identities; declaring conversion practices as the harmful and degrading methods that they are; discouraging the participation of their members in conversion practices; declaring support for affirmative therapies; and calling for the protection of the fundamental rights of sexual and gender minority persons as equal members of society.

In addition, there is a need for mental health professional bodies to issue guidelines for practitioners on what to do when confronted with a request for conversion practices, taking into consideration the local social and political realities. Of the many mental health professional groups in Africa, such as the Association of Psychiatrists in Nigeria, the South African Society of Psychiatrists, the Nigerian Psychological Association, the Kenya Psychiatric Association, the Tanzanian Psychological Association, the Psychiatry Association of Ghana, as well as many others, only the Psychological Society of South Africa has issued a public statement on sexual and gender diversity,[112] as well as guidelines for professionals working with sexual and gender minority persons.[113] Other such mental health professional groups in Africa urgently need to follow suit. Such position statements can and will serve as a veritable tool for advocates working with families, faith-based practitioners, and the community on the eradication of conversion practices.

Mental health professional bodies in Africa should also issue statements condemning, on health grounds, the criminalization of sexual and gender minority expression and identities. It is the right professional and ethical thing to do. This is because criminalization is part of the societal drivers of stigma, discrimination, and violence against sexual and gender minority persons in Africa,[114] and these social prejudices and violent acts have been linked directly with mental health disparities impacting sexual and gender minority persons.[115]

Moreover, the codes of medical ethics enjoin medical professional bodies to advocate for the repeal of laws or policies that violate individuals' rights to health. The Medical and Dental Council of Nigeria's Code of Medical Ethics states explicitly that:

> **Practitioners shall always strive to observe the laws of the land but may participate, individually or collectively, in accordance with citizenship rights to bringing pressure to bear on governments or authorities, to change or modify laws or actions**

112 Ingrid Lynch et al., "The Psychological Society of South Africa Sexual and Gender Diversity Position Statement: Contributing Towards a Just Society," *South African Journal of Psychology* 44, no. 3 (2014), doi:10.1177/0081246314533635.
113 Pillay et al., "The Psychological Society of South Africa's Guidelines for Psychology Professionals Working with Sexually and Gender-Diverse People."
114 See, for instance, Human Rights Watch, *"Tell Me Where I Can Be Safe": The Impact of Nigeria's Same Sex Marriage (Prohibition) Act*, October 2016, https://www.hrw.org/report/2016/10/20/tell-me-where-i-can-be-safe/impact-nigerias-same-sex-marriage-prohibition-act.
115 Ji Hyun Lee et al., "Discrimination, Mental Health, and Substance Use Disorders Among Sexual Minority Populations," *LGBT Health* 3, no. 4 (2016), doi:10.1089/lgbt.2015.0135; Joanne DiPlacido and Carolyn R. Fallahi, "Stigma and Sexual and Gender Minority Mental Health," in *The Oxford Handbook of Sexual and Gender Minority Mental Health*, ed. E.D. Rothblum (New York, NY: Oxford University Press 2020), doi:10.1093/oxfordhb/9780190067991.013.37; Kristi Gamarel et al., "A Mixed-Methods Study of Relationship Stigma and Well-Being among Sexual and Gender Minority Couples," *Journal of Social Issues* 79, no. 1 (2023), doi:10.1111/josi.12552.

considered inequitable or inimical to the interest of the profession or the society.[116]

This is a clarion call to the Association of Psychiatrists in Nigeria and indeed, other mental health professional groups in Africa to do their part to eradicate harmful conversion practices.

Responsibilities of Civil Society Organizations Working to Promote the Wellbeing of Sexual and Gender Minority Persons

There is a huge gap in Africa regarding public knowledge and understanding of the nature of sexual and gender diversity.[117] There is also a lack of harmonization between the few current efforts among different stakeholders to improve sexual and gender diversity literacy at the community level and eradicate conversion practices. This is best achieved by fostering dialogue between stakeholders, including medical and health professional bodies, faith-based organizations, families, the media, human rights organizations, political leaders, educational institutions, and community-based organizations, to raise awareness about the human rights impact of conversion practices and to popularize the ideals of affirmative therapy.[118] Civil society organizations (CSOs) have a unique role to play in developing and delivering awareness programs aimed at sensitizing communities, including religious communities, on the nature of sexual and gender diversity, and other programs to eliminate stigma.[119]

Working in collaboration with local mental health professional bodies, CSOs in Africa need to develop training hubs for affirmative therapy for mental health practitioners who desire to acquire such skills. Where is it safe and possible to do so, there is also a need for CSOs to establish affirmative therapy centers, as special "places of refuge," within the existing public mental health services in the countries where they are based. Such "places of refuge" should be deliberately designed and staffed in such a way that sexual and gender minority persons can feel safe to discuss issues affecting them, including their need for affirmative therapy, all within the same public mental health space used by other members of the society. This will improve access to services and reduce stigma.

Civil society organizations should also advocate for law and policies that regulate or prohibit conversion practices in Africa, especially in the health sector. as is increasingly being done in other countries around the world.[120] In addition, civil society organizations should create platforms to assist survivors of conversion practices within the formal healthcare ecosystem, to seek redress within the provisions of their respective healthcare regulatory councils and even, where relevant, in civil or criminal courts.

Responsibilities of the State (Governments)

International human rights charters and laws, including the African Charter on Human and Peoples' Rights (ACHPR), impose a responsibility on state parties to ensure that persons, including healthcare practitioners, refrain from violating human rights through degrading treatments, as well as other harmful and discriminatory practices. Aside from the fact that the

116 Medical and Dental Council of Nigeria, *Codes of Medical Ethics in Nigeria*, 16.
117 Athenkosi Sopitshi, "Attitudes, Knowledge and Beliefs around Homosexuality: Exploring the Views of 5th Year Medical Students" (MA diss., University of Cape Town 2016), https://open.uct.ac.za/handle/11427/22930.
118 Outright, *Converting Mindsets*.
119 Ibid.
120 Jack Drescher et al., "The Growing Regulation of Conversion Therapy," *Journal of Med Regulation* 102, no. 2 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5040471/; Outright, *Converting Mindsets*.

ACHPR guarantees the rights of every citizen of member states, to enjoy equality of rights and freedom "*without distinction of any kind….*" (article 2), articles 4 and 5 of the Charter enjoin state parties to ensure the inviolability of the human person and protection against inhuman or degrading treatment in whatever form, and article 16 requires that "*every individual shall have the right to enjoy the best attainable state of physical and mental health*."[121] Therefore, state parties have a responsibility to protect sexual and gender minority persons from "treatment" such as conversion practices that harm people's physical and mental health, discriminate, and may amount to torture or cruel, inhuman and degrading treatment.

Other than a pending bill before the legislative house in South Africa seeking to add a clause to the existing Children's Act 38 of 2005, with the aim to criminalize conversion practices on children, there is currently no legislative or regulatory effort towards eradicating conversion practices in Africa. In other parts of the world, the recognition of the harms of conversion practices has led to the promulgation of national and sub-national laws banning conversion practices in the health care sector. Laws explicitly prohibit healthcare practitioners from providing a diagnosis or treatment aimed at changing a person's sexual orientation or gender identity in Albania, Argentina, Brazil, Ecuador (specifically in rehabilitation institutions), and Uruguay. Similar laws prohibit health sector pathologization of or efforts to change a person's sexual orientation, but do not extend to gender identity in Fiji, Nauru, and Samoa.[122] In other countries and regions, such as Malta, legislation prohibiting conversion practices extends beyond the health sector, but reserves stiffer penalties for health workers who engage in conversion practices, based on the understanding that they have an elevated responsibility to act in the interests of protecting patients' health.[123]

Whilst some countries in Africa have improved protections for LGBTQ persons within their legal frameworks, most countries in Africa actually criminalize minority gender and sexual expressions and identities rather than adopting legislation to protect sexual and gender minority persons such as the prohibition of conversion practices in health care settings.[124] This is against the spirit of equal rights and freedom "without discrimination of any kind" as enshrined in article 2 of the ACHPR.

Governments in Africa have an urgent responsibility to their citizens to decriminalize minority gender and sexual expressions and identities and consensual sexual conduct, and to take steps to eradicate conversion practices. Without decriminalizing LGBTQ people, governments perpetuate harm and tacitly lend their support to violations of medical ethics, including in the form of conversion practices. They also deny a segment of the population the right to the highest attainable standard of health.

121 African Charter on Human and Peoples' Rights.
122 Jowett et al., *Conversion Therapy*; ILGA World, "Curbing Deception: A World Survey on Legal Regulation of So-Called 'Conversion Therapies,'" 2022, https://www.ohchr.org/sites/default/files/Documents/Issues/SexualOrientation/IESOGI/CSOsAJ/ILGA_World_Curbing_Deception_world_survey_legal_restrictions_conversion_therapy.pdf.
123 David De Groot, "Bans on Conversion 'Therapies:' The Situation in Selected EU Member States," European Parliament, June 2022, https://www.europarl.europa.eu/RegData/etudes/BRIE/2022/733521/EPRS_BRI(2022)733521_EN.pdf. Several other European countries ban all acts and utterances that seek to change a person's sexual orientation or gender identity, including by ordinary members of the public. Outright does not at this time fully endorse such laws, which rely heavily on criminalization to address social harms, may be applied in a discriminatory manner against racial, ethnic and religious minorities, and presume that no one can consent to any act that harms them, a belief that has in itself been used to justify criminalization of queer and sex worker communities. For that reason, this report focuses on the possibility of prohibitions in the health care sector, which do not raise the same questions given health workers' clear responsibilities to uphold medical ethics, and, if they are part of the public sector, to advance the human right to the highest attainable standard of health.
124 Arimoro, "Interrogating the Criminalisation of Same-Sex Sexual Activity."

Table 6

SUGGESTED ROLES AND RESPONSIBILITIES OF DIFFERENT STAKEHOLDERS IN ERADICATING CONVERSION PRACTICES IN THE HEALTHCARE SPACE IN AFRICA

Stakeholder	Suggested Roles and Responsibilities
Mental health professionals	➢ Acquaint self with information on the current state of knowledge on sexual and gender diversity and best-practice guidelines on the handling of sexual and gender minority issues within the healthcare space. ➢ Serve as informed advocates on sexual and gender diversity issues. ➢ Eschew conversion practices and adopt affirmative therapy in line with global best practices.
Mental health professional bodies (individually and in collaboration with CSOs)	➢ Develop and disseminate accurate information and skills to handle sexual and gender diversity issues to mental health workers through webinars, seminars, workshops, and training hubs. ➢ Provide trainings on affirmative therapy and require these as a form of continued education requisite to retaining or renewing licenses. ➢ Issue position statements and take a stand on gender and sexual diversity issues, including opposing the pathologization and criminalization of sexual and gender diversity. ➢ Issue practice guidelines for handling sexual and gender diversity issues to practitioners.
Civil society organizations (individually or in collaboration with mental health professional body)	➢ Develop and deliver public awareness programs on sexual and gender minority issues. ➢ Champion the integration of affirmative therapy into the service framework at public mental health service points. ➢ Advocate for the enacting of laws and policies to prohibit forms conversion practices in the healthcare space and to decriminalize sexual and gender minority persons.
Governments	➢ Uphold the fundamental rights of sexual and gender minority persons as part of human rights, as enshrined in international and regional human rights standards, including the African Charter on Human and Peoples' Rights. ➢ Decriminalize gender and sexual minority expression and identities. ➢ Publicly condemn conversion practices as harmful and degrading treatment and explore legislation or regulations to prevent them, especially in the healthcare space. ➢ Provide support for affirming health care.

V. Conclusion

In conclusion, considerable research data and lived-experience accounts have established that sexual and gender minority persons in Africa are being made to undergo conversion practices. Deep-seated personal prejudices and discriminatory local legislation and policies around sexual and gender diversity have encouraged and have been used to justify conversion practices in communities in Africa. In addition, driven by early misconceptions of sexual and gender diversity as a disorder, medical practitioners were misled into carrying out conversion practices on LGBTQ persons within the healthcare space.

Contemporary scientific evidence and practice standards in the medical and psychological fields have, however, continued to emphasize that homosexuality and transgender expressions are normal variants of human gender and sexual diversity and do not represent disorders in need of treatment. Furthermore, global reviews of available scientific evidence also established, without equivocation, that conversion practices are not only futile, but they are harmful, dehumanizing, and associated with sundry adverse physical and mental health consequences. Therefore, conversion practice violates international and African codes of medical practice which forbid practitioners from engaging in harmful or degrading treatment and offering ineffectual treatment, especially in the absence of a disease. There is an urgent need for professional bodies within the health sector in Africa, with the accompaniment and support of civil society, to emphasize these facts by issuing statements that denounce conversion practices and working assiduously to eradicate them.

ANNEX

List of Associations That Condemn Conversion Practices and LGBTQ Pathologization

The following national mental health associations, institutions, or government bodies related to mental health have issued statements, laws, or policies that firmly reject the pathologization of consensual same-sex relations and desire. (In addition to the countries on this list, Outright International is aware of a similar statement from Thailand's Department of Mental Health, but we did not have a citation at time of publication.) Other mental health bodies around the world should follow suit.

Argentina

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Turkish Psychological Association, *Ethics Code*, para. 2.5(b), April 18, 2004, https://www.cag.edu.tr/uploads/site/lecturer-files/turkish-psychological-association-ethics-code-5z3a.pdf

United Kingdom

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United States of America

American Psychiatric Association, *Position Statement on Conversion Therapy and LGBTQ Patients*, https://www.psychiatry.org/getattachment/3d23f2f4-1497-4537-b4de-fe32fe8761bf/Position-Conversion-Therapy.pdf, November, 2018

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Outright International
216 East 45th Street, 17th Floor, New York, NY 10017
T +1 212 430 6054 • E comms@outrightinternational.org
outrightinternational.org