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*Provisional Agenda Item 8.7-D*

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### **D. ADDRESSING THE CAUSES OF DISPARITIES IN HEALTH SERVICE ACCESS AND UTILIZATION FOR LESBIAN, GAY, BISEXUAL, AND TRANS (LGBT) PERSONS: PROGRESS REPORT**

#### **Background**

1. The adoption of Resolution CD52.R6, *Addressing the Causes of Disparities in Health Service Access and Utilization for Lesbian, Gay, Bisexual and Trans (LGBT) Persons* by the PAHO Member States at the 52nd Directing Council in 2013 (1) marked an important milestone in working towards universal health by recognizing that marginalized populations, including LGBT persons, historically face stigma and discrimination as well as other conditions that constitute critical barriers to health. Resolution CD52.R6, urged PAHO Member States to *a)* promote health services that respect human dignity and health rights taking into account sexual and gender diversity; *b)* enact policies, plans, and legislation that are sensitive to the stigma and discrimination experienced by LGBT persons and that allow for increased availability and access to health services for these populations; and *c)* collect data on LGBT persons' health and access to health services.
  2. Additionally, Resolution CD52.R6 requested the Director of the Pan American Sanitary Bureau (PASB or Bureau) to prepare and present to Member States a report on the health situation and access to care of LGBT persons, the barriers they can face in accessing health care services, and the impact of reduced access for this population (the Director's Report).
  3. The present document summarizes progress made to date on the implementation of Resolution CD52.R6, describes the existing gaps in LGBT persons' access to health services, and offers preliminary recommendations for strengthening its implementation. The information presented in this document is based on initial findings from two online survey/questionnaires prepared by the Bureau -one addressed to Ministries of Health (MOH) personnel in PAHO Member States and the other to nongovernmental
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organizations (NGOs)<sup>1</sup>- and is supplemented with an extensive review of the literature on the subject, as cited herein. The findings from these sources serve as the basis for the Director's Report, currently in draft form, which will be finalized in consultation with Member States and relevant stakeholders, as mandated by Resolution CD52.R6. The draft Director's Report is based on the conceptual framework established by the Strategy for Universal Access to Health and Universal Health Coverage (2) which serves as a guide for strengthening the health system's response to the health needs of LGBT populations. The Director's Report will be finalized and presented to Member States in 2018.<sup>2</sup>

### **Update on Progress Achieved by Member States**

4. Member States are making progress in providing health services to meet the health needs of LGBT persons. Two-thirds of the countries responding to the PASB's survey reported that they offer LGBT-sensitive services through the public health system. In addition, LGBT NGOs provide a wide array of services. The health inequities and concerns reported in the literature can be extrapolated to LGBT populations in the Americas.<sup>3</sup> Even though Member States recognize a range of health problems affecting the LGBT populations, LGBT health needs and inequities in health are largely considered from an HIV/STI bias. As a result, the needs of trans persons and lesbian and bisexual women are rendered invisible. This perspective is reflected in the provision, structure, and funding of health services and ultimately impacts the overall health of LGBT persons.

5. The preliminary findings of the draft Director's Report show that, despite efforts by Member States, the provision of health services tailored to the needs of LGBT persons is heterogeneous in the Region. Most often, the services are offered through the public health system on an undifferentiated basis and are centralized in large urban settings. In the case of HIV, for example, even though services are prevalent and are claimed to be LGBT-sensitive, they may: *a) fail to provide adequate preventive measures; b) lack resources to meet the health needs of LGBT persons; c) be offered in settings where LGBT individuals are still stigmatized and discriminated against; and*

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<sup>1</sup> A total of 33 countries and territories responded to the MOH questionnaire (Argentina, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, Turks and Caicos, United States of America, Uruguay, Venezuela, British Virgin Islands), while 28 NGOs from 18 countries responded to the other questionnaire.

<sup>2</sup> To appear under the title: *Addressing the Causes of Disparities in Health Service Access and Utilization: Assessing the Health Situation and Access to Care for LGBT People in the Americas.*

<sup>3</sup> The health issues mentioned most often in terms of health service inequities and gaps included: limited availability of hormone therapy; transition-related surgical procedures; health complications related to unsupervised use of hormones and bodily modification (e.g., use of industrial oil or liquid silicone) for transgender populations; access to services to address anal health, mental health, and certain types of cancer in gay men; access to pre- and post-exposure prophylaxis and human papillomavirus (HPV) vaccination for gay and bisexual men; and access to gynecological services, reproductive health services, and certain types of cancer and sexual violence for lesbian women.

d) entail direct payment at the point of service. It is clear that improving HIV services for LGBT persons continues to be crucial.

6. With regard to policies and legislation affecting LGBT persons, half of the 33 MOH that responded to the PASB questionnaire reported having antidiscrimination policies in place and laws tailored to meet the specific needs of LGBT persons. Furthermore, 48.5% of the MOH respondents confirmed that they had a national legal framework and/or a set of laws in place that promote the rights of LGBT persons. Almost half of all the responding countries and territories have enacted legislation aimed at eradicating violence and discrimination against LGBT persons, while 33.3% have existing laws (or laws in preparation) calling for the creation of LGBT-sensitive health services. Examples of laws promoting LGBT rights cited by the MOH respondents included such subjects as antidiscrimination, LGBT-inclusive adoption, marriage/civil unions, gender identity, universal health, and gender violence. In addition, more than half the MOH respondents reported that they have developed policies and laws that address LGBT health.

7. Health-related legislation cited by the MOH respondents includes laws that recognize LGBT groups as a population in conditions of vulnerability with unique health needs. However, some countries and territories still have laws that criminalize LGBT persons. This situation is critical because, according to the literature reviewed, laws of this kind can create an environment in which violence against LGBT individuals is permitted or tolerated, further promoting abuse towards these populations. Even though policies and laws exist, their application and enforcement varies widely within and between countries and territories.

8. Those countries and territories responding to the questionnaire have a wide array of mechanisms for accountability that articulate different government structures, including the MOH and Office of the Ombudsman, as well as LGBT NGOs and civil society organizations (CSOs). Fewer than 20% of the MOH respondents cited the creation of specific entities or councils that focus exclusively on issues related to sexual and gender diversity. Initiatives of this kind are more likely to be found in countries and territories where LGBT-affirmative legislative actions and policies are more robust (3).

9. More than 50% of the countries responding to the questionnaire reported having policies, norms, or guidelines for delivering health services to LGBT persons. Most of the existing health policies and standards focus on HIV prevention and treatment and do not address additional health needs. Nevertheless, a number of the MOH respondents (24.2%) reported that they have policies and guidelines on sexual and gender diversity or standards of care for LGBT populations. Examples of these norms include the promotion of specific health services (particularly for transgender individuals, such as the provision of hormone therapy) and LGBT-friendly clinics, nondiscrimination on the basis of sexual orientation and gender identity in the health care context, and best practices for LGBT health care. In addition, about 70% of the MOH respondents reported the existence of

LGBT-focused training activities related to HIV/STI, human rights, health needs, or stigma and discrimination.

10. The preliminary findings of the draft Director's Report also indicate that stigma and discrimination continue to be major obstacles to access health services for LGBT persons. The majority of MOH and NGO respondents (75% and 96.4%, respectively) referred explicitly to stigma and discrimination as a barrier to health for LGBT persons. They note that these individuals may avoid or delay care or hide their sexual orientation and/or gender identity from their health care providers in an effort to protect themselves against stigmatization. In fact, lack of competence in dealing with LGBT health issues on the part of health care providers was identified as a main barrier by 92.9% of the NGO respondents. LGBT individuals often end up relying on NGOs, CSOs, or other networks to obtain information, improve their health literacy, and find health services that are tailored to their needs without any support from national health authorities in the dissemination of this information. The pathologization of LGBT identities, particularly transgender identities, continues to disempower LGBT individuals and may become the foundation for stigma in health care settings. It is also at the cornerstone of the prevalence of conversion therapy.

11. In addition, the fact that LGBT individuals are not well represented in positions of authority or in the health care national context further ostracizes them from the health system by making them invisible and preventing them from making decisions that would benefit their health and their community. Some studies in the Region have shown that LGBT persons report experiencing violence and discrimination from health care providers themselves (4). To address stigma and discrimination, 78.8% of the questionnaire respondents stated that a number of LGBT-inclusive strategies are applied in their national health care settings. The most widely used inclusion strategies are the creation of accessible processes for filing complaints and the posting of visible nondiscrimination statements. In addition, most LGBT NGOs/CSOs/networks provide legal counseling to the LGBT community in cases of discrimination. Legal services might take the form of peer support, guidance from volunteer attorneys, human rights protection organizations, and/or links to national ombudsman offices.

12. Other barriers identified in the preliminary findings are limitations on health insurance coverage, discrimination in the labor market or educational settings, and scarcity of resources for the provision of appropriate health services. Reduced health insurance coverage was also noted in the literature reviewed (5). In fact, because of difficulties in the labor market, one estimate (6) indicates that approximately 90% of trans women living in the Americas engage in sex work, and estimates for individual countries may be even higher. Also, studies have reported that LGBT persons are more likely to delay or not receive care because of its restrictive cost (7-10).

13. More than half the MOH respondents reported that their countries gather disaggregated LGBT health data. Even though LGBT health data can be gathered by including questions about sexual orientation and gender identity (SOGI) in health data

collection tools, health information systems, hospital records, and national censuses, this is far from a typical situation in the Americas. Even when such questions are asked, they might not be included in all tools, or they may be drafted in a way that limits the inclusion of all L-G-B-T identities (i.e., using "sex" instead of gender, and following a binary male/female model), further complicating the collection of data on LGBT health.

14. In addition to working on the draft Director's Report, the Bureau continues to promote increased access to quality and comprehensive health services for LGBT populations. These efforts include training in human rights and LGBT rights at the request of individual Member States, regional meetings on gender diversity and universal health, advocacy for LGBT inclusion in documents and policies, and the implementation of other related resolutions (Resolution CD50.R8, Health and Human Rights, approved in 2010 (11), Resolution CD54.R9, Strategy on Health-related Law, approved in 2015 (12), and Resolution CD53.R14, Strategy for Universal Access to Health and Universal Health Coverage, approved in 2014, to mention a few).

#### **Action Necessary to Improve the Situation**

15. In light of the progress made to date and the challenges that remain, PAHO Member States may wish to consider the following recommendations:

- a) Strengthen and/or establish LGBT-sensitive and comprehensive health services grounded in evidence that address the specific health needs of LGBT persons taking into account gender identity and diversity of expression. Each L-G-B-T population requires particular health services in order to meet the person's unique health needs, and therefore specific care standards or guidelines for each L-G-B-T identity are necessary. In order to improve access to health services, it is important to avoid the centralization of LGBT-sensitive services, develop capacity in the first level of care, and promote LGBT-sensitive services in both the public and private sectors. It is also essential to ensure that information regarding LGBT health resources is available at the community and health service level and to develop strategies that allow health providers to refer LGBT persons to other services that are LGBT-sensitive.
- b) Improve the training of health care providers so that they are able to address LGBT health needs with gender, diversity, and rights-based approaches that will help to end any form of discrimination. Collaborate with educational national authorities to modify the curricula of health-related academic programs to include LGBT content, either as modules within existing courses or as specific independent courses.
- c) Consider the specific health needs of LGBT persons in the development and/or implementation of health policies and health system strengthening initiatives as part of the effort to advance toward universal health. Reinforce mechanisms of national accountability with the active participation of government agencies or other bodies in monitoring effective compliance.

- d) Improve efforts to ensure that LGBT persons can enjoy access to and the use of health services without discrimination by including provisions in Member States' national antidiscrimination laws that explicitly forbid discrimination on the basis of sexual orientation and gender identity. Train and sensitize legislators and policy-makers on issues related to sexual and gender diversity, with emphasis on the impact of stigma and discrimination on LGBT health.
- e) Strengthen health information systems and surveillance mechanisms to generate periodic reports that include LGBT health conditions and barriers to access. Include sexual orientation and gender identity items in existing nationally representative health surveys in order to gather data that can be disaggregated by sexual orientation and gender identity. This information is crucial to tailoring health services, policies, and legislation to meet the needs of LGBT populations. It is also necessary in order to monitor barriers and assess health needs.
- f) Strengthen national intersectoral mechanisms and links to the community in order to improve the health and well-being of LGBT persons. This includes cooperation and coordination between the MOH and the education, labor, justice, social welfare, and housing ministries, law enforcement agencies, legislatures, and LGBT NGOs/CSOs/networks.
- g) Use Resolution CD54.R9, Strategy on Health-related Law, together with Resolution CD53.R14, Strategy for Universal Access to Health and Universal Health Coverage, and other PAHO resolutions, to foster the establishment of legal, policy, and regulatory frameworks that promote enjoyment of the highest attainable standard of health as a fundamental right of every human being, as established in the Constitution of the World Health Organization, without distinction of sex, gender, gender identity, or gender expression.

#### **Action by the Pan American Sanitary Conference**

16. The Conference is invited to take note of this progress report and to formulate the recommendations it deems relevant.

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