

Improving the health and well-being of lesbian, gay, bisexual and transgender persons

Report by the Secretariat

1. This report has been prepared in response to the request by Member States for information on the main challenges to the health and well-being of lesbian, gay, bisexual and transgender (LGBT) persons, and proposals on how to address these challenges.¹

MAIN HEALTH CHALLENGES FACING LGBT PERSONS

2. Although data on morbidity and mortality and on access to health services are scant, existing research and data point to the fact that LGBT persons often experience poorer health outcomes than the general population and face barriers to health care that profoundly affect their overall health and well-being.

3. Since the beginning of the HIV epidemic in the early 1980s, men who have sex with men and transgender people have been disproportionately affected by HIV.

4. Surveillance data in low-income and middle-income countries show that men who have sex with men are 19.3 times more likely to be infected with HIV than the general population. Moreover, in sub-Saharan Africa, HIV prevalence among such men ranges from 6% to 31%, and the few existing epidemiological studies among transgender people show disproportionately high HIV prevalence rates, ranging from 8% to 68%.

5. Many lesbian, gay and bisexual people are subject to institutionalized prejudice, social stress, social exclusion (even within families) and anti-homosexual hatred and violence, and internalize shame about their sexuality. An extensive review in the United States of America revealed that lesbian, gay and bisexual young people are at increased risk of suicidal ideation and attempts, as well as depression, and may have higher rates than heterosexual youth of smoking, alcohol consumption and substance use. A survey in the United Kingdom of Great Britain and Northern Ireland revealed that almost 65% of lesbian, gay and bisexual young people have been bullied in schools because of their sexual orientation and more than 25% had been physically abused. A recent population-based study in Sweden found that the relationship between sexual orientation and experienced health status was mediated by low social capital (trust), threat of violence, and violence itself.

¹ See document EB133/1(annotated).

6. Violence against homosexual and transgender persons has been recorded in all regions. It may be physical (including murder, beatings, kidnappings, rape and sexual assault) or psychological (including threats, coercion and arbitrary deprivation of liberty).
7. Men who have sex with men and transgender persons face significant barriers to good-quality health care owing to widespread stigmatization and ignorance in mainstream society and within health systems about different gender identities. Recent studies in the United States of America reveal that lesbians and bisexual women tend to use preventive health services less frequently than heterosexual women for fear of encountering anti-homosexual attitudes among health providers.
8. In countries where homosexuality is deemed a crime, health professionals may be required by law to report the individuals concerned to the appropriate authorities, thereby effectively failing to meet the obligation of confidentiality incumbent on health professionals. If people feel that confidentiality and privacy are not guaranteed, they may decide not to seek services, thus jeopardizing their own, and potentially others', health and safety. Health care providers are influenced by their own cultural, moral or religious backgrounds with regard to their perceptions of sexual orientation, sexual behaviour or gender identity, which affect the delivery of health care. LGBT health workers may in turn be subject to discrimination because of their sexual orientation. Training and system-wide policies are needed to ensure that health care is accessible to all and provided without judgmental attitudes. Medical ethics and international human rights law require health workers to respect each particular individual's life situation. All people should be treated with respect and dignity and should be informed and empowered to make their own decisions regarding medical treatment and care, on the basis of genuinely informed consent.
9. The Council of Europe has documented examples of medical textbooks in Europe that portray homosexuality as a disease. Services that purport to "cure" people with non-heterosexual sexual orientation lack medical justification and represent a serious threat to the health and well-being of affected people. So-called "reparative" therapy intended to "cure" individuals of their homosexual attraction is unscientific, potentially harmful and contributes to stigmatization.
10. Very few medical curricula and health standards across the world have incorporated a comprehensive approach to transgender health care into health provider training, leading to a lack of technical competence in this area. Few health care providers or practitioners can provide adequate information, let alone comprehensive, safe and appropriate services, which may or may not include hormone therapy, surgery, psychotherapy and counselling.
11. To achieve a better understanding of the health needs of all LGBT persons, more data are needed on the demographics of these populations, particularly in low-income and middle-income countries, as well as improved methods for collecting and analysing data.
12. Better coordinated studies at the global level can lead to deeper understanding of disparities in health outcomes. LGBT persons should be involved in all stages of research, from design to implementation. Better knowledge, understanding and coordination can also pave the way for improving provider attitudes and education, the overall health care environment, and the experiences of LGBT persons seeking care, providing a base from which to redress existing health inequities. As a first step, a rigorous and systematic review of the literature is proposed.

13. It is equally important that a review be conducted of laws, government policies and health system practices that constitute barriers to health care for LGBT persons and which increase the risk of negative health outcomes, and of positive policies and practices that have demonstrably improved health care access and outcomes within the overall objective of universal health coverage.

14. Countries can act now to redress inequities experienced by LGBT persons in accessing health services and to tackle the social and legal factors contributing to these inequities in both access to services and health outcomes.

ACTION BY THE SECRETARIAT

15. WHO's global health sector strategy on HIV/AIDS, 2011–2015,¹ which guides the health sector's response to HIV, has a focus on key populations and addresses the social determinants of health that both drive the epidemic and hinder response. **The global strategy and regional adaptations recommend that countries ensure access to comprehensive services for men who have sex with men and other most-at-risk populations.**

16. The Secretariat, recognizing the particular vulnerabilities to infection with HIV of men who have sex with men and transgender persons, has conducted a series of regional consultations in all WHO regions except the South-East Asia Region in order to disseminate WHO's recent guidelines and to advocate the introduction of effective programmes to provide comprehensive HIV prevention, care and treatment services for these populations. The Regional Office for the Americas and the Regional Office for the Western Pacific are drafting additional guidance on specific health issues for transgender persons. The Regional Office for the Americas/PAHO has led work to reduce homophobic bullying and violence in the Region. The Secretariat is currently working with the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States' President's Emergency Plan for AIDS Relief in order to increase funding and improve implementation of HIV programmes for men who have sex with men and transgender persons. WHO is also leading new work in association with UNAIDS, UNESCO, UNFPA and UNICEF on HIV prevention, care and support for adolescent men who have sex with men and transgender youth.

17. More than 20 years ago, the World Health Assembly removed homosexuality (ICD-9 code 302.0) from the International Statistical Classification of Diseases and Related Health Matters (Ninth Revision) when it adopted the Tenth Revision of the Classification.² Categories describing specific groups of transgender or gender-nonconforming individuals were, however, retained in the ICD-10 Classification of Mental and Behavioural Disorders; categories related to sexual orientation were also retained that could be used to assign disorder labels to people based on being lesbian, gay or bisexual under certain circumstances.

18. In the context of the development of the eleventh revision of the International Classification, scheduled to be submitted to the Sixty-eighth World Health Assembly in May 2015, a joint Working Group on the Classification of Sexual Disorders and Sexual Health was established in order to make recommendations for changes to the classification of categories related to sexual orientation and gender identity.

¹ Endorsed by the Sixty-fourth World Health Assembly in resolution WHA64.14.

² See World Health Assembly resolution WHA43.24.

19. With regard to gender identity, the Working Group has recommended abandoning a psychopathological model of transgender identity in favour of a model that reflects current scientific evidence and best practice, responds better to the needs and rights of this vulnerable population, and is more supportive of the provision of accessible and high-quality health care services. The Working Group has therefore recommended reconceptualizing categories related to transgender identity along these lines, and moving them out of the Mental and Behavioural Disorders chapter of the International Statistical Classification. Based on an extensive review, the Working Group has recommended the deletion of all categories related to sexual orientation from the Mental and Behavioural Disorders chapter of the International Statistical Classification, as no legitimate health-related use of these categories could be identified. The proposals are being field tested and are open to public review and comment.¹

ACTION BY THE EXECUTIVE BOARD

20. The Executive Board is invited to consider this report.

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¹ <http://www.who.int/classifications/icd/revision/en/>.