



UNFPA notebooks

United Nations Population Fund. **Uruguay**. 9th Year. Nº8. **November 2015**.

Dissemination Series

Experiences in health and sexual diversity policies in Uruguay

Cecilia Rocha Carpiuc



dissemination series

Experiences in health and sexual diversity policies in Uruguay

Cecilia Rocha Carpiuc



United Nations
Population Fund
Uruguay

© United Nations Population Fund (UNFPA), 2015.
All rights reserved.

The views expressed in this publication are those of the author(s) and do not necessarily represent those of the United Nations, including UNFPA, or the UN Member States. The designations employed and the presentation of material on any maps do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations or UNFPA concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries.

Design & Printing: Imprenta Rojo S.R.L.

Translator: Gaston Bouchard

Legal Deposit: 367.859

ISBN: 978-92-990077-8-5



table of contents

Preface.....	5
Presentation.....	7
1. Introduction	9
2. Regional and international regulatory framework.....	12
3. Background and national regulatory framework.....	16
4. Experiences in health and diversity.....	21
4.1 Homophobia-Free Health Centres	21
4.2 Healthcare for transgender people in the UDA (Training and Treatment Unit) of the Primary Care Level/ASSE (State Health Services Administration) Saint Bois	24
5. Best practices and lessons learnt	28
6. Challenges.....	30
7. Final Thoughts.....	34
8. References: Literature reviewed and presentations cited	35
9. Glossary of Acronyms	37
APPENDIX.....	38



Cecilia Rocha Carpiuc holds a Bachelor's Degree in Political Science and a Master's Degree in Public Policies and Gender. She is a member of the National Research System and Assistant Professor of the Institute of Political Science, University of the Republic.

The basis for this document is presentations on experiences made by various professionals and institutions detailed in the Presentation of this publication.



Preface

The process of health care reform in Uruguay involved major challenges for the public and private institutions which later comprised the SNIS (National Integrated Healthcare System). With the Stewardship and the Ministry of Public Health, this system was implemented in the country by means of complementation agreements between the various health effectors. The interagency work led to substantial progress in accessibility to health services and improved health care quality.

In this context, Health and Sexual Diversity policies in Uruguay have been the result of a combination of knowledge and actions between Academia, Civil Society Organizations and State Institutions, catalyzed by international cooperation. This process, which has been becoming increasingly visible since its beginnings in previous administrations, has now reached a key point in its history. In this regard, our efforts to address the health issues of the lesbian, gay, bisexual and transgender population need to be translated into concrete actions that will ensure actual inclusion in every service.

It is fair to recognize the leading role that ASSE (State Health Services Administration) has been playing in the pursuit of this objective. By virtue of its status as a national benchmark, ASSE has led the work on increasing access for individuals that encounter barriers to health care, whether these barriers are geographical, economic, cultural or based on discrimination. It is therefore important to assess some experiences that have taken place in ASSE centres, where on-going dialogue with social organizations and a focus on training human resources were the cornerstones.

Worth noting is the partnership established between the United Nations Population Fund (UNFPA), *Colectivo Ovejas Negras*, ASSE, the Sexual and Reproductive Health Branch of The Ministry of Public Health, and the University of the Republic, led by the Institute of Health Psychology (School of Psychology), the Department of Family and Community Medicine, and the Department of Infectious Diseases (Medical School). This partnership has gone beyond concrete work on a service and has helped to put the issue on the agenda.

This notebook reports on two experiences: those of Homo/Lesbo/Transphobia-Free Health Centres and the evening health care service for transgender individuals provided by the Training and Treatment Unit of Saint Bois Hospital. These processes have resulted in a marked improvement in the quality of health care from a perspective of respect for human rights, inclusion and equity, which have all contributed to the construction of people's health in its broadest sense.

We now need to replicate these diversity and inclusion experiences with a focus on rights. The origin of these experiences lies in our public services, with ASSE as a pioneer. We must work on guidelines that will make access universal and nationwide, respecting the right of individuals to access health care within the community where they live and interact, from a family and community perspective.

But apart from the fact that the focus should be on primary health care, it should be noted that the approach must cut across all levels and services, and the benefits should include those involving interventions throughout the system. It is necessary to learn from the initiatives implemented here, where we see, for instance, coordination with the secondary and tertiary levels, which we have the challenge of devolving throughout the country. Continuing the work of broadening the scope of these initiatives will result in a more inclusive, friendlier SNIS (National Integrated Healthcare System) with a more comprehensive approach.

Dr Cristina Lustemberg
Undersecretary
Ministry of Public Health

Dr Susana Muñiz
President
State Health Services Administration

Presentation

This work is based on interventions by various government, academia, civil society and international cooperation stakeholders at the breakfast meeting “*Towards a policy of comprehensive, inclusive and quality health for LGBTI people*” organized as part of the programme of activities “September: Month of Sexual Diversity” held in Uruguay every year. The contents systematize the contributions of the various participants at the meeting and put the themed experiences in the perspective of the broader context of public policies on sexual diversity developed in Uruguay¹. The document focuses on the presentations of health policy and sexual diversity experiences in Uruguay made by:

- Daniel Márquez - State Health Services Administration.
- Rafael Aguirre and Florencia Forrissi - Ministry of Public Health.
- Diana González - Consultant - “Homophobia-Free Health Centres” Pilot Project.

In addition to the contributions and/or comments made by Patricia Gainza - Ministry of Social Development, Diego Sempol - *Colectivo Ovejas Negras*, Mariana González Guyer - Member of the Board of Directors of the INDDHH (National Human Rights Institution), Luis Mora - Chief of the Gender, Human Rights and Culture Branch, UNFPA - New York. The interventions of participants were also taken into account.

The document was reviewed by Alfonso Barragües - Human Rights Advisor - UNFPA - New York and Valeria Ramos - Officer-in-Charge - UNFPA Uruguay, and it includes their contributions.

¹ The programme of the activity is available in the Appendix. In all, 40 representatives of various organizations took part, including the Ministry of Public Health, Ministry of Social Development, the Ministry of Home Affairs, the State Health Services Administration, the Uruguayan Parliament, the National Human Rights Institution, the National Health Board, the Municipality of Montevideo, the Schools of Medicine, Social Sciences and Psychology of the University of the Republic, the United Nations Population Fund, sexual diversity organizations (FUDIS [Uruguayan Federation of Sexual Diversity], ATRU [Uruguayan Transgender Association] and Colectivo Ovejas Negras) and organizations focusing on health (Iniciativas Sanitarias [Health Initiatives]).

1. Introduction

Over the last decade Uruguay has been recognized at the continental level as “a leader in LGBT² rights” (Alidadi et al, 2015: 3). In the words of Luis Mora, Chief of the Gender, Human Rights and Culture Branch of the United Nations Population Fund (UNFPA) -New York, the global picture in relation to the rights of people who identify themselves as lesbian, gay, bisexual, transgender and intersex (LGBTI) is alarming: in 70 countries worldwide same-sex relationships are punished, and a third of the countries that are United Nations (UN) member states have a clear definition against diversity. Even countries that are open to the topic face major challenges when designing and implementing public policies to achieve the objective of promoting equality and preventing discrimination based on gender identity and sexual orientation. Uruguay’s work stands out among the Latin American countries that have made significant progress in this area (Mora, 2015).

In a short period of time, the country witnessed a number of major legal victories that helped to remove legal discrimination based on sexual orientation and gender identity. The main regulations enacted in this area are the following³:

- The Law on Combating Racism, Xenophobia and Discrimination specifically identifies “sexual orientation and gender identity” as a source of discrimination (2004);
- Concubinage Law, which recognizes same-sex couples (2007);

2 Lesbian, Gay, Bisexual and Transgender. This paper prefers to use the term LGBTI to visibilize the intersex population, who have not yet been sufficiently addressed on the local diversity agenda.

3 The entire legislation can be found at: www.parlamento.gub.uy

- Law 18590 - Code for Children and Adolescents enacted provisions concerning adoption which protect and fully recognize the rights of the children of LGBT families by allowing joint adoption by couples living in concubinage (2009);
- The Law on the Right to Gender Identity and Name and Sex Change in identity documents allows transgender people to obtain a document consistent with their gender identity and does not make the change conditional on prior sex-reassignment operations or hormone treatment of any kind (2009);
- The Same-Sex Marriage Act establishes the right of same-sex couples to marry on an equal footing with heterosexual couples (2013);
- Law 19167 on Assisted Human Reproduction grants gays, lesbians and transgender individuals access to these benefits, albeit with certain limitations (2013)⁴.

Progress was made possible primarily by a strengthened sexual diversity social movement that managed to attract public support for the agenda⁵,

4 As explained by González and Soto (2014: 25-26), the law states that “these techniques can be applied to any person as the main therapeutic approach to infertility as far as they are the most suitable medical procedure for conception ‘in the case of couples biologically impaired to do so’, and in the case of ‘women regardless of their marital status.’ It defines infertility as ‘the inability to achieve pregnancy by natural means after twelve months or more of intercourse.’ Although it does not specifically mention homosexual individuals or couples, it may be construed that they can be accessed by all women and men if they are members of couples ‘biologically impaired for procreation.’ The process of exception surrogacy is also accepted in the situation of a woman ‘whose womb cannot bear a child,’ which excludes the possibility of surrogacy by a male couple or a transgender female.”

5 The “Diversity March” - held every year in September - has become one of the most significant public social events in the country (Sempol, 2013).

build partnerships with other civil society groups and sensitized stakeholders of the political system to include their demands on the political-governmental agenda (Sempol, 2013).

At present, the country is faced with the challenge of turning this *de jure* equality into a *de facto* equality. It is necessary for the new regulations to reflect and positively change the daily lives of individuals so as to achieve real *social recognition* of sexual diversity (Pecheny, 2001). With human rights as a paradigm, this involves the Executive committing itself to the development of specific public policies in this area (Pautassi, 2010). To reinforce this line of action, in 2010 the Uruguayan government began testing the implementation of various programmes, projects and actions in the social, educational, employment and health areas.

The work of the Ministry of Social Development (Mides) has been particularly remarkable in that it has generated actions aimed at transgender people, who are regarded by both the State and civil society as the worst affected by the homo-lesbo-transphobia prevailing in society. The following are some of the most outstanding actions taken:

- mechanism to support the gender identity adaptation process, providing access to the possibilities under Law 18620;
- transgender people's access to the *Tarjeta Uruguay Social* (Social Uruguay Card) without exceptions. This benefit provides a monthly amount to be spent on food and cleaning products in affiliated stores (first case of affirmative action for this group);
- inclusion of the perspective of sexual diversity and special quotas to facilitate transgender people's access to training programmes, education and employment ("*Uruguay Trabaja*" (Uruguay Works), "*Ley de Empleo Juvenil* (Youth Employment Law)-*Primera Experiencia Laboral* (First Work Experience)", "*Yo estudio y Trabajo*" (I Work and Study) and "Nexus" are some examples);
- launch of an employment call aimed exclusively at transgender people for a position in the Ministry of Social Development;

- mainstreaming of the sexual diversity perspective within the ministry by means of different instruments, especially workshops to train employees and raise their awareness, and the inclusion of the category "transgender" as an option in the gender identity variable on forms for accessing social benefits;
- agreement with the UdelaR (University of the Republic) for the production of academic knowledge regarding public policies and sexual diversity;
- creation of an Advisory Council on Sexual Diversity involving civil society to advise the Ministry of Social Development on policy development;
- incorporation of measures aimed at young transgender people in the 2015-2025 Youth Action Plan;
- collaboration agreement with the CENESEX (National Centre for Sex Education) of Cuba, which includes training Uruguayan medical professionals in hormone therapy and sex reassignment surgery for transgender people; and the
- Creation of the CRAM (*Centro de Referencia Amigable* or Friendly Reference Centre), in collaboration with the School of Psychology of the University of the Republic. The service provides counselling to LGBTI individuals, usually aimed at responding to various issues that may arise in connection with sexual-gender diversity (Gainza, 2015)⁶.

The experience of the Ministry of Social Development in the area of sexual diversity was possible largely thanks to a shift in the social policy paradigm towards the human rights perspective after rethinking issues such as people's poverty and socio-economic vulnerability from a different viewpoint and mindful of crosscutting discrimination and inequality (Gainza, 2015; Rocha, 2014).

⁶ For more information see Sempol (2014), Rocha Carpiuc (2014) and Lukomnik (2013).

The systematization of experiences in this field in Uruguay is relevant to efforts to improve them (Sempol, 2015). It also helps to disseminate learning and innovative practices in public policy that will be technically and politically useful to governments interested in implementing the regulations that are being passed at the global level in specific services and programmes (Mora, 2015).

With this goal in mind and based on the interventions made at the Working Breakfast “Towards a policy of comprehensive, inclusive and quality health for LGBTI people,” which took place on the 18th of September 2015 in the city of Montevideo, this document summarizes two success stories in the area of sexual diversity and health policies in Uruguay: the pilot project “Homophobia-Free Health Centres” and the experience of care for transgender people as part of the UDA (Training and Treatment Unit) of the RAP-ASSE (Primary Care/ State Health Services Administration), located on the premises of Gustavo Saint Bois Hospital.

The text is organized as follows. Firstly, there is a brief summary of the current regulatory framework at the international and regional level. Secondly, the document presents the background and national regulations on health and sexual diversity. Thirdly, two initiatives of interest are described. The fourth part highlights best practices and lessons learnt from both experiences. The fifth section identifies the main challenges for the Uruguayan State and civil society in their efforts to enable LGBTI people in Uruguay to fully enjoy their health rights. Finally the document presents the final thoughts.

2. Regional and international regulatory framework

The right to health is recognized at the United Nations (UN) and (Organization of American States) OAS level. The International Covenant on Economic, Social and Cultural Rights (ICESCR) of 1966 states that “the States Parties [...] recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (Article 12). At the inter-American level, the Additional Protocol to the American Convention on Economic, Social and Cultural Rights “Protocol of San Salvador” states that “Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.”⁷

The International Committee on Economic, Social and Cultural Rights of the UN in its General Comment No. 14 of 2000 interprets and explains this right, and does so inclusively, incorporating a holistic notion of health that entails a close relationship with other rights. Thus, it includes timely and appropriate health care and the main social determinants of health, emphasizing access to clean drinking water, sanitation, nutrition, housing, environment and sexual and reproductive health. It attaches particular importance to the “participation of the population in all health-related decision-making at the community, national and international levels.”⁸ This Comment sets out four key dimensions to this right (item 12):

- 1) Availability: A sufficient number of functioning public health and healthcare facilities, goods

⁷ <http://www.oas.org/juridico/spanish/tratados/a-52.html> (accessed 1/10/15).

⁸ “Substantive issues arising in the implementation of the international covenant on economic, social and cultural rights. General Comment No. 14”. http://www.derechos.org/ve/pw/wp-content/uploads/ObsGral_151.pdf (accessed 17/9/15).

and services, as well as programmes

- 2) Accessibility: non-discrimination, accessibility, affordability, and access to information.
- 3) Acceptability: respectful of medical ethics and cultural diversity, sensitive to gender and life cycle requirements, and respectful of confidentiality.
- 4) Quality: skilled medical personnel, scientifically approved drugs and hospital equipment, and adequate sanitation.

In turn, in its general comment No. 20 on discrimination and economic, social and cultural rights, the Committee explained that among the prohibited grounds of discrimination under Article 2 of the ICESCR, sexual orientation and gender identity are implicitly included under “other status.”⁹

Although at the international and regional level there is still no specific binding convention or treaty on the subject of sexual diversity, there have been many pronouncements by human rights bodies on the rights of LGBTI individuals (González and Soto, 2014:11). The right to health and protection from medical abuses are recognized in the “Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity” (2007), an instrument that details human rights from the sexual diversity

⁹ “The right to the highest attainable standard of health”: 11/08/2000. E/C.12/2000/4 11 August 2000. <http://www.cetim.ch/es/documents/codesc-2000-4-esp.pdf> (accessed 17/9/15).

perspective and was adopted as an international standard by the UN system and OAS.¹⁰ While the nature of this instrument is not inter-governmental, it has the authority of having been developed by international, reputable human rights experts.

PRINCIPLE 17. The Right to the Highest Attainable Standard of Health

Everyone has the right to the highest attainable standard of physical and mental health, without discrimination on the basis of sexual orientation or gender identity. Sexual and reproductive health is a fundamental aspect of this right.

States shall:

Take all necessary legislative, administrative and other measures to ensure enjoyment of the right to the highest attainable standard of health, without discrimination on the basis of sexual orientation or gender identity;

Take all necessary legislative, administrative and other measures to ensure that all persons have access to healthcare facilities, goods and services, including in relation to sexual and reproductive health and to their own medical records, without discrimination on the basis of sexual orientation or gender identity;

Ensure that healthcare facilities, goods and services are designed to improve the health of every individual without discrimination on the basis of their sexual orientation and gender identity, respond to their needs and take into account their singularities, and that

medical records related to these aspects are treated with confidentiality;

Develop and implement programmes to address discrimination, prejudice and other social factors which undermine the health of persons because of their sexual orientation or gender identity;

Ensure that all persons are informed and empowered to make their own decisions regarding medical treatment and care, on the basis of genuinely informed consent, without discrimination on the basis of sexual orientation or gender identity;

Ensure that all sexual and reproductive health, education, prevention, care and treatment programmes and services respect the diversity of sexual orientations and gender identities, and are equally available to all without discrimination;

Facilitate access for those seeking body modifications related to gender reassignment to competent, non-discriminatory treatment, care and support;

Ensure that all health service providers treat clients and their partners without discrimination on the basis of sexual orientation or gender identity, including with regard to recognition as next of kin;

Adopt the policies and programmes of education and training necessary to enable persons working in the healthcare sector to deliver the highest attainable standard of healthcare to all persons, with full respect for each person's sexual orientation and gender identity.

¹⁰ "Principles on the application of international human rights law in relation to sexual orientation and gender identity" (2007). http://www.yogyakartaprinciples.org/principles_sp.htm (accessed 17/9/15).

PRINCIPLE 18. Protection from Medical Abuses

No person may be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity. Notwithstanding any classifications to the contrary, a person's sexual orientation and gender identity are not, per se, medical conditions and are not to be treated, cured or suppressed.

Yogyakarta Principles (2007: 23-25)

The following briefly outlines milestones and other documents relating to the subject¹¹:

- The General Comments of the Committee on the Rights of the Child (GC CRC): No.3 (on HIV and the Rights of the Child, 2003), No. 4 (Adolescent health and development in the context of the CRC, 2003), No. 13 (Right of the Child to freedom from all forms of violence, 2011) and No. 15 (Right of the child to the enjoyment of the highest attainable standard of health; 2013).
- In June 2011, the United Nations Human Rights Council adopted resolution 17/19, the first UN resolution on human rights, sexual orientation and gender identity. Its passage paved the way for the first official United Nations report on the subject, "Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity" (A/HRC/19/41), prepared by the Office of the United Nations High Commissioner for Human Rights. The report provided evidence of a systematic pattern of violence and discrimination directed

11 Abstract based on González and Soto (2014), Sempol et al (2015) and UN websites.

12 <http://acnudh.org/wp-content/uploads/2012/03/Leyes-y-pr%C3%A1cticas-discriminatorias-y-actos-de-violencia1.pdf> (accessed 17/9/15).

against individuals in all regions because of their sexual orientation and gender identity, including discrimination in health care, and made a set of recommendations addressed to States designed to strengthen protection of the human rights of LGBTI persons.¹²

- The 2012 Report "Born free and equal. Sexual orientation and gender identity in international human rights law" by the United Nations High Commissioner especially urges States to ensure "non-discriminatory access to basic services, including in the context of employment and health care"¹³ and recognizes the particular problems faced by transgender people in accessing health care: "Gender reassignment therapy, where available, is often prohibitively expensive and State funding or insurance coverage is rarely available. Healthcare professionals are often insensitive to the needs of transgender persons and lack the necessary professional training. In addition, intersex children, who are born with atypical sex characteristics, are often subjected to discrimination and medically unnecessary surgery, performed without their informed consent, or that of their parents, in an attempt to fix their sex."¹⁴
- The report of the Pan American Health Organization (PAHO) "Blueprint for Comprehensive Health Services for Transgender Communities in Latin America and the Caribbean" (2013)¹⁵ states that health services should offer the following features: friendly care and recognition of the social identity of transgender people, hormone therapy and hair removal programmes, counselling if requested by the user, and sex reassignment surgery.
- The "Sexual Health, Human Rights and the Law" report of the World Health Organization (WHO,

13 Page 11. http://www.ohchr.org/Documents/Publications/BornFreeAndEqualLowRes_SP.pdf (accessed 17/9/15).

14 Ditto, page 50.

15 <http://www.paho.org/arg/images/gallery/Blueprint%20Trans%20Espa%C3%83%C2%B1ol.pdf> (accessed 17/9/15).

16 http://apps.who.int/iris/bitstream/10665/175556/1/9789241564984_eng.pdf (accessed 17/9/15).

2015) includes a chapter on non-discrimination in access to health services, addressing the specific needs of particular populations, including sexual orientation and gender identity, and a section is devoted to transgender people and another to intersex people¹⁶. This document reports on regional experiences that incorporate the specific health needs of transgender people, Argentina's case standing out for incorporating certain free services in its health system (hormone therapy and sex-reassignment surgery) and guaranteeing them by including them in its legal system.

Finally, we should mention the adoption, in the context of the First Meeting of the Regional Conference on Population and Development in Latin America (ECLAC) in 2013, of the Montevideo Consensus on Population and Development¹⁷, which sets out new commitments in connection with sexual and reproductive rights for LGBTI people: promoting policies to help ensure that individuals can exercise their sexual rights regarding their sexual orientation and gender identity, without coercion, discrimination or violence, and eradicate discrimination based on sexual orientation and gender identity in the exercise of sexual rights and the manifestations thereof.

¹⁷ http://www.cepal.org/celade/noticias/documentosdetrabajo/8/50708/2013-595-consenso_montevideo_pyd.pdf (accessed 17/9/15).

3. Background and national regulatory framework

As regards the national background in health and sexual diversity, between 1991 and 2012 a service of free sex reassignment surgery operated at the *Hospital de Clínicas Manuel Quintela* as a public service managed by the University of the Republic. This service, however, had many weaknesses: it was based on the “gender dysphoria” perspective, so the process started with a number of psychiatric diagnoses, followed by hormone treatment, and finally surgery – a process that took eight years for each user on average. In addition, its implementation was affected by coordination difficulties between the system areas involved (Sempol, 2013).

At the Ministry of Public Health level, the first incorporation of LGBTI people on the agenda was related to the National Programme of Sexually Transmitted Infections / STI-HIV/AIDS, although it now recognizes the shortcomings of this first approach: firstly, because it does not encompass the diversity existing within the diversity group; secondly, the stigma and prejudice associated with dealing with diversity only in connection with certain issues associated with risk:

“Traditionally, the health of transgender women, gay and bisexuals males, and other men who have sex with men has been addressed and made visible through vulnerability to HIV and other STIs, while the health of lesbians and transgender men has scarcely been considered in health strategies. Considering comprehensive health strategies for these groups ‘made invisible’ that go beyond STIs and contribute to the eradication of the stigma and discrimination was

another priority” (National STI-HIV/AIDS Programme. Report for the period 2011 -2014, cited in Forrisi and Aguirre, 2015).

Following Forrisi and Aguirre (2015), the list below is a review of other activities conducted by the MSP (Ministry of Public Health)¹⁸ along these lines:

- graphic campaigns on prevention targeting men who have sex with men (MSM), transgender people, sex workers.
- Participation in the preparation of the guide “Health of transgender people” PAHO/WHO.
- Inclusion of the “gender identity” variable in HIV/AIDS epidemiological reporting.
- Virtual capacity-building for South-South Cooperation:
 - Public policies to improve the Sexual Diversity population’s access to health: Friendly clinics - May 8, 2014
 - Comprehensive health care for transgender people - June 10, 2014
 - Anal intercourse: concepts and recommendations for health personnel. July 16, 2014
- First Meeting of Development of Leadership in LGBT Organizations (organized in conjunction

18 The Ministry of Public Health is the body of the national Executive responsible for “establishing the policies and strategies for the performance of essential public health functions, so as to ensure collective health as a basic human right and a public good that is the responsibility of the State and “guiding the operation of the National Integrated Healthcare System in accordance with a healthcare and management model based on the principles of primary healthcare.” <http://www.msp.gub.uy/institucional/misi%C3%B3n-y-visi%C3%B3n> (accessed 8/10/15).

with the Ministry of Social Development, United Nations Development Programme-UNDP, UNAIDS / Joint United Nations Programme on HIV/AIDS and UNFPA) - 13, 14, and 15 October 2012.

The issues raised at this event were problems in this area identified by civil society, and possible solutions to them were discussed, with an emphasis on the following points:

<p>What is wrong? Discrimination, mistreatment, stigmatization and the health personnel's lack of confidentiality (doctors and non-doctors) hinder access to quality in health centres (hospitals, outpatient clinics)</p>	<p>What can we do? Gather evidence of stigmatization and discrimination in the public and private health sector. Special focus on suicide among LGBT people.</p>
<p>What is wrong? Drug use among sex workers and LGBT people. There is a perception of widespread drug use among transgender sex workers as a means of coping with the conditions of sex work.</p>	<p>What can we do? Research substance abuse among the LGBT population, particularly the young and young adults, and among transgender sex workers.</p>

Source: Forrisi and Aguirre (2015).

- Workshop on a comprehensive approach to transgender people and their communities in Uruguay (organized in conjunction with PAHO/WHO and the Management Unit of the Global Fund to Fight AIDS, Tuberculosis and Malaria) - October 24, 2013. Among the contents dealt with at the event, the main emerging conclusion identified by the Ministry of Public Health was the significance of comprehensive, crosscutting care for transgender people, addressing their health requirements in their relationship

with other human rights such as employment and education. On this occasion, the promotion of homophobia-free services and the consideration of body adaptation treatments (hormone therapy, surgery, dermatological procedures) were already advanced as lines of development, not as “procedures of a cosmetic/aesthetic nature but as necessary treatments required by transgender people as part of a comprehensive approach to their health and as a recognition of their rights” (Report by the rapporteur on the Workshop on a comprehensive approach to transgender people and their communities in Uruguay, quoted in Forrisi and Aguirre, 2015).

This activity was carried out as part of the project “Towards social inclusion and universal access to comprehensive prevention and care in HIV/AIDS for the most vulnerable populations in Uruguay,” supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (2012). Its main State recipients were the Ministry of Public Health and ANII (National Agency for Research and Innovation), along with three other sub-recipients from organized civil society: MYSU (Women and Health in Uruguay), the Virchow Centre and Latin American Initiative. Its actions were geared towards transgender people and MSM. In this context, five EDISA (Diverse Areas for Social Inclusion and Action) became operational in different departments in the country (Artigas, Colonia, Montevideo, Maldonado, Melo) in early 2013, in addition to two mobile centres. However, later that same year the Global Fund left the country, and the services were discontinued¹⁹.

In hindsight, the Ministry of Public Health identified the results of the work, disaggregated by degree of progress²⁰:

MIDDLE DEGREE PROGRESS:

- promoting homo/lesbo/transphobia-free centres. Promoting and supporting training for refocusing health services at the primary level of sexual

19 <http://www.proyectovihuruguay.org/index.php/proyecto> (17/9/15) and Sempol et al (2015).

20 The listing was taken verbatim from the presentation by Forrisi and Aguirre (2015).

and reproductive care and health, ensuring accessibility and comprehensive quality care for the LGBT population.

- promoting not only coordination between civil society organizations but also between them and the government sector, and participation in steering bodies (development of guidelines and standards).

LOW DEGREE PROGRESS:

- articulating with the education sector to encourage recognition of LGBT people's rights.
- promoting the inclusion of gender identity and sexual diversity issues in the curricula of formal education (primary schools, secondary schools, university studies in the health area).
- conducting or supporting media-based dissemination activities aimed at the public and private sector population, companies and institutions - which will include information on respect for human rights, sexual diversity and gender equality.
- drafting a list of institutions working in the field.
- advocating the inclusion of diversity in records and research.
- promoting and monitoring consensus mechanisms created among institutions to record and reverse stigmatization and discrimination situations on the basis of national legislation and taking account of international standards.

MIXED PROGRESS:

- developing guidelines on comprehensive care for the LGBT population together with Sexual and Reproductive Health (Programme for males and comprehensive health for females). *Participation was limited to the development of the Global Fund's guide for MSM and transgender women.*
- promoting training for Primary Care health services and Sexual and Reproductive Health Services in comprehensive quality healthcare for

sexual diversity. *There was some progress in Primary Care and no progress in Sexual and Reproductive Health.*

NO PROGRESS:

- articulating with intersectoral initiatives that develop public statistics using a comprehensive approach to report on the situation of the LGBT population and people living with HIV.
- Articulation of the CONACIDA-MCP (National Committee on AIDS - Country Coordination Mechanism) with the mass media to promote the acceptance of diversity.

It must briefly be pointed out what the current situation is in relation to the Uruguayan health system inasmuch as it acts as the context for the development of initiatives that will be discussed shortly. In fact, the assessments that have been made of the experiences identify some of these factors as enabling their emergence and success (Sempol et al 2015, González and Soto, 2014).

In 2007 and 2008 the SNIS (National Integrated Healthcare System) was set up. The Law that created it (No 18211) states that "the protection of health is a fundamental human right for whose full enjoyment the State must take responsibility by creating the conditions that will allow the entire population residing in the country to access comprehensive health services."²¹

The human rights perspective is also reflected in its guiding principles, including a reference to the intersectoral approach with other policies aimed at improving the quality of life of citizens, universal coverage, issues relating to information and prevention or the need for user participation in public policy decisions (section 3) (Ministry of Social Development, 2015).

The SNIS (National Integrated Healthcare System) was organized in three levels of healthcare depending

²¹ <http://www.parlamento.gub.uy/leyes/ AccesoTextoLey.asp?Ley=18211&Anchor> (accessed 8/10/15).

on the needs of users and the complexity of the benefits. Of the three levels, it established work on the first level (Primary Health Care strategy), which functions as the “gateway” and an individual’s first contact with the health system, as a priority. This shift is significant because the recommendations of including sexual diversity in health care available to other cases suggest prioritizing work at this level²².

As the complexity of the needs and problems to be addressed increases, the resources are organized in levels two and three. The second level involves “hospitals and associated establishments that provide services related to care in internal medicine, paediatrics, obstetrics and gynaecology, general surgery and psychiatry,” while the third “is related to the treatment of complex pathologies requiring specialized high-tech procedures” (Vignolo et al, 2011). It is estimated that between the first and the second level, as much as 95% of the population’s health problems can be solved, while the third level is reserved for the treatment of low-prevalence situations (Sempol et. al, 2015). The significance has also been emphasized of mainstreaming sexual diversity in the first level instead of creating institutes and specialized places at higher levels, which will result in segregation of LGBTI people instead of promoting their social integration²³.

At around the same time, the University Reform was implemented. As part of the reform, a new curriculum was drafted for the MD degree course, prioritizing among other things teaching at the community level and the student’s early insertion therein. In this context, the Department of Family and Community Medicine was established in 2007 (Sempol et. Al, 2015), a specialty consistent with a “clear interdisciplinary and intersectoral perspective, with teaching, assistance, outreach and research in primary care for the individual, family and community as its aims.

This profile contributes to a teaching-learning and healthcare process that is on-going, comprehensive, holistic and adapted to the social and community reality in which the prospective professional or specialist is inserted and where he/she undergoes the educational process”.²⁴

These developments helped to address sexual diversity in the experiences that will be discussed in the next section from an interdisciplinary and intersectoral, longitudinal (including people’s health throughout their life cycle) and social perspective, mindful of the social environment in which the users, their families and their communities are embedded. (Márquez, 2015; Sempol et al, 2015).

Although not directly linked to the experiences in question, it is fair to mention other initiatives that were implemented at the time that were related to the mainstreaming of diversity in the educational field and are part of the context of the development of initiatives. Firstly, the inclusion of sexual diversity as a principle and right to be respected and as specific content to be included in the curriculum of primary and secondary education (Freitas de León, 2011) through the PES (Sexual Education Programme) of ANEP (National Administration of Public Education) created in 2007. Although the programme has its shortcomings, it resulted in the implementation of training activities for teachers and sexuality referrers and the preparation of materials on sexual and gender diversity, with the support of UNFPA and INMUJERES (National Institute for Women) of the Ministry of Social Development. Another noteworthy development was the reformulation of the curriculum for the Psychology course at the University of the Republic in 2013, which led to the introduction of compulsory and optional courses addressing various issues

22 The significance of working on the transformation of primary care was emphasized by the President of ASSE, Susana Muñiz, in her speech during the opening ceremony. This good practice has also been identified in experiences in Argentina. See: Municipality of Rosario and Ministry of Health, Office of the President, “Contributions to the comprehensive healthcare of transgender people from a local perspective. Rosario

experience 2006 - 2011”. <http://www.rosario.gov.ar/sitio/verArchivo?id=6893&tipo=objetoMultimedia> (accessed 30/9/15).

23 This is the spirit of the actions that are currently being undertaken by the public health authorities on this subject. It is also present in the initiatives discussed below. At the event concerned, the point was highlighted by Márquez (2015).

24 <http://www.medfamco.fmed.edu.uy/> (accessed 24/6/15)

related to the gender, sexuality and sexual diversity agenda.

In addition to the general non-discrimination rule mentioned in the introduction, another legislative breakthrough was the recognition of the users' rights to equal treatment without discrimination in the health system under Law 18335 on the rights and obligations of patients and users of health services in 2008²⁵. That same year, Law 18426 on Sexual and Reproductive Health²⁶ was passed. Its regulatory decree (293/2010) states that the services must ensure both universal access and equal treatment and confidentiality, and they must include the specific needs resulting from the population's diverse sexual and gender identities²⁷.

In the context of the implementation of Law 18426 on Sexual and Reproductive Health and at the suggestion of the Working Group on Sexual Diversity that operated under the aegis of the Municipality of Montevideo²⁸ with the participation of civil society, the Ministry of Public Health with the support of UNFPA drafted the Chapter on Sexual Diversity in the Guidelines on Sexual and Reproductive Health (2009)²⁹. The document expresses the political will to continue and reinforce this line of work, making recommendations on the inclusion of this perspective in all the services provided by the SNIS (National Integrated Healthcare System), including among others:

- raising awareness and building the capacity of health teams to provide adequate care to people with a non-heteroconforming sexual orientation and gender identity;
- the introduction of materials that include messages and images including sexual diversity into the institutional communication strategy of health care providers;
- making changes to health system forms for the purpose of contributing to comprehensive, inclusive care; among others (González and Soto, 2014).

25 <http://www.parlamento.gub.uy/leyes/AccesoTextoLey.asp?Ley=18335&Anchor> (accessed 8/10/15).

26 <http://www.parlamento.gub.uy/leyes/AccesoTextoLey.asp?Ley=18426&Anchor> (accessed 8/10/15).

27 <http://www.dem.fmed.edu.uy/materno/Material/Decreto%20Salud%20Sexual%20y%20Reproductiva.pdf> (accessed 8/10/15).

28 The Municipalities are the executive authorities in the second tier of government in Uruguay: the departmental level. The Department of Montevideo includes the capital city of Uruguay.

29 <http://www.unfpa.org.uy/publicaciones/guias-en-salud-sexual-y-reproductiva,-capitulo:-diversidad-sexual.html> (accessed 1/10/15).

4. Experiences in health and diversity

4.1 Homophobia-Free Health Centres³⁰

The first noteworthy initiative was the creation in June 2012 of the pilot project on creating CSLH (Homophobia-Free Health Centres), which was implemented in two health centres located in ASSE (State Health Services Administration)³¹: first in the *Ciudad Vieja* (Old Town) Health Centre located in the capital city, Montevideo, at the *Metropolitana RAP* (Primary Care Network)³² level (South Region), and then it was expanded to the outpatient clinic in “Barros Blancos” in the department of Canelones.

The overall project objective was to generate a pilot learning experience between the medical community and the LGBT group that would result in a “homophobia-free” local outpatient clinic because of its optimal levels of health care for the LGBT community and systems of work for subsequent expansion of the project at both the intervention and health training levels. Its specific objectives were to:

- train health workers, community stakeholders, and the FCM (Family and Community Medicine)

30 This section is based on González (2015) and González and Soto (2014). The systematization of the experience is published at: www.unfpa.org.uy

31 ASSE is the leading state-run provider of comprehensive health care. It contains a network of services across the country. It is defined as “the benchmark organization in health care at the national level in promoting humanized care, with equal access and providing excellent service” http://www.asse.com.uy/uc_2113_1.html (accessed 8/10/15).

32 This Network is the executive unit of ASSE, which has been organizing and managing primary care in the city of Montevideo since March 2005. Its mission is to provide comprehensive primary care, with a focus on prevention and an emphasis on health promotion.

residents and their teachers at a primary healthcare centre.

- raise the awareness of the surrounding community of the need for public services that will respect diversity.
- encourage and facilitate access to health services for the LGBT population.
- systematize successes and failures so that the methodology used for the experience becomes replicable in other public and private healthcare services in the country (Gonzalez and Soto, 2014: 37).

In this regard, the initiative involved the production of protocols and creation of opportunities for comprehensive training and capacity-building in sexual diversity aimed at medical, administrative and maintenance staff. This made it possible to take account of the realities and specific health needs of LGBT people using a non-discrimination, universal approach (Johnson and Sempol, 2015). The creation of specific health services or services targeted at this sector was not promoted. Instead, the intention was to transform the health institutions so as to mainstream the sexual diversity perspective in them (González and Soto, 2014).

The experience emerged from the combination of needs and interests of different civil society, State and international cooperation stakeholders:

- RAP-ASSE (Primary Care / State Health Services Administration);

- *Colectivo Ovejas Negras*, a sexual diversity civil society organization³³;
- the Ministry of Public Health, through the Department of Sexual and Reproductive Health, where the National STI-HIV/AIDS programme operates.
- The University of the Republic, through the Medical School-*Fmed* (promoted by the Department of FCM from the beginning, later by the Department of Infectious Diseases) and the School of Psychology (Gender Programme, Reproductive Health and Sexualities of the Health Psychology Institute); and
- UNFPA.

Its implementation involved forming a Management Team with leading figures from FCM Department of the University of the Republic, RAP-ASSE (Primary Care / State Health Services Administration), the Ministry of Public Health, UNFPA and *Ovejas Negras* (González and Soto, 2014). In the systematization by González and Soto (2014: 33), the process of devising the project is described as a “snowball” effect:

“The participation of institutions and various fields in this experience is built progressively on the basis of a chain reaction, with the experience - in a snowball fashion - gradually incorporating stakeholders interested in addressing issues of sexual diversity in health.

The various accounts of those interviewed revealed that unplanned situations led to the gradual recruitment of stakeholders that were crucial for a synergy that had two purposes: to develop this innovative pilot experience and to facilitate internal institutional insertion as a member.”

The origin of this journey was a paradigmatic academic athenaeum held in 2010 at the Old Town Health Centre on the case of teenage lesbian who lost custody of her child by order of the Judiciary, which inevitably led to a discussion of the intersection of the factors that give rise to discrimination. González and Soto (2014:35) called the athenaeum a milestone experience in that it implied “an institutional coming out of the closet by all the institutions involved”:

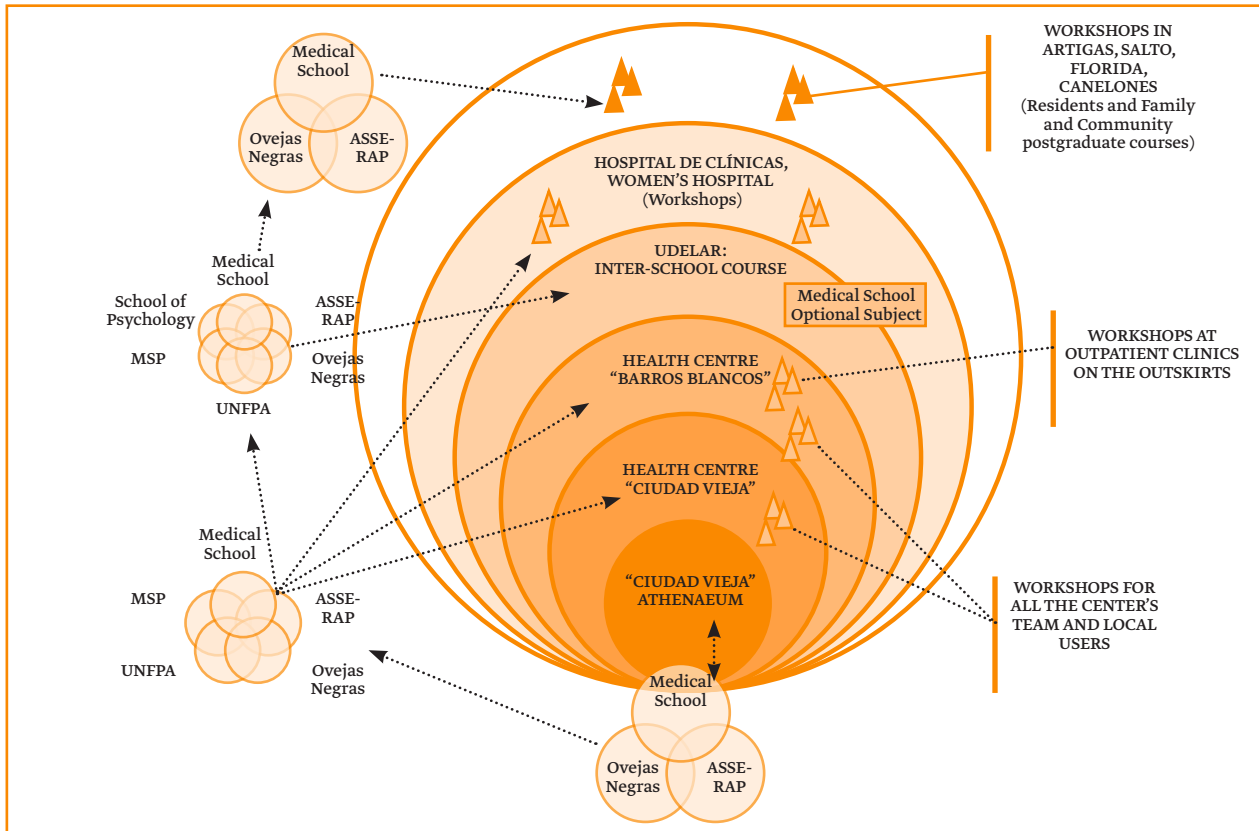
“The feeling of injustice spread like a shock wave among the Health Centre’s staff, aroused interest and resulted in the need to review and be reviewed in practice. The closure of the Athenaeum was an opening for the continuity of a process that began there. The team of resident family and community doctors, along with *Colectivo Ovejas Negras*, share the need for a broader perspective in addressing sexual diversity in the area of health.

All the conditions were in place for the different stakeholders: political will, a realization of the significance of the problem, an interest in ensuring maximum accessibility to services of primary healthcare services, availability, openness to address the problems, and *Ovejas Negras*’s ability and desire to join this process” (González and Soto, 2014: 35).

Through the figure below, the consultants seek to reflect the abovementioned “shock wave.”

³³ A non-governmental organization founded in December 2004 to defend the rights of lesbian, gay, bisexual and transgender people in Uruguay. Some of its objectives are to combat discrimination and stigmatization, helping to build a society that will integrate sexual diversity as a democratic asset. Its actions address different areas, such as issues related to health, among others.

Figure 1. The process of constructing the CSLH (Homophobia-Free Health Centre) experience



Source: González and Soto (2014: 36).

Some of the activities carried out during the implementation of the pilot project were:

- Design of the intervention plan, which included: discussions, training, review of forms and development of new questions, reviewing diagnostic processes, assessment of potential derivations and finding institutional agreements where it was not possible to respond to project deployment needs, schedule, monitoring and assessment.
- Advertising the existence of this “homophobia-free” service both at the city (through clubs, pubs, sports teams, “pickup” spots, blogs and websites commonly used by the community, etc.) and local level.
- Monitoring, discussion, processing and assessment of the actions being undertaken. This process and its systematization are instrumental in achieving

our overarching goal: for this project to serve as a “trial” before the implementation of a more widespread change in various public and private healthcare centres.³⁴

The available systematization highlights the following results achieved by the project:

- the sexual diversity perspective and the need for health care and promotion for LGBT people was addressed and made visible in two health centres by all the staff working there.
- an awareness and training process was initiated that allowed the review of misconceptions and prejudices accompanying the practices that reproduce discrimination and stigmatization of

³⁴ Taken from the website of UNFPA, Uruguay. <http://www.unfpa.org.uy/proyectos/proj/centros-de-salud-libres-de-homofobia.html> (accessed 29/9/15).

this population by healthcare workers, teachers, community stakeholders and FCM residents.

- members of the community surrounding health centres were informed of the purpose of the pilot experience, in order to gain support for the process and engage the LGBT population in the area.
- the conditions came into place for incorporation of the issues as the core content of an optional subject on the medical degree course at the University of the Republic, and a continuous training course was run within the University of the Republic which was open to the participation of other areas of health (an approach used to institutionalize issues that are not found in the curriculum).
- the identification of LGBT people with HIV and AIDS and their inherent stigmatization with no consideration of other health needs was questioned.
- the gaps became apparent in medical coverage for transgender people, mainly in terms of hormone therapy and sex reassignment surgery.
- action was taken for the training of health operators in order to respond to the health needs of the transgender population and include this issue on the health policy agenda.
- a partnership was built for collaboration between government, academia, civil society and international cooperation in order to achieve a synergy that would produce motivation, commitment, multiplication of experiences, openness to learning and to other ways of understanding diversity.
- an interdisciplinary dimension was incorporated into the approaches, the contents, the teaching staff and participants in general (González, 2015).

4.2 Healthcare for transgender people in the UDA (Training and Treatment Unit) of the Primary Care Level/ASSE (State Health Services Administration) Saint Bois³⁵

Since 2014 the UDA (Training and Treatment Unit) of the RAP-ASSE (Primary Care) has been implementing a healthcare experience for transgender people which operates on the premises of the *Centro Hospitalario del Norte Gustavo Saint Bois*, located in Villa Colón, department of Montevideo. The UDAs are “areas where, in a coordinated fashion, the teaching services of *Fmed* (Medical School) are integrated into the operation of the health services of public and private providers through healthcare functions, undergraduate and graduate teaching, outreach and research.”³⁶

The experience arose from the creation of a new evening/night shift in the outpatient clinic to respond to service accessibility problems detected in a survey. This space is coordinated by doctors from the FCM speciality and is open to the entire population. It was in this context that the first transgender person was treated, after which it was necessary to begin to think of how to provide better care tailored to their needs, and how to promote a friendly environment for their care (Márquez, 2015).

The first action taken to move in this direction was the capacity-building and training of health professionals in issues of sexual diversity. For this purpose, an academic Athenaeum entitled “Care for transgender people: another challenge for the National Integrated Health System” was held, at which specialists from different specialties (Department of Family and Community Medicine and the Obstetrics/Gynaecology Clinic, Academic Unit of

35 This section is based on the presentation made by Márquez (2015).
36 Document “Saint Bois Health Centre. Project on Building a Training and Treatment Unit. Strengthening primary care using an interdisciplinary and community participation approach” (p. 1). www.medfamco.fmed.edu.uy/Archivos/Proyectos/udas/UDA_SB.doc (accessed 24/6/15).

Bioethics of *Fmed* (Medical School), Department of Endocrinology, Department of Infectious Diseases, Mental Health professionals and some foreign interns) discussed the issue on the basis of two clinical cases (Márquez, 2015).

In addition, intersectoral and interdisciplinary coordination - identified by the leaders of the experience as a key dimension for its success - started to be promoted. There was also articulation with other services at the first and second level of care, and with the third level especially for performing surgery, which was made possible by the participation of Obstetrics/Gynaecology Clinic A located in the *Centro Hospitalario Pereira Rossell (CHPR)* and more recently by the cooperation of Plastic Surgery. The articulation with the Ministry of Social Development was also a significant factor in that it enabled the adoption of an approach to health as a human right interdependent on other rights such as identity, work and social inclusion (Márquez, 2015; Gainza, 2015).

The outputs of the UDA experience were mainly two:

1. **“Boarding ladder”:**

This is an instrument that concentrates a set of agreed-upon work guidelines on the treatment of transgender people, based on the identification of needs voiced by the user. It also plays a key role in informing people of their health process. As shown in Figure 2, this device recognizes the significance of health and non-health aspects, such as having the right to a change of name and registered sex.

Among the health aspects, it contemplates performing an initial physical examination; a genital physical examination; a specific paraclinical test before hormone therapy is indicated; periodic monitoring of the hormone process, and possible surgery. So far, this has been implemented for transgender males in their first stage, genital surgery, which involves hysterectomy with annexectomy - (see Figure 3 for more information on this point). Hormone

therapy is accompanied by an informed consent which states what transformations are expected, when they can be expected to occur, and reversibility or otherwise of the processes. Moreover, the “boarding ladder” includes the psychological counselling dimension cutting through its stages, rather than placing it as a prerequisite and authoritative step to determine whether or not the person can “go ahead” with the set sequence, as is often the case with health services, whose organization is based on “gender dysphoria.” The concept guiding the implementation of the “boarding ladder” is care for healthy users, rather than “patients” that require the intervention of the health system for their “normalization.” This means that no diagnosis of disease is required for interventions, in accordance with the trend towards the depathologization of transgender identities (Márquez, 2015; Sempol et al, 2015).

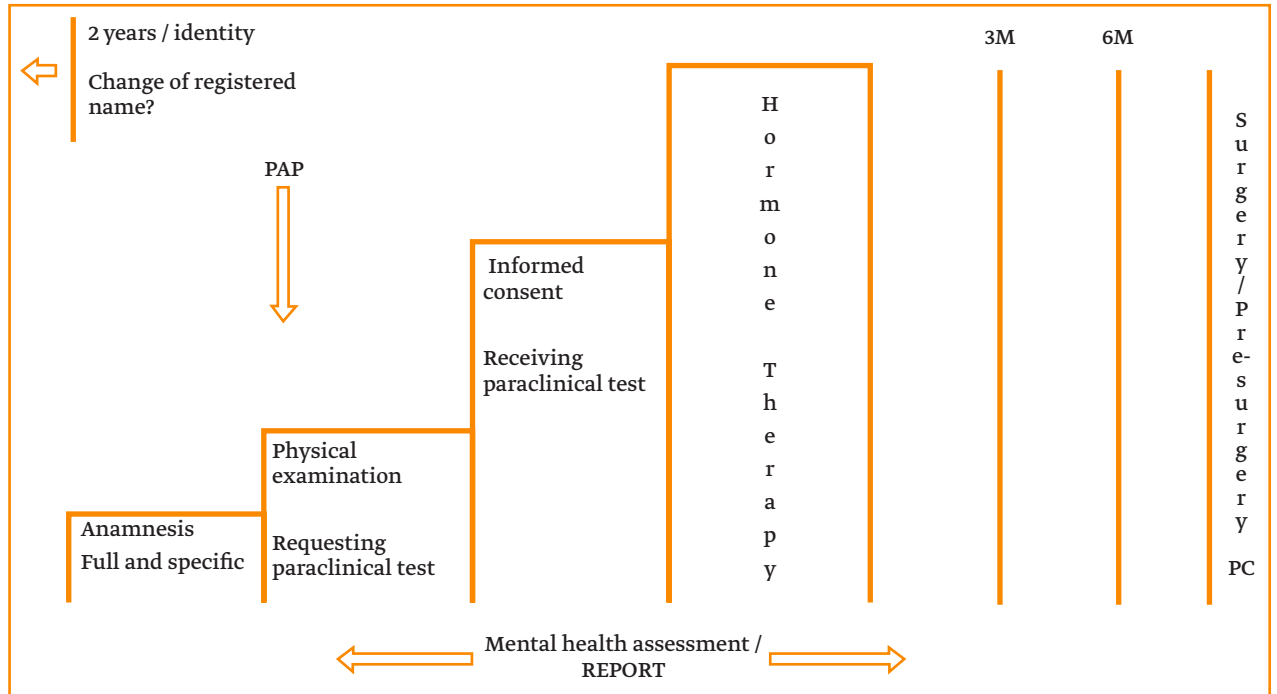
2. **Diversity-Friendly Medical Record:**

A medical record format has been devised that contains specific questions for transgender people (incorporating issues such as occupational health, for instance) and uses the gender identity and name which the person recognizes as his/hers (Márquez, 2015).

The progressive changes that took place in the UDA for the provision of a specific and friendly service to sexual diversity led to a “snowball” effect, as was the case with the previous experience, with transgender people approaching timidly at first and then in increasingly large numbers. According to reports from the service, between June 2014 and June 2015 they received a total of 600 consultations, 192 of which were from people who recognize themselves with this gender identity (Márquez, 2015).

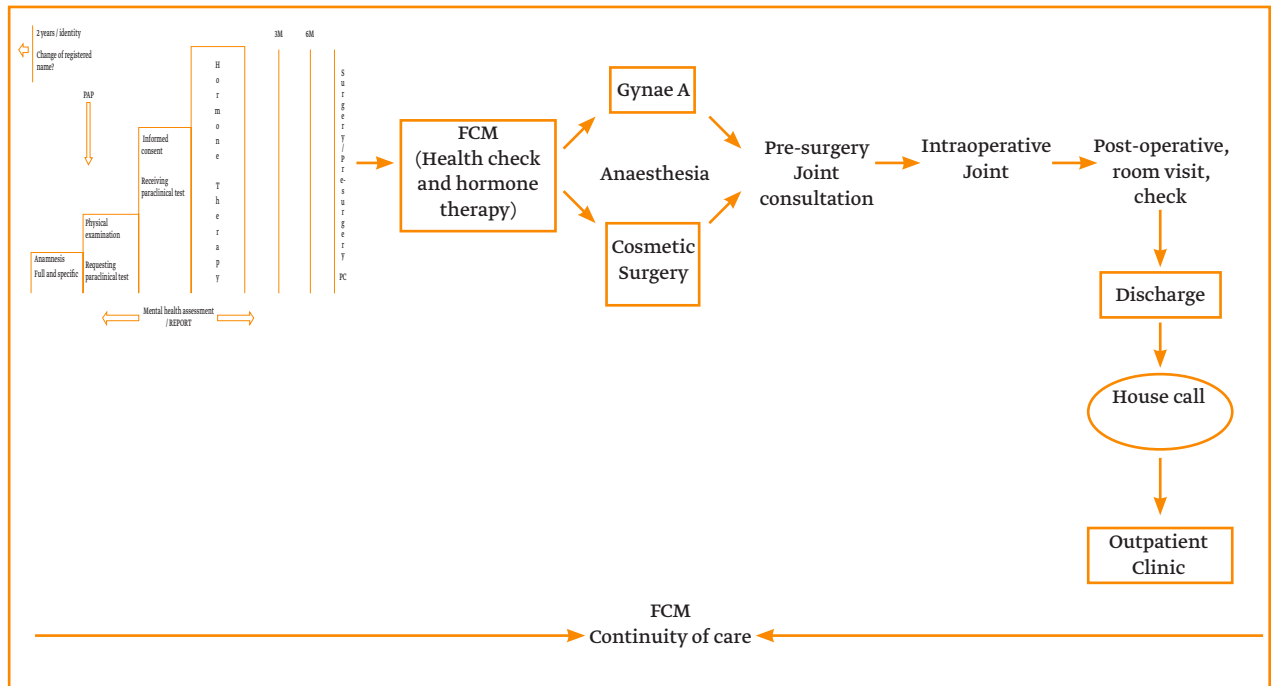
It must also be noted that the service promoted the active participation of users and groups socially organized around gender and sexual diversity

Figure 2. “Boarding ladder”.



Source: Márquez (2015).

Figure 3. Extended “boarding ladder”: the surgery process



Source: Márquez (2015).

during the process of constructing the experience. Additionally, the meeting in this space of transgender men - a population with less visibility and fewer networks among them than transgender women in this country - contributed to the formation of the first group of transgender men at the national level, called “Trans Boys Uruguay” (Sempol et al, 2015).

The initiative also had repercussions at the teaching-learning level. As noted above, the UDAs are healthcare settings but also formative environments. Available data indicate that in the year that has elapsed since the inception of the experience, the participants - apart from the teachers responsible for the service - have been:

- 10 undergraduate medical students.
- 4 postgraduates in Family and Community Medicine.
- 1 postgraduate in Endocrinology.
- 4 Psychology students
- 1 Endocrinologist.
- Foreign interns from Brazil, Argentina, Spain and Peru.³⁷
- Internships from other UDAs who applied for training in the topic (Márquez, 2015).

It should be noted that the experience had an impact beyond the UDA and counterparts that contributed to its development. The inauguration of new authorities in ASSE in 2015 catapulted the experience, with the definition of the general measures at the level of the main public health provider of SNIS (National Integrated Healthcare System) (Sempol et al, 2015). In May, in the course of an activity carried out by various public institutions in commemoration of the International Day Against Homophobia, Transphobia and Biphobia, ASSE’s President, Dr Susana Muñiz, publicly announced that

transgender people would access hormone treatment at the primary care level³⁸. At present, RAP-ASSE is developing a specific healthcare protocol to improve the quality of care for this population, mainly focusing on hormone therapy. The need for accurate indications in hormone therapy is due to the fact that there are many medical discussions on the subject, so the indication requires accuracy (Márquez, 2015).

³⁷ The presence of foreign interns served to multiply the experience in their countries.

³⁸ “Comprehensive right to health: Transgender people will have access to hormone therapy and a healthcare protocol.” http://www.asse.com.uy/uc_7835_1.html (accessed 3/7/15).

5. Best practices and lessons learned³⁹

This section and the next present an overview of the initiatives analyzed, highlighting best practices and lessons learnt during the process of designing, implementing, and then the challenges of future improvement.

Stakeholders and their relationships:

- Strategic partnership between social organizations, academia, government stakeholders and international cooperation.
- The involvement of civil society in the process of constructing and implementing the experiences helped to raise the teams' awareness and tailor the services provided to the needs of the population.
- It has been emphasized that the presence of the University of the Republic legitimizes the diversity and public policy agenda (González, 2015). The partnership between *Fmed* (Medical School) and ASSE has been especially mentioned as good practice.⁴⁰
- The active participation of the Ministry of Social Development on the health agenda contributes to understanding health as a right in its comprehensive dimension and coordinating policies in this sector with the rest of those that make up the social protection matrix (Gainza, 2015;

³⁹ This list was drawn up from interventions at the working breakfast. If the name of the person who raised the point is not stated, it is because it was an item that had been mentioned by many or all the participants in the debate or added by the consultant based on all the systematized information.

⁴⁰ The point was raised during the debate in an intervention by Dr. Zaida Arteta, a member of the Department of Infectious Diseases, Fmed (Medical School).

Márquez, 2015). As noted above, the Ministry of Social Development has made significant progress in the development of social policies with a focus on diversity, thus becoming a key partner in achieving effective designs and implementations.

Cultural change and discursive frameworks:

- Eradication of pathologizing approaches to transgender identities, creating healthcare precedents different from the service developed in the late '90s based on "gender dysphoria". The concept of the patient-doctor relationship is replaced by one that deals with healthy users with the autonomy and ability to make decisions on their own bodies, gender and sexual identity (Sempol et al, 2015; Márquez, 2015).
- Fine-tuning between civil society and State stakeholders involved in the experiences in a discursive and political context of human rights and social inclusion. Thinking of health as a human right implies conceiving of it in its entirety and in relation to other rights (Gainza, 2015; Márquez, 2015; González, 2015).
- Capacity-building and awareness campaigns were a key tool for the success of the initiatives (González, 2015; González Guyer, 2015; Márquez, 2015). They facilitated the review of stereotypes and practices and had an impact on personal and institutional processes that go beyond the project (González and Soto, 2014). But as highlighted by Mariana González Guyer, representative of INDDHH (National Human Rights Institution) at

the event, the use of effective methodologies in training is just as important as the training itself. The experiences analyzed were aided by the use of experiential work activities, the interdisciplinary approach and audio-visual materials produced by civil society on sexual diversity.⁴¹ Furthermore, the closing of the health centre for training for one day was highlighted as an example of best practice of the CSLH pilot, as a sign of the significance attached to the subject and a way of including all the staff in the activity (González, 2015).

and ensuring from the beginning that there will not be any exclusions on the grounds of the socioeconomic status of the population (Muñiz, 2015).

Institutions and intervention strategies:

- Adherence to a universalist perspective that addresses the issue from a comprehensive perspective, avoiding stigmatization and segmentation, which results in the creation of exclusive LGBT services. The goal is to mainstream diversity throughout the health care system, rather than the creation of specialized institutes.
- Work on Primary Care has proved effective in that it is the “gateway” of individuals to the healthcare system, and it approaches the issue focusing not on the disease but on a comprehensive perspective (Márquez, 2015; Sempol et al, 2015).
- A major constraint of the CSLH pilot experience in attracting transgender users was that it did not offer free hormone therapy or treatments for the transformation of secondary sexual characteristics, two key needs in the field of health for transgender identities (Johnson and Sempol, 2015). This deficit was reversed by the UDA experience and ASSE’s subsequent decision to provide hormone therapy.
- The main public/state provider of SNIS has taken the lead in transformations in the health sector in relation to the inclusion of diversity, facilitating the adoption by the Ministry of Public Health of policies covering the rest of private providers

⁴¹ Part of the experience involved producing the videos called “What’s the difference?” Available at: <https://www.youtube.com/watch?v=doyf6m79Zls> (accessed 8/10/15).

6. Challenges

Stakeholders and their links:

- Constructive dialogues and partnerships between civil society and the State, recognizing and respecting the counterparts' specific dynamics and timing (Lustemberg, 2015).
- Creating formal opportunities for the participation of social stakeholders in different stages of the process of developing health policies.
- Enhancing coordination between the specific initiatives that are being undertaken to maximize their impact (UDA [Training and Treatment Unit], Old Town Health Centre and Barros Blancos, CRAM [Friendly Reference Centre], etc.). The Ministry of Public Health - in its capacity as governing body for health policies - should play a leading role in identifying and articulating the institutions that are working from this perspective (Forrisi and Aguirre, 2015).
- Establishing mechanisms for linking and interaction in the treatment of prevalent diseases (STI-HIV, mental health, anorectal health) (Forrisi and Aguirre, 2015).
- The role of international cooperation was essential in the promotion of "seed" experiences whose methodologies can be disseminated and replicated in the country and abroad.

Cultural change:

- Strengthening the link between the health system and the education system⁴², using the Law on Sexual and Reproductive Health as a platform and the interagency commission composed of the Sex Education Committee of ANEP (National Administration of Public Education), the Ministry of Public Health through the Sexual and Reproductive Health Area of the Department of Strategic Health Programming, the Ministry of Social Development through INMUJERES, and UNFPA.⁴³
- Organizing campaigns to raise awareness of LGBTI health and rights targeting the general public, aiming to eradicate stigmatization and promote social recognition of sexual diversity (González, 2015). Changing the legislation is not enough; it is also necessary to aim at cultural changes, and for that purpose, it is necessary to combat the general public's ignorance about the subject, which is one of the main sources of discrimination (González Guyer, 2015).
- Multiplying training in human rights and sexual diversity aimed at health personnel - medicine, nursing, psychology - as well as the maintenance and administrative staff of health facilities. Enhancing the line of training for teams working on Sexual and Reproductive Health and Primary Healthcare proposed by the Ministry of Public Health.

42 Dr Clara Niz's intervention in the exchange at the Breakfast Meeting.

43 <http://www.unfpa.org.uy/calendario/index.php?EventId=48> (accessed 8/10/15).

- making further progress in the process of incorporating these topics into the curriculum of degree courses in healthcare. The abovementioned experience of the School of Psychology is a reference in this regard.⁴⁴
- It is important to work on the education dimension in close connection with academic research. The academic debate on the concept of health and notions of “healthy users” versus “pathology” arising from these experiences is still pending.
- The concepts of health associated with comprehensive, cross-sectoral and interdisciplinary approaches, as well as continuity of care and the social and family approach, are typical of the specialty of medicine that was most closely linked to the surveyed experiences: FCM (Márquez, 2015). Although the guidelines of the health reform helped to boost this paradigm throughout the system, a specific effort is necessary to “soak” other specialties with these discourses and interpretive frameworks, which were key to the emergence and success of the initiatives.

Diagnoses, assessment and monitoring:

- Surveying progress in the compliance with the Chapter on Sexual Diversity of the Guidelines on Sexual and Reproductive Health in the various health care providers and the employees’ degree of knowledge of this instrument. The results of the review can serve as a baseline/diagnosis to design new strategies at the Ministry of Public Health (Forrisi and Aguirre, 2015).
- Making specific diagnoses of the status of Uruguay’s intersex people, a group that remains invisible on the agenda and has a fundamental link with the health system (González, 2015). Another element that needs to be analyzed in greater depth is the issue of transgender identities in children and adolescents in order to develop policies that will consider the generational dimension.⁴⁵

⁴⁴ Intervention by Gonzalo Gelpi from the School of Psychology, University of the Republic, in the debate.

⁴⁵ Suggested made by Valeria Ramos (UNFPA-Uruguay) during the review of the document.

- Institutionalizing the initiatives described, facilitating the building of state capacities that will help to:
 - have records with reliable information and statistics constructed from a human rights, gender and sexuality perspective, which is essential to improving the design and implementation of health policies and monitoring them. Promoting coordination and dissemination of public information and statistics among institutions (e.g., Ministry of Social Development-Ministry of Public Health). Producing quantitative and qualitative information on the health needs of the LGBTI population, so as to have a baseline for the formulation of comprehensive public policies (González and Soto, 2014; Forrisi and Aguirre, 2015; Sempol, 2015).
 - keep a record of devices, tools and methodologies that have been produced in these processes, so as to “put them down in writing,” contribute to their sustainability over time, and facilitate the transfer of learning to other health centres and outpatient clinics.
 - have designs of the experiences that are formalized in documents, with a statement of clear goals and objectives. This is essential to monitoring and assessing policies (González, 2015; González and Soto, 2014).

Institutions and construction of intervention strategies:

- Continuing and expanding the process of mainstreaming diversity in sexual health services including all SNIS health effectors, prioritizing primary care and emergency services (Muñiz, 2015; Forrisi and Aguirre, 2015; Sempol, 2015).
- Standardizing the following for all SNIS effectors:
 - use of the name chosen by the person in accordance with their gender identity, even before the amendment of identification documents.

- compulsory benefits in all three levels of care, including treating the effects of violence based on homo/lesbo/transphobia and those specific to transgender people (hormone therapy, hair removal and body adaptation surgery).
 - treatment of gender identity and sexual orientation data in the medical record, ensuring that registration respects diversity.
 - allocation of beds, rooms and bathrooms in accordance with gender identity in hospital facilities and health centres, even before the amendment of identification documents.
 - health interventions in connection with intersex people (González, 2015).
- The name Homophobia-Free Health Centres chosen for the experience proved problematic in two ways: i) it does not visibilize the specificity of violence and discrimination affecting different sexual diversity groups, such as lesbians and transgender people, so it would be more appropriate to refer to Homo/lesbo/transphobia-Free Health Centres, as indeed various stakeholders involved in the experience are calling them⁴⁶; ii) it caused confusion by being interpreted as centres for the exclusive care of the LGBT population. Another latent tension is the visibility of the rights and needs of LGBT people in health and the inclusion of all diversities (González and Soto, 2014).
 - Decentralization of the experiences analyzed and outreach throughout the country, especially in the north of the country, where conditions and health indicators in general show a significant (negative) differential in relation to other regions (Lustemberg, 2015; Márquez, 2015). The President of FUDIS (Uruguayan Federation of Sexual Diversity) and the representative of the “*Gente Diversidad*” group from the department of Salto, in attendance at the event discussed herein, especially focused on highlighting these difficulties in other

departments of the country that are far from the capital.

- Managing the growing public demand for health services that contemplate gender and sexual diversity. This demand emerged as a result of the experiences surveyed to ensure adequate healthcare for all individuals (Márquez, 2015).
- Moving forward in the area of benefits provided to transgender people, developing not only hormone and surgery therapy protocols but also more general protocols that address comprehensive care⁴⁷. The focus on care for transgender people should not overshadow the significance of addressing all forms of diversity, also paying attention to discrimination against gays, lesbians and bisexuals (González and Soto, 2014).⁴⁸
- Establishing protocols for non-discriminatory care that will apply to all the staff in health institutions, pointing out the minimum conditions to be met by a primary care service to qualify as free from discrimination based on gender identity and sexual orientation⁴⁹. Among other things, the systematization of CSLHs suggests considering the following issues:
 - Use of non-discriminatory language;
 - Continuous training for staff;
 - Availability of information on sexual diversity for users,
 - Availability of quality services, medicines and tests;
 - Availability of healthcare services for violent homo/lesbo/transphobia-based situations provided by specialized personnel as well as

46 As an example, see the intervention by Sempol (2015) at the roundtable opening the meeting.

47 Once again, the Argentina case is a nearby reference to be taken into account. See the document “Comprehensive healthcare for transgender people: Guidelines for health teams” prepared by the Ministry of Health. <http://www.msal.gov.ar/images/stories/bes/graficos/0000000696cnt-guia-equipos-atencion-Salud%20integral-personas-trans.pdf> (accessed 9/30/15).

48 This item was also mentioned by the President of FUDIS [Uruguayan Federation of Sexual Diversity], Mercedes da Rosa.

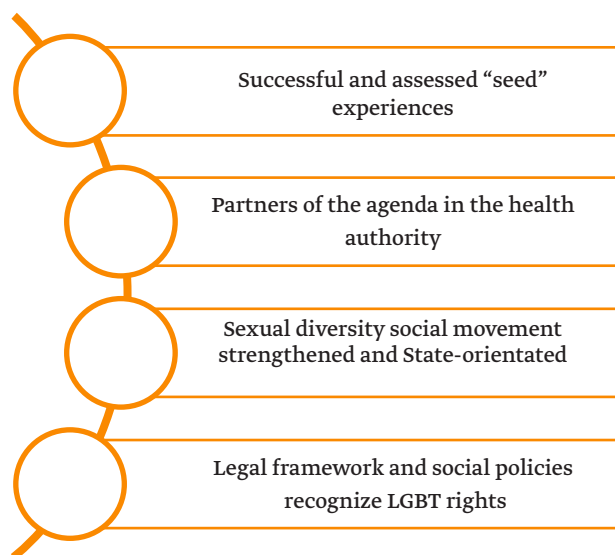
49 The most significant point made by González Guyer (2015) was the usefulness of having such instruments as “seals of approval” to be given to centres that meet certain conditions, without mistaking them for centres intended only for LGBTI people.

- registration and systematization of situations of homo/lesbo/transphobia based violence;
- Establishing the criteria for registration of sexual orientation, gender identity and other sensitive data in the medical record;
 - Criteria regarding the use of bathrooms in the establishment and suiting them to diversity (Gonzalez and Soto, 2014).
- Devising complaint mechanisms, as a complement, for users facing discrimination in health institutions (González, 2015). Additionally, it is suggested that access should be facilitated and existing mechanisms in the context of the INDDHH should be disseminated for this purpose, since, as explained by the institution's representative at the event, the reception of complaints about discrimination based on gender identity and sexual orientation in the health area is almost negligible (Gonzalez Guyer, 2015).⁵⁰
 - The systematization of CSLHs identified that there are health needs that are not adequately satisfied yet or are not satisfied at all, highlighting the case of situations of homophobic and transphobic violence at the domestic, community, workplace or school levels, among others. (González and Soto, 2014: 43). A recommendation arising from this weakness is integrating prevention, detection, response to violence based on sexual orientation and gender identity as part of an approach to gender-based violence at the healthcare level. Some of the specific recommendations in the report are that healthcare services managed by specialized staff should be made available for situations of homo/lesbo/transphobia-based violence, and situations of homo/lesbo/transphobia-based violence should be registered and systematized (González and Soto, 2014:63).
 - Continuing to work on improving the legislative framework; although the new laws promoting rights for LGBTI people have come a long way, they still coexist with others that reproduce heteronormative and sexist models, and with gaps or loopholes that may lead to conflicting results (González Guyer, M., 2015; González, 2015). In particular, some difficulties have been identified in the implementation of the rules, as the available enforcement mechanisms that ensure that citizens can enjoy their rights are still fragile (monitoring, accountability, assessment, complaints and reparations) (González and Soto, 2014).

⁵⁰ For a thorough analysis of the anti-discrimination law in Uruguay and the use of complaint mechanisms available for different kinds of discrimination, thematic areas and institutions, see Sempol (2015).

7. Final Thoughts

The prospects are positive. The review conducted in Uruguay reveals that there is a set of favourable conditions for progress towards the design of a national health policy from the gender and sexual diversity and human rights perspective.⁵¹



The progress that is made will depend on the synergy achieved by the stakeholders and the strategies they develop to take advantage of the window of political opportunity that has opened for the formulation of health policies from a human rights and sexual diversity perspective.

⁵¹ The breakfast meeting was attended by the health authorities, Undersecretary of Public Health Cristina Lustemberg, and the President of ASSE, SNIS's main public health provider, and they ratified their willingness to advance this agenda.

8. References: literature reviewed and presentations cited.

Alidadi, F., J. Arias, R. Bintrim, M. Miller, A. La Rotta y A. Tummin (2015). “Índice de Inclusión Social 2015”, en *The Policy Journal for our Hemisphere*, Vol. 9, N°3.

Gainza, P. (2015). Presentación realizada en la Mesa de Apertura del Desayuno de Trabajo “Hacia una política de salud integral, inclusiva y de calidad para las personas LGBTI”. 8 de setiembre de 2015, Montevideo.

González, D. (2015). “Centros de salud libres de homofobia: Experiencia Piloto. Sistematización de la experiencia”. Presentación realizada en el Desayuno de Trabajo “Hacia una política de salud integral, inclusiva y de calidad para las personas LGBTI”. 8 de setiembre de 2015, Montevideo.

González, D. e I. Soto (2014). “Sistematización del proyecto: Centros de Salud Libres de Homofobia - experiencia piloto. Informe final”. UNFPA. Inédito.

González Guyer, M. (2015). Comentarios realizados al Panel de Contribuciones en el marco del Desayuno de Trabajo “Hacia una política de salud integral, inclusiva y de calidad para las personas LGBTI”. 8 de setiembre de 2015, Montevideo.

Forrisi, F. y R. Aguirre (2015). “Los requerimientos de salud de la población LGBT: una respuesta en construcción”. Áreas Programáticas Salud Sexual y Reproductiva y Salud de las Mujeres. Presentación realizada en el Desayuno de Trabajo “Hacia una política de salud integral, inclusiva y de calidad para las personas LGBTI”. 8 de setiembre de 2015, Montevideo.

Freitas de León, P. (2011). *Vestidos en el Aula. Guía educativa sobre diversidad afectivo sexual*. Montevideo: Llamale H.

Johnson, N. y D. Sempol (2015). “Igualdad de género y derechos de la diversidad sexual: avances y rezagos en el gobierno de Mujica”. Instituto de Ciencia Política (en prensa).

Lukomnik, J. (2013). *La identidad de género en las políticas sociales: Informe de monitoreo sobre las políticas de inclusión de la población trans*. Montevideo: Mides.

Lustemberg, C. (2015). Presentación realizada por la Vice-Ministra de Salud Pública en la Mesa de Apertura del Desayuno de Trabajo “Hacia una política de salud integral, inclusiva y de calidad para las personas LGBTI”. 8 de setiembre de 2015, Montevideo.

Márquez, D. (2015). “Atención Integral a las Personas Trans”. Adjunto a la Presidencia de ASSE. Presentación realizada en el Desayuno de Trabajo “Hacia una política de salud integral, inclusiva y de calidad para las personas LGBTI”. 8 de setiembre de 2015, Montevideo.

Mides (2015). *Diversidad sexual y derecho a la salud: El acceso de las personas trans. Documento Base, TRANSFORMA 2015*. Documento en línea, disponible en: http://www.mides.gub.uy/innovaportal/file/57928/1/doc_base_transforma_2015.pdf (accessed 8/10/15).

Mora, L. (2015). Comentarios realizados al Panel de Contribuciones en el marco del Desayuno de Trabajo “Hacia una política de salud integral, inclusiva y de calidad para las personas LGBTI”. 8 de setiembre de 2015, Montevideo.

Muñoz, Susana (2015). Presentación realizada por la Presidenta de la Administración de Servicios Sanitarios del Estado en la Mesa de Apertura del Desayuno de Trabajo “Hacia una política de salud integral, inclusiva

y de calidad para las personas LGBTI”. 8 de setiembre de 2015, Montevideo.

Pautassi, L. (2010). “El aporte del enfoque de Derechos a las políticas sociales. Una breve revisión”. Presentación realizada en el Taller de expertos Protección social, pobreza y enfoque de derechos: vínculos y tensiones. CEPAL- GTZ. Documento en línea, disponible en: http://www.eclac.cl/dds/noticias/paginas/7/37567/LauraPautassi_Derechos_polsoc.pdf (accessed 8/10/15).

Pecheny, M. (2001). “De la “no-discriminación” al “reconocimiento social: Un análisis de la evolución de las demandas políticas de las minorías sexuales en América Latina”. Ponencia presentada en el XXIII Congreso de la Latin American Studies Association, Washington DC, 6-8 de setiembre. Documento en línea, disponible en: <http://www.pseudoghetto.com/PechenyMario.pdf> (accessed 8/10/15).

Rocha Carpiuc, C. (2014). *Diversidad sexual en Uruguay. Las políticas de inclusión social para personas LGBT del Ministerio de Desarrollo Social (2010-2014)*. Montevideo: Mides.

Sempol, D. (Coord); M. Calvo, C. Rocha Carpiuc y M. Schenck (2015). *Corporalidades trans y sistema biomédico: El caso de la Unidad Docente Asistencial del Saint Bois*. Informe del convenio ICP-UdelaR/Mides: Montevideo (en prensa).

Sempol, D. (2015). Presentación realizada en la Mesa de Apertura del Desayuno de Trabajo “Hacia una política de salud integral, inclusiva y de calidad para las personas LGBTI”. 8 de setiembre de 2015, Montevideo.

Sempol, D. (2014). “Jóvenes y trans: posibles líneas de acción para el Plan Nacional de Juventud (2015-2025)”. En INJU *Plan de Acción de Juventudes 2015-2025. Estudios*. Montevideo: Mides.

Sempol, D. (2013). *De los baños a las calles. Historia del movimiento lésbico, gay, trans uruguayo (1984-2013)*. Montevideo: Debate.

Vignolo, J., M. Vacarezza, C. Álvarez y A. Sosa (2011). “Niveles de atención, de prevención y atención primaria de la salud”. *Arch Med Int*, Vol. 33, N° 1, pp. 7-11. http://www.scielo.edu.uy/scielo.php?script=sci_arttext&pid=S1688423X2011000100003&lng=es (accessed 17/9/15).

9. Glossary of Acronyms

- ANEP - National Administration of Public Education
- ANII - National Agency for Research and Innovation
- ASSE - State Health Services Administration
- CONACIDA-MCP - National Committee on AIDS - Country Coordination Mechanism
- CSLH - Homophobia-Free Health Centre
- ECLAC - Regional Conference on Population and Development in Latin America
- EDISA - Diverse Areas for Social Inclusion and Action
- FCM - Family and Community Medicine
- Fmed - Medical School, University of the Republic.
- FUDIS - Uruguayan Federation of Sexual Diversity
- ICESCR - International Covenant on Economic, Social and Cultural Rights
- INDDHH - National Human Rights Institution
- INMUJERES - National Institute for Women, Ministry of Social Development
- LGBTI - Lesbian, gay, bisexual, trans, intersex
- Mides - Ministry of Social Development
- MSM - Men who have sex with men
- MSP - Ministry of Public Health
- MYSU - Women and Health in Uruguay
- NHIS - National Integrated Health System
- OAS - Organization of American States
- PAHO - Pan American Health Organization
- PES - Sex Education Programme
- RAP - Primary Care Network
- UDA - Training and Treatment Unit
- UdelaR - University of the Republic
- UN - United Nations
- UNAIDS - Joint United Nations Programme on HIV/AIDS
- UNDP - United Nations Development Programme
- UNFPA - United Nations Population Fund
- WHO - World Health Organization

APPENDIX

Programme

Breakfast meeting as part of September: Month of Sexual Diversity

Tuesday, September 8, 2015, from 8.45 to 12.00, Balmoral Plaza Hotel - Plaza Cagancha 1126

Towards a policy of comprehensive, inclusive and quality healthcare for the LGBTI community

We seek to generate an intersectoral space for reflection aiming at the effective implementation of comprehensive health policies targeting the LGBTI population from a rights, gender and diversity perspective. The starting point will be the experiences and inputs available from the Ministry of Public Health, ASSE, the Ministry of Social Development, the University of the Republic, Civil Society and UNFPA.

Agenda of the meeting:

- 8.45 am - Welcome Breakfast
- 9.00 am - Opening roundtable: Cristina Lustemberg, Deputy Minister of Public Health; Susana Muniz - President of ASSE; Patricia Gainza, Ministry of Social Development, Valeria Ramos - UNFPA, Diego Sempol - *Ovejas Negras*
- 9.15 am - Panel of contributions: Diana Gonzàlez -Consultant - "Homophobia-Free Health Centres," Daniel Márquez - ASSE «An approach to the comprehensive health of transgender individuals," Ministry of Public Health - "The requirements of LGBT Health: A response under construction."
- 10.00 am - Commentators: Mariana Gonzalez Guyer - Member of the Board of the INDDHH, Luis Mora - Chief of the Gender, Human Rights and Culture Branch - UNFPA - New York.
- 10.30 am - General exchange.
- 12.00 - Closure



The United Nations Population Fund, UNFPA, provides technical and financial support in the areas of population and development, reproductive health and gender, strengthening national capacities for the design and implementation of policies, strategies and programmes.

UNFPA supports countries in using population data for policies and programs to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.



United Nations Population Fund
La Cumparsita 1373 Oficina 803
C.P. 11200, Montevideo, Uruguay
Phone: (598) 2903.69.81
<www.unfpa.org.uy>