PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

52nd DIRECTING COUNCIL
65th SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 30 September-4 October 2013

Provisional Agenda Item 4.12

CD52/18 (Eng.)
30 September 2013
ORIGINAL: ENGLISH

ADDRESSING THE CAUSES OF DISPARITIES IN HEALTH SERVICE ACCESS AND UTILIZATION FOR LESBIAN, GAY, BISEXUAL AND TRANS (LGBT) PERSONS

Concept Paper

Introduction

1. Many countries throughout the Region of the Americas have identified the need to address and end stigma and discrimination in the health sector against Lesbian, Gay, Bisexual and Trans (LGBT) persons. This proposal seeks to improve access to care and the overall health indicators of these populations as a part of the Americas' work to address the health needs of vulnerable populations.[1]

2. Stigma and discrimination in the healthcare setting are critical concerns that have been most often discussed in the context of health systems and services, universal health coverage and the social determinants of health (SDH).

[1] The Directing Council of PAHO has urged Member States to sustain and reinforce prevention activities and the reduction of stigma within health services in the context of certain groups in situation of vulnerability, including "men who have sex with men" and "LGBT" persons. See, for example, the resolution "Scaling-up of treatment within a comprehensive response to HIV/AIDS" (http://www1.paho.org/english/gov/cd/CD45.r10-e.pdf) and the technical document "Health and Human Rights" (http://www2.paho.org/hq/dmdocuments/2010/CD50-12-e.pdf).

3. The use of gender-based analysis is an important tool for strengthening health systems, delivery and monitoring of national plans, policies, programs and laws.[2]

4. United Nations General Assembly Resolution A/67/L.361 on Global Health and Foreign Policy "acknowledges that universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services … with a special emphasis on the poor, vulnerable and marginalized segments of the population" *(1).*

Background

5. The LGBT community is often a vulnerable and marginalized segment of the population due to the stigma and discrimination members of the population experience.

6. Health inequities and inequalities are often linked to SDH (*2*), which the World Health Organization (WHO) defines as, "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness". The WHO resolution on SDH urges Member States "to take into account health equity in all national policies that address SDH" and to ensure equitable access to health promotion, disease prevention and health care *(3).*

7. The World Conference on SDH in Rio de Janeiro recognized the need for positioning human health and well-being as one of the key features of what constitutes a successful, inclusive and fair society in the 21st century as consistent with our commitment to human rights at national and international levels; that governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures; and the need to develop policies that are inclusive and take account of the needs of the entire population with specific attention to members of vulnerable groups and high-risk areas*;(4).*

[2] The Directing Council of PAHO has urged Member States to use a gender-based analysis, new technologies and projection models to strengthen the planning of health systems, delivery and monitoring of national plans, policies, programs and laws. See, for example, Resolution "Plan of action for implementing the gender equality policy." (http://www2.paho.org/hq/dmdocuments/2009/CD49.R12%20(Eng.).pdf) and the Resolution "Plan of action on adolescent and youth health." (http://www2.paho.org/hq/dmdocuments/2009/CD49.R14%20(Eng.).pdf) .

Most Significant Challenges

Discrimination against and exclusion of LGBT Persons in the Health Care Sector

8. While data on morbidity and mortality as well as on access to health services are limited, existing research and preliminary epidemiological strategic information point to the fact that LGBT persons face barriers to accessing appropriate patient-centered health care and fail to make early and opportune use of health care services or use them at all. WHO noted in a 2011 report that longstanding evidence exists of "widespread stigma against homosexuality and ignorance about gender identity, both within mainstream society and within health systems."[3]

9. Respectful and nondiscriminatory access to quality care is consistent with the WHO Constitution which recognizes that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" and that "Governments have a responsibility for the health of their peoples."[4]

Understanding the range of barriers to accessing Health Care

10. Many of the barriers LGBT people experience in accessing quality health care are due to widespread stigmatization and discrimination in mainstream society and within health systems.

11. Barriers to care can take many forms, from outright discrimination to more subtle substandard care. Some of the types of barriers include:[5]

- **inadequate understanding of status-specific conditions**: e.g., not addressing special health care needs of LGBT individuals or trauma-related health and behavioral health issues associated with discrimination*(5,6);*
- **denial of care**: e.g. when people are turned away from a hospital or local clinic because of who they are or assumed to be *(5);*

---

[3] "*Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people*" WHO, Department of HIV/AIDS, June 2011. (hereinafter Prevention and Treatment Report) http://www.who.int/hiv/pub/guidelines/msm_guidelines2011/en/.

[4] The WHO Constitution was adopted by the International Health Conference held in New York from 19 to 22 June 1946, and was signed on 22 July 1946 by the representatives of 61 States.

[5] The Pan American Sanitary Conference has referred to administrative, geographic, economic, cultural, social barriers and indifference about using the gender identity perspective in health service delivery. See, for example, the "Regional policy and strategy for ensuring quality of health care, including patient safety", available at: http://www1.paho.org/english/gov/csp/csp27-16-e.pdf .

- **inadequate or substandard care**: e.g., verbal abuse, disrespectful behavior, or the provider simply not taking the time to adequately address the patient's needs*(6)*;
- **restricting the inclusion of significant individuals in family treatment or in support or decision-making** roles *(7)***;**
- **inappropriate assumptions about cause of health or behavioral health conditions** *(5)***; and**
- **avoidance of treatment** *(5)*.

12. In addition, issues related to patient confidentiality, while important to all patients, may be particularly important to LGBT people who have not yet disclosed their sexual orientation and/or gender identity in their communities. Disclosure of LGBT status may raise concerns regarding arrest, discrimination, social exclusion, and physical harm.[6] If people feel that confidentiality and privacy are not assured, they may decide not to seek services, or may withhold other key information from their provider for fear that the provider will make this information public, thus jeopardizing their own, and potentially others', health and safety.[7] Such disclosure by health care providers or other governmental and private actors is not relevant for provision of services or promotion of public health goals and may negatively impact adherence to treatment and even retention of patients within the health system.

LGBT Health Disparities

13. WHO has already recognized the global public-health burden that discrimination against members of any marginalized group places on those individuals, "magnif[ying their] poverty and ill-health[8] as well as the burden it places on society as a whole.[9] Specifically as it relates to the LGBT community, WHO noted in its 2011 report cited

---

[6] The Pan American Sanitary Conference has identified the respect for privacy, confidentiality and the integrity of the users of health services as a strategic line of action to promote quality care and users' safety. Please see supra note 5 ~~6.~~

[7] The phenomenon of "self-exclusion" means that people who have the right to health services and access to them, prefer not to use them because of the patient's language, beliefs or the perception of disrespectful treatment. See, for example, the Pan American Sanitary Conference technical document "Extension of social protection in health", available at: http://www1.paho.org/english/gov/csp/csp26-12-e.pdf.

[8] See WHO's Secretariat fact sheet on the "Health of indigenous peoples," available at: http://www.who.int/mediacentre/factsheets/fs326/en/index.html.

[9] WHO Secretariat has stated that societies that address discrimination create conditions necessary for the better health of all and that societies that address discrimination on the basis of sex and gender roles, race, and religion and tackle homophobia, sexism, and racism also create conditions necessary for the better health of all. See: http://www.who.int/hhr/activities/q_and_a/en/Health_and_Freedom_from_Discrimination_English_699KB.pdf and http://www.who.int/hhr/information/Item_10_57th_Session_of_Commission.pdf.

above, long-standing evidence indicates that transgender people "experience *significant barriers to quality health care* due to widespread stigma against homosexuality and ignorance about gender variance in mainstream society and within health systems" (emphasis added).[10]

14. Considerable evidence exists that LGBT persons experience worse health disparities and outcomes than heterosexual persons in every country across the globe. Some findings regarding LGBT persons include:

(a) Higher rates of depression, anxiety, smoking, alcohol abuse, substance abuse, suicide, and suicidal ideation as a result of chronic stress, social isolation, and disconnectedness from a range of health and support services.[11]

(b) Lesbian and bisexual women may use preventive health services less frequently than heterosexual women, and may be at a greater risk of obesity and breast cancer *(8).*

(c) Gay men are at higher risk of HIV and other STIs, including viral hepatitis.

(d) Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.

(e) Lack of support from families or communities drives LGBT youth to be significantly more likely to be homeless, which results in other social and health problems.[12]

(f) Transgender individuals have a high prevalence of HIV/STIs, victimization, mental health issues, and suicide and are less likely to have health insurance than heterosexual or LGB persons. Trans individuals are also at higher risk of being unemployed, experiencing discrimination in the workplace, and being victims of violence in the community *(9)*.

Proposal

15. As noted above, while it is known that misunderstanding or stigma and discrimination leads LGBT persons to not receive or seek care, the true scope of the global burden remains an enigma as this population has been the subject of relatively little health research.

---

[10] See, "Prevention and Treatment Report", supra note 3, p. 10.
[11] Id.
[12] In the US, according to survey of agencies which provide services to homeless populations, including youths, "40% of homeless youth are LGBT. In comparison, the general youth population is only 10% LGBT." http://williamsinstitute.law.ucla.edu/wp-content/uploads/Durso-Gates-LGBT-Homeless-Youth-Survey-July-2012.pdf.

16. To achieve a better understanding of the health needs of all LGBT persons, more data is needed on the demographics of these populations, as well as improved methods for collecting and analyzing quantitative and qualitative data, involving civil society and faith based organizations.

17. PAHO already does a significant amount of work compiling and analyzing data on access to care issues of people pertaining to other marginalized communities. Encouraging data collection on LGBT access to care especially in Member States would further Member States' commitment to universal access for all persons in a manner consistent with the WHO Constitution and technical PAHO/WHO documents and resolutions mentioned in this document.

Action by the Directing Council

18. The Directing Council is invited to review and consider the information presented in this concept paper and to consider approving the draft resolution included in Annex A.

Annex

References

1. United Nations. *Global health and foreign policy*. A.G. Res. A/67/L.36 (2012). Available at: http://ncdalliance.org/sites/default/files/resource_files/Global%20Health%20and%20Foreign%20Policy%20resolution%202012_67th%20GA.pdf.

2. World Health Organization (WHO), World Health Assembly. *Commission on Social Determinants of Health*. Geneva, Switzerland: WHO; 16 March 2009. (Document A62/9). Available at: http://apps.who.int/gb/ebwha/pdf_files/A62/A62_9-en.pdf.

3. World Health Organization (WHO), World Health Assembly. *Reducing health inequities through action on the social determinants of health*. Geneva, Switzerland: WHO; 22 May 2009. (Resolution WHA 62.14). Available at: http://apps.who.int/gb/ebwha/pdf_files/A62/A62_R14-en.pdf.

4. World Health Organization (WHO), World Conference on Social Determinants of Health. *Rio Political Declaration on Social Determinants*. Rio de Janeiro, Brazil: WHO; 21 October 2011. Available at: http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf.

5. Hatzenbuehler, Mark, L.; Katie A. McLaughlin; Katherine M. Keyes and Deborah S. Hassin. The Impact of Institutional Discrimination on Psychiatric Disorders in Lesbian, Gay, and Bisexual Populations: A Prospective Study. *Am J Public Health*. 2010 March; 100(3): 452–459.
6. Rachlin, K, Green, J, and Lombardi, E. Utilization of health care among female-to-male transgender individuals in the United States. *Journal of Homosexuality*, 2008; 54 (3), 243-58.

7. Henrici, Roxane, Homophobia: Does It Affect the Quality of Care? *The Journal of Undergraduate Nursing Writing*. Volume 1 Number 1, October 2007.

8. Brooks, V.R. The theory of minority stress. In V.R. Brooks (Ed.), Minority stress and lesbian women, 1981; 71-90. Lexington, MA: Lexington Books.

9. Lombardi, E. Enhancing transgender health care. *American Journal of Public Health* 2001; 91 (6): 869-972.

PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

52nd DIRECTING COUNCIL
65th SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 30 September-4 October 2013

CD52/18 (Eng.)
Annex A
ORIGINAL: ENGLISH

PROPOSED RESOLUTION

ADDRESSING THE CAUSES OF DISPARITIES IN HEALTH SERVICE ACCESS AND UTILIZATION FOR LESBIAN, GAY, BISEXUAL AND TRANS (LGBT) PERSONS

Proposed by the USA

THE 52nd DIRECTING COUNCIL,

Having considered the concept paper *Addressing the causes of disparities in Health Services Access and Utilization for Lesbian, Gay, Bisexual and Transgender (LGBT) Persons* (Document CD52/18) and accepting that working towards universal access requires addressing political, sociocultural and historic barriers to care for members of stigmatized, discriminated against and marginalized populations, including LGBT persons;

Recalling WHA Resolutions 62.12 and 62.14 as examples of the commitment of the international community to support the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action, decentralization and community participation as the basis for strengthening health systems;

Mindful of the Pan American Sanitary Conference Resolution CSP27.R10 (2007), *Regional policy and strategy for ensuring quality of health care, including patient safety*, and the Directing Council Resolutions CD45.R10 (2004), *Scaling-up of treatment within a comprehensive response to HIV/AIDS*; CD49.R12 (2009) *Plan of Action for implementing the gender equality policy*; CD49.R14 (2009) *Plan of Action on Adolescent and Youth Health*; and CD50.R8 (2010) *Health and Human Rights*;

Aware that the Pan American Sanitary Conference has identified that quality of care in health services is also measured in limited access, marked by administrative, geographic, economic, cultural and social barriers and indifference on integrating a gender perspective in health service delivery in the context of the *Regional policy and strategy for ensuring quality of health care, including patient safety*, Document CSP27/16 (2007);

Alarmed at trends in violence toward and persecution of LGBT persons, and noting that violence against LGBT persons, in particular sexual violence, is a critical indicator of marginalization, inequality, exclusion and discrimination;

Recognizing that the stigma and discrimination LGBT persons face often prevents them from accessing needed health care services, including mental health and a wide array of services, and that this and other factors of social and cultural exclusion result in health inequity, inequality and increased vulnerability to adverse health outcomes;

Attaching utmost importance to the elimination of health inequalities, including those associated with gender identity and gender expressions;

Concerned that a failure to target and provide accessible health services to the populations that need them weakens the effectiveness of health systems;

Reaffirming that universal access to care is a key component of strong national health systems, and that universal care should advance the efficiency and equality of access for all to health care services and social and financial protection in a non-discriminatory manner;

Acknowledging the critical role of civil society, including faith-based organizations, in promoting access to health care services for all,

***RESOLVES*:**

1. To urge Member States to:

(a) work to promote the delivery of health services to all people with full respect for human dignity and health rights and within each Member States' legal framework, taking into account the diversity of gender expression and gender identity;

(b) give priority to promoting equal access to health services in national policies, plans and legislation and to consider developing and strengthening universal comprehensive social protection policies, including health promotion, disease prevention and health care, and promoting availability of and access to goods and services essential to health and well-being, taking into account the stigma, discrimination and persecution experienced by those in the LGBT community;

(c) collect data about access to health care and health facilities for LGBT populations, taking into account privacy rights regarding all personal health-related information with the purpose of strengthening the planning, delivery and monitoring of health care and services, and health related policies, programs, laws and interventions for LGBT persons.

2. To request the Director to:

prepare, within existing resources, a report on health situation and access to care for LGBT persons, barriers they can face in accessing health care services and the impact of reduced access for this population, in consultation with Member States and relevant stakeholders.

- - -