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

### Background

1. In 2013, Member States of the Pan American Health Organization (PAHO) approved Resolution CD52.R6, Addressing the Causes of Disparities in Health Service Access and Utilization for Lesbian, Gay, Bisexual, and Trans (LGBT) Persons (1). The resolution urged Member States to *a)* promote the delivery of health services to all people, taking into account the diversity of gender expressions and gender identity; *b)* enact policies, plans, and legislation that promote equal access to quality services that take account of the needs and barriers faced by LGBT people, and *c)* collect data about access to health care and health facilities for LGBT people with the purpose of strengthening programs, policies, and legislation.
2. The resolution also requested the Director of the Pan American Sanitary Bureau to prepare a report about the health situation and access to care of LGBT populations, the access barriers they face, and the impact of reduced access. In 2018 Document CD56/INF/11 was presented to the 56th Directing Council (2). Information was collected through separate questionnaires sent to all Member States and selected civil society organizations (CSO). A total of 33 countries and territories and 28 CSOs responded to the surveys.
3. This report summarizes the progress on implementing Resolution CD52.R6 and the recommendations from Document CD56/INF/11. The recommendations included, among others, developing a health care system that is equally accessible to all people; offering mental, behavioral, and physical LGBT-sensitive services that are accessible and high-quality; collaborating with the education sector to modify health-related curricula to include LGBT content; establishing regular training programs on LGBT health for health providers and administrative staff; collecting data on sexual orientation and gender identity to monitor access barriers; and strengthening intersectoral cooperation to address the health of LGBT people (2).

### Analysis of Progress Achieved

4. The Strategy for Universal Access to Health and Universal Health Coverage (3) provided the conceptual framework for this report and served as a guide for the collection, analysis, and interpretation of the data. The report has three objectives: *a)* to describe the health situation of LGBT populations and the impact that reduced access to care has on their health; *b)* to identify the administrative, economic, social, and cultural barriers that prevent LGBT populations from accessing quality services; and *c)* to formulate recommendations for Member States to guide the implementation of CD52.R6.

5. To support the development of this report, an interprogrammatic technical working group<sup>1</sup> updated the questionnaires used in 2018 to collect information from Member States and CSOs. The updated questionnaires were sent to the 35 Member States and 25 selected CSOs, and a total of 27 Member States and seven CSOs responded. In addition, a desk review of 32 articles was conducted to support the progress assessment. The Member State questionnaire covered eight domains, detailed in the main findings below. The CSO questionnaire explored most of the same topics and the collaborative efforts being undertaken between CSOs and government institutions to meet the health needs of LGBT populations.
6. The main findings are summarized below.
- a) On legislation, policies, and regulations that protect the health and well-being of LGBT populations:
- i. Nineteen Member States reported having legislation and regulations at the constitutional level and other levels (labor, civil, criminal, or ministerial laws or policies) to protect LGBT populations, and/or they referred to constitutional or high court decisions that have interpreted laws advancing, or in accordance with, LGBT populations' rights and against stigma and discrimination. While some countries reported having made progress since 2018, there is not enough information to determine actual progress, particularly regarding the extent to which existing legislation and regulations are being implemented effectively. Other Member States reported that there is no explicit reference to LGBT populations and/or diverse sexual orientations or identities in their national health laws or policies.
- b) On financial protection in health for LGBT populations:
- i. Eleven Member States stated that there are financial or geographic barriers that make it difficult for LGBT populations to access health care.
- c) On guidelines and protocols for the provision of comprehensive clinical care to LGBT populations:
- i. Twelve Member States reported not having specific protocols or guidelines for care of LGBT populations. Some stated that guidelines and protocols related to HIV and sexually transmitted infections (STI) services for LGBT populations were available. A limited number of Member States have, or are in the process of developing, guidelines for the provision of clinical care for transgender people.
  - ii. Twenty-four Member States reported not having a standard approach for the clinical and surgical management of intersex people. Two Member States reported having a standard of care based on children's rights that prioritizes the consent of intersex children and adolescents.

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<sup>1</sup> The interprogrammatic technical working group comprises representatives from the following PAHO/WHO units and departments: Office of the Deputy Director (DD); Equity, Gender, Human Rights, and Cultural Diversity (DHE/EG); HIV, Hepatitis, Tuberculosis, and Sexually Transmitted Infections (CDE/HT); Health Analysis and Equity Metrics (EIH/HA); Primary Health Care and Integrated Services Delivery (HSS/PH); Mental Health and Substance Use (NMH/MH); and PAHO Globe.

- d) On LGBT populations' access to health care services:
- i. All Member States reported providing open access services at the point of care. In some countries, however, many of these services are concentrated in urban areas, making access costly for people outside the cities. Other barriers reported by some Member States and CSOs included understaffing and unavailability of requested services to meet the needs and demands of LGBT populations; limited knowledge and experience among health providers of LGBT health; stigma and discrimination; health systems that fragment health care; and scarcity of resources for LGBT programs.
- e) On mechanisms to assess the efficacy and quality of care for LGBT populations:
- i. Twenty Member States reported conducting evaluations of the efficacy and quality of services provided to LGBT users. Most of the evaluations were conducted when an issue was raised rather than as a periodic exercise to monitor the quality of services. In addition, evaluation findings do not always lead to improvements in services. Several Member States also reported having systems for service users to file complaints of mistreatment by health personnel, but how these complaints are resolved is unknown.
- f) On inclusion of health promotion and disease prevention in health plans and programs for LGBT populations:
- i. According to more than half of the respondents, prevention and health promotion are included in the provision of care for LGBT populations. Some Member States include prevention efforts in services related to mental health, communicable diseases, and noncommunicable diseases. However, services are mostly provided in a general setting and are not always tailored to meet the needs and demands of LGBT populations.
- g) On training and sensitization for health care teams:
- i. Most of the training initiatives reported by the respondents consisted of optional and formal sensitization workshops and sessions for medical and administrative staff, often delivered in collaboration with CSOs. The duration, methodology, and content of the training initiatives were not reported. Technical updates on LGBT health for clinical staff were not as widely reported.
  - ii. Five Member States reported having preservice curricula in academic settings. Details of the content and information about which institutions and faculties use the curricula are not available.
- h) On availability of quality data on LGBT populations and mechanisms for analyzing the health situation of these populations:
- i. Twenty-one Member States reported conducting mainly HIV and STI situation analysis and, to a lesser extent, assessments of violence and mental health among LGBT populations. Only a few respondents indicated that data disaggregated by sexual orientation and gender identity was collected, analyzed, and disseminated. The inclusion of LGBT populations in national health plans is also mostly limited to HIV and STI prevention and care strategies.

i) On collaboration between ministries of health and public and private entities to promote, protect, and address the health needs of LGBT populations:

- i. All the respondents stated that there were mechanisms in place to facilitate collaboration of health ministries with other entities. The most frequently reported collaborations are with other ministries, civil society organizations, and United Nations agencies, and they seem to be mostly focused on HIV prevention and care. The extent to which these collaborations consider diverse sexual orientations or identities, and the associated health and social needs, is unknown.

7. The report recognizes advances in the existence of HIV policies and legislation and increased awareness that stigma and discrimination present an obstacle to accessing health services. It also finds impediments in legislation, policies and protocols, capacity-building, data collection and utilization, and social protection and participation that impact the health and well-being of LGBT populations. The barriers facing LGBT populations in the Region can be summarized as follows:

- a) Persistent patterns of stigma and discrimination within health services.
- b) Uneven application and enforcement of anti-discrimination laws, including accountability mechanisms.
- c) Limited LGBT-sensitive services that are mostly centralized and that prioritize HIV and STI prevention and care over the broader health needs and demands of LGBT populations.
- d) Insufficient availability of comprehensive health policies, protocols, and standards of care that consider diversity and the specific needs of each LGBT group.
- e) Training deficit among health staff, with an absence of technical updates on LGBT health for clinical staff and of sustained sensitization programs that can transform the attitudes and behaviors of clinical and administrative staff.
- f) Exclusion of LGBT populations in developing national health plans, intersectoral mechanisms, and monitoring of health services quality.
- g) Absence of disaggregated data and limited understanding of the health situation of each LGBT group beyond HIV and STIs.

### **Action Needed to Improve the Situation**

8. After setting out key findings and identifying barriers that affect the access of LGBT populations to health services, the progress report concludes with the following recommendations for consideration by Member States. These are intended to promote reflection and action aimed toward achieving universal access to health services for LGBT populations, as established in Resolution CD52.R6.

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- a) On legislation, policies, plans, and regulations:
    - i. Develop or strengthen legislation, policies, regulations, and enforcement mechanisms to guarantee access to health and social services for LGBT populations, including derogation of legislation that generates stigma, discrimination, and punishment, and enactment of legislation that criminalizes hate crimes. In addition, create or strengthen regulations and policies to protect intersex people from unnecessary and cosmetic surgeries and allow the development of their identities before decisions concerning their bodies can be made.
    - ii. Incorporate actions into national health plans that respond to the needs of LGBT populations beyond HIV and STI prevention and care, including differentiated approaches that meet the needs of each LGBT group.
    - iii. Develop protocols and guidelines for the management of diseases that disproportionately affect LGBT populations and for the provision of respectful and compassionate care to all LGBT groups who use health care services.
    - iv. Address financial barriers through mechanisms that eradicate the need for direct payment at the point of care.
  - b) On data collection and utilization
    - i. Strengthen existing information systems to collect quantitative and qualitative data on health, sexual orientation, and gender identity, and analyze and disseminate information that can be used for planning and decision-making.
    - ii. Conduct periodic analysis of the LGBT health situation to monitor for inequities, barriers, and mistreatment that these groups may encounter when accessing health services.
  - c) On capacity-building and training
    - i. Collaborate with the higher education sector to include LGBT content in preservice training for health care providers so they can better meet the health needs of all LGBT groups.
    - ii. Institute a training strategy that includes technical updates on LGBT health, beyond HIV and STIs, for clinical staff, as well as sensitivity and antidiscrimination training for clinical and administrative staff.
  - d) On social participation and intersectoral cooperation
    - i. Engage LGBT groups and CSOs in dialogues to better understand the health care needs and demands of these populations throughout the life course and create mechanisms to increase their participation in designing and monitoring health policies and programs.
    - ii. Strengthen intersectoral cooperation between ministries of health and ministries of education, labor, and social services, as well as judicial branches, parliaments, and other institutions, to effectively address the needs and demands of LGBT populations and the inequities they face.
  - e) On access to health services
    - i. Strengthen the health system's capacity to provide services that are equally accessible to all people, including LGBT populations, through inclusive policies and practices that explicitly include protections for sexual orientation and gender identity.

- ii. Promote a primary health care approach that effectively addresses the needs of LGBT populations, adopting strategies that ensure accessibility, inclusivity, and comprehensive care.
- iii. Enhance people-centered care by focusing on the health demands and needs of LGBT populations, ensuring the provision of sensitive services that are accessible, available, acceptable, and high-quality.

### **Action by the Executive Committee**

9. The Executive Committee is invited to take note of this document and provide any comments it deems pertinent.

### **References**

1. Pan American Health Organization. Addressing the causes of disparities in health service access and utilization for lesbian, gay, bisexual, and trans (LGBT) persons [Resolution CD52.R6]. 52nd PAHO Directing Council, 65th Session of the Regional Committee of WHO for the Americas; 30 September – 4 October 2013. Washington, D.C.: PAHO; 2013. Available from: <https://iris.paho.org/handle/10665.2/4434>.
  2. Pan American Health Organization. Report of the Director on addressing the causes of disparities in health services access and utilization for lesbian, gay, bisexual, and trans (LGBT) persons [Document CD56/INF/11, Corr.]. 56th PAHO Directing Council, 70th Session of the Regional Committee of WHO for the Americas; 23–27 September 2018. Washington, D.C.: PAHO; 2018. Available from: <https://iris.paho.org/handle/10665.2/49649>.
  3. Pan American Health Organization. Strategy for universal access to health and universal health coverage [Resolution CD53.R14]. 53rd PAHO Directing Council, 66th Session of the Regional Committee of WHO for the Americas; 29 September – 3 October 2014. Washington, D.C.: PAHO; 2014. Available from: <https://iris.paho.org/handle/10665.2/7652>.
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