SYSTEMATIZATION
OF PILOT EXPERIENCES

HOMOFOBIA FREE
HEALTH CENTERS

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UNFPA
HOMOFOBIA FREE HEALTH CENTERS:
SYSTEMATIZATION OF PILOT EXPERIENCES
The Project “Homophobia Free Health Centers” (Centros de Salud Libres de Homofobia, in Spanish) was implemented by:

- Sexual and Reproductive Health Area of the Ministry of Public Health
- First Level Attention Network of the State Health Services Administration
- Family and Community Medicine Department of the School of Medicine – University of the Republic
- Black Sheep Collective

They were joined for the training strategy by:

- Infectious Diseases Cathedra of Parasitology and Mycology Department of the School of Medicine - University of the Republic
- Gender, Reproductive Health and Sexuality Program of the Health Psychology Institute of the School of Psychology – University of the Republic

The United Nations Population Fund, UNFPA, provided technical and financial support to this project.

Authors of the systematization:
Dra. Diana Gonzalez
Lic. Isabel Soto

People linked to the Project were interviewed as part of the research for this systematization.

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Design: Marcelo Simonetti / JIRAJA Responsiva
Cover illustrations: Willy Terzano
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ACRONYMS

ANII-  Agencia nacional de Investigación e Innovación / National Agnecy for Research and Innovation
ANTTEL-Administración Nacional de Telecomunicaciones /National Administration of Telecommunications
ASSE- Administración de Servicios de Salud del Estado / State Health Services Administration
BPS- Banco de Previsión Social / Bank of Social Security
CE - Council of Europe’s Commissioner for Human Rights
CECAP- Centro de Capacitación y Producción. /Capacitation and Production Center
CEDAW- Committee on the Elimination of Discrimination against Women.
CEPE- Centro Público de Empleo /Public Center of Employment
CRC - UN Committee on the Rights of the Child
EDISA- Espacios Diversos de Inclusión Social y Acción. / Diverse Spaces of Social Inclusion and Action.
ETAF -Equipo Territorial de Atención Familiar / Territorial Team of Family Attention
GC – General Comment
GFATM - Global Fund to fight AIDS, Tuberculosis and Malaria
HCHR - United Nations High Commissioner for Human Rights
HFHC- Centros de Salud Libres de Homofobia / Homophobia Free Health Centers
HIV – Human Immunodeficiency Virus
HPV – Human Papilloma Virus
IACHR- Inter-American Commission on Human Rights
IAHR-Court - Inter-American Court on Human Rights
INAU- Instituto del Niño y el Adolescente del Uruguay / Uruguay’s Institute of the Child and the Adolescent
JUNASA: Junta Nacional de Salud / National Board of Health
LGTB- Lesbian, Gay, Trans and Bisexual.
LGTBI-Lesbian, Gay, Trans, Bisexual and Intersexual.
MEC- Ministerio de Educación y Cultura / Ministry of Education and Culture
MGAP- Ministerio de Ganadería, Agricultura y Pesca /Ministry of Livestock, Agriculture and Fisheries
MIDES- Ministerio de Desarrollo Social / Ministry of Social Development
MSP-Ministerio de Salud Pública/Ministry of Public Health
MTSS- Ministerio de Trabajo y Seguridad Social / Ministry of Work and Social Security
MYSU- Mujer y Salud en Uruguay / Woman and Health in Uruguay
OAS - Organization of American States
OTE- Oficina Territorial / Territorial Office
PAHO - Pan-American Health Organization
PIAS- Plan Integral de Atención de Salud en Uruguay /Integral Plan of Health Attention in Uruguay.
RAP- Red de Atención Primaria / Network of Primary Attention
SH&RHS - Sexual Health and Reproductive Health Services
SR – Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health
SRT- Special Rapporteur on the Question of Torture
SIPIAV- Sistema Integral de Protección a la Infancia y a la Adolescencia contra la Violencia / Integral System of Childhood and Adolescence Protection Against Violence
SNIS - Sistema Nacional Integrado de Salud / National Integrated Health System
SOCAT - Servicio de Orientación y Consulta /Orientation and Consultation Service
STD - Sexually Transmitted Disease
UDA- Unidad Docente Asistencial / Educational Health Care Unit
UdelaR- Universidad de la República / University of the Republic
UNAIDS - Joint United Nations Programme on HIV/AIDS
UNDP - United Nations Development Programme
UNFPA - United Nations Population Fund
YGK –Yogyakarta Principles
1. PRESENTATION

In 2010 the project “Homophobia Free Health Centers” (Centros de Salud Libres de Homofobia, in Spanish) started as a challenge that emerged from the meeting of needs and interests of different actors. This motivated the Colectivo Ovejas Negras (Black Sheep Collective), the Health Services Administration, the Ministry of Public Health, the University of the Republic (UdelaR), and the United Nations Population Fund (UNFPA) to get together to start this experience.

The systematization, as a process, enables to observe and retrieve aspects of a particular journey, to share the analysis with those involved in it, while highlighting key elements and learnings to plan the following steps.

This document, organized in chapters, addresses the conceptual approaches that guided the analysis and the interpretation of the experience, and highlights a special section used for the analysis of the Human Rights and the international standards on the right to health of the LGTBI population, as a forward-planning tool.

The particular context in which the experience is developed is also analyzed, observing some characteristics that have made possible to start a path in the delayed recognition of sexual diversity in the public policies level.

The journey along this experience form the point of view of the different actors involved has enabled us to rebuild the process and collect information while capturing the purpose of the project. This systematization has allowed us to stop at some central aspects that are reflected upon at the end of the document in several axis of analysis that give place to a series of learned lessons.

The last chapter suggests a spectrum of recommendations, at different dimensions and levels that go from the learnings obtained in this pilot project to the references to international standards on human rights.

This systematization was conducted in 2014; this publication was updated with the changes and new actions that occurred in the current year (2015).

The authors of this document want to thank the interviewed persons for the information they provided and to specially thank Florencia Forrisi from Ovejas Negras, Leticia Rieppi from the MSP, Alicia Sosa from ASSE and Alfonso Barragues, Luis Mora, Sonia Heckadon, and Valeria Ramos from UNFPA for their contributions.
2. INTRODUCTION

This document presents the systematization and analysis of the Homophobia Free Health Centers Project, to be used as an input in discussions enabling agreements on future decisions, in accordance with healthcare standards that have an approach based on gender, sexual diversity, and human rights.

To fulfil this objective, the team in charge addressed the guidelines of the calling through the following goals:

- To capture the experience with the potential to illustrate useful models for Uruguay and other countries that are currently working in the development of similar systems and processes;
- To compile the standards used in the design, implementation, and monitoring of the discrimination and homophobia free services, and to review those standards by the light of the regulatory schemes, standards, and principles of human rights.
- To define parameters and criteria to guide in the design and implementation of programs in a bigger scale.
- To offer recommendations to institutionalize standards and interventions regarding discrimination and homolesbotransphobia free health services.

Methodology to the systematization

To accomplish the requested work, a descriptive and analytic-quantitative methodology was used on the process and contents of the Homophobia Free Health Centers Project.

In this work, the experience of formulating, designing, and implementing the Homophobia Free Health Centers Project is described and the process and contents of such experience is analyzed taking into account the international and national standards on human rights.

Previous studies and research work on the project were used as sources of information, as well as the opinion of key participants about the political-strategic element, the management, the academia, and the experience of the users.

Finally, conclusions and recommendations are presented following criteria of relevance, innovation, impact, replicability, and sustainability, while pointing to the results obtained, the main challenges, the success factors, and the learned lessons.
3. ANALYSIS AND DOCUMENTATION CONCEPTUAL FRAMEWORK

3.1 Theoretical perspectives: general reference framework

The theoretical approaches used in this study are that of the rights and that of the gender, with emphasis on sexual diversity.

3.1.1 Rights perspective.

The rights perspective starts by recognizing all people as holders of human rights. This approach results from human rights social movements that demand that the differences are not translated into discrimination, but into a regulation that takes into account human diversity according to age, sex, sexual identity and orientation, ethnic, racial and nationality origin among others.

The regulation resulting from the demands of those social groups, as international instrument of human rights, makes those persons that are being discriminated or in unequal conditions complete holders of rights and as a consequence in the position to demand their enforcement and accountability from the State, which is obliged to adapt with no delay the legal and institutional apparatus.

In the words of the Inter-American Human Rights Court:

“... The due diligence in reference to violations of human rights implies “to organize the governmental apparatus and, in general, all the structures through which public power is exercised, so that they are capable of juridically ensuring the free and full enjoyment of human rights”.

Inter-American Court of Human Rights

According to this approach:

• The main responsibility of the State is to respect, protect and enforce the Human Rights
• The persons, as holders of rights, can demand the full enforcement of their rights.
• The Law is used as a tool to promote equality.
• The international and national Human Rights instruments lay down minimum standards for their enforcement.
• The citizens participation, in advocacy and monitoring actions, is a fundamental component to achieve full effect of the human rights

1 Inter-American Court of Human Rights, Case of Velásquez Rodríguez, Judgment of July 29, 1988, Series C No. 4, paragraph 166
Essential dimensions that have to be incorporated when developing laws with a rights perspective:

<table>
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<th>DIMENSION</th>
<th>WHAT DOES IT IMPLY?</th>
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<tbody>
<tr>
<td>Equality and non-</td>
<td>The State guarantees equality, taking into account the immediate, subjacent, and deep consequences of discrimination based on categories such as gender, sexual orientation, age, disability, or the place of residence.</td>
</tr>
<tr>
<td>discrimination</td>
<td></td>
</tr>
<tr>
<td>Empowering</td>
<td>The laws, programs, plans, and services see their subjects as reflexive ones, with the ability to exert their power. It demands the promotion of public and private spaces to exert citizenship.</td>
</tr>
<tr>
<td>Participation</td>
<td>The community is actively involved in solving its problems. The active, free, and significant participation is the mechanism that strengthens the institutionalism.</td>
</tr>
<tr>
<td>Reporting</td>
<td>The State, as main rights guarantor, implements the evaluation and monitoring mechanisms that are needed to generate an exhaustive report that facilitates enforceability.</td>
</tr>
<tr>
<td>Enforceability</td>
<td>Accessible and transparent mechanisms to demand their enforcement have been created.</td>
</tr>
<tr>
<td>Resources</td>
<td>The distribution of public resources through the budget, social expenses, and fiscal policy generate equality. They show the State's priorities and its commitment to the human rights of the country's inhabitants.</td>
</tr>
</tbody>
</table>

In this approach, the operation and the utilization of the mechanisms of rights’ enforceability acquire greater significance. These mechanisms are essential elements to guarantee compliance with the rights. Among these mechanisms it is included both the system of justice administration and “the administrative processes of decision review and of citizen inspection and control of policies, the spaces for users and consumers to complain, the events of political control in the parliaments, the specialized institutions that protect essential rights (like ombudspersons, consumer and competition protection offices), the possibility for the target people of the policies and social programs to present complaints and seek legal action.” (PAUTASSI, 2010).  

3.1.2 Gender approach.

The gender approach or perspective is an analysis framework that allows identifying, understanding, and explaining the existing inequalities among the persons caused by the prevailing gender system in place.

Analyzing a social problem or a public policy from the gender perspective makes it possible to recognize and make visible the relationships between the existing powers based on the categories “feminine” and “masculine”- and their manifestation as an unequal access to opportunities and rights - in order to promote a favorable transformation towards equality.

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ALESINA and GONZALEZ (2013) highlight that:

- This gender system refers to the set of practices, symbols, stereotypes, tastes, believes, rules, and values that a society develops based on the external genital anatomy, and that give meaning to the personal relationships.
- The gender is made up as a power system that gives structure to the human relationships.
- As long as we are dealing with cultural constructions, all the elements of this system change with time and context, and can be transformed through interventions.
- Women have been discriminated as a result of being identified with the “feminine” category, loaded with values lower in the hierarchy to those in the "masculine" category.
- The dual regulations, supported by the dichotomy female-male stigmatize and discriminates other expressions of the sexuality, therefore discriminating homosexual and transgender people.
- The institutions reproduce the prevailing gender patterns and consolidate the inequalities.

3.1.3 The emphasis on the sexual diversity

The perspective of the sexual diversity enriches the rights and gender approaches, questioning heterosexuality as part of the hegemonic patriarchal imperative. The respect and recognition of the diversity constitute the basis for equality and non-discrimination from a human rights perspective. In the words of Lazzaroto: “It is not about opposing the two areas of struggle: that of the equality and that of the difference, instead it is about knowing that the first one is nothing more than a prerequisite, a sort of ontological plinth for the deployment of the second”.

The different sexual orientations and gender identities show that it is not possible to identify a unique essence of the human sexuality. The sexual orientation refers to the emotional, affective, and physical attraction towards persons of the same sex, different sex, or both; meanwhile, the gender identity refers to the inner self and individual experience of the person, that may or may not correspond to the biological (at birth), registered in the birth certificate, assigned, or other sex.

The meanings assigned to the sexed bodies and the organization of the eroticism are developed by an environment that is determined by multiple factors; therefore they vary substantially from one society to another, as a result of their own historical contexts, which host these processes.

This is about a cultural system that defines heterosexuality as the norm, with the resulting discrimination and undervaluation of other forms of sexual expression. This model and its expression in the area of sexual-

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6 SOTO, Isabel (2011): La sexualidad en clave de género (s), documento elaborado para el curso Género(s), diversidad sexual y salud sexual y reproductiva realizado por el Colegio de las Américas.
ity flows in the form of symbols, regulations, mandates, that promote predominant “central” identities: be it a “feminine sexuality” or a “masculine sexuality”, and it does not consider other expressions that will have to stay in the “periphery” of the “socially accepted”. However, this dichotomy, center-periphery, introduces another side: the homogenization of the sets by installing new assumptions that hide the range of realities. That is to say, several aspects are made invisible, like the very socio-demographic heterogeneity of LGBTI people, and also the diversity in the ways of heterosexual living and the similarities or resemblances that exist between heterosexual people and diversity sectors.7

“There is a big variation in the negotiations that the persons establish with themselves and with the environment according to their sexual orientation, gender identity and expressions, and sexual practices; some of them reject the practices and identities that part from heteronormativity, and experience them in a guilty and shameful way; others partially integrate them but build their identity around a founding secret; and finally, there are those who live with them without major problems.”8

These dissident sexualities are affected by elements that determine their specificity: how visible they are (homosexuality is not always visible, this is not so for the trans gender identity) and the level of rejection by the early social nucleus (family, childhood and adolescence environment, etc.) (Pecheny, 2002).9

According to Pecheny, the lack of visibility of the dissident characteristics enables, mainly gay and lesbian persons, to deal with the information about their sexuality according to their interlocutor and the situation, and therefore represents a protection mechanism that is not present in other sexual diversity realities. To this author, homosexuality constitutes an identity and personal relationships’ founding secret10 from the early stages in the psychosocial development. This secret bears a stress, a fear of rejection and of being under threat of segregation, not just from the surroundings, but from the close and significant ties of his/her personal history; the process of revealing the secret is identified as the “coming out of the closet”.

In this work we follow the below definitions adopted by the IACHR (OAS)11:

**Sexual Orientation**: “(…) each person’s ability to feel a deep emotional, affective and sexual attraction towards persons of a different gender from his/her own, or of the same gender, as well as the ability to have intimate and sexual relations with these persons.”12

**Heterosexuality**: “(…) a person’s ability to feel a deep emotional, affective and sexual attraction towards persons of a gender different from their own and the ability to have intimate and sexual relations with these persons.”13

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8  Ibid
9  PECHENY, Mario (2002). “De la “no discriminación” al “reconocimiento social”. Un análisis de la evolución de las demandas políticas de las minorías sexuales en América Latina”.
10  The word secret comes from the Latin “secretus” that comes from the verb secernere, which means “to put aside”. The Latin verb secernere might be a combination from the Indo-European “se” (means separation and is present in other verbs like separate, segregate, select) and the Latin verb cernere (to analyze, to distinguish). Secernere is not just to put something aside, it is to put it where it does not call the attention or where it can not be distinguished or analyzed. Translated from http://etimologias.dechile.net/
13  COMISION INTERAMERICANA DE DERECHOS HUMANOS (2012) Orientación sexual, identidad de género y expresión de
Homosexuality: “(...) each person’s ability to feel a deep emotional, affective and sexual attraction towards persons of the same gender as his/her own, as well as the ability to have intimate and sexual relations with these persons.”

- Lesbian: a woman whose sexual orientation is homosexual.
- Gay: a male whose sexual orientation is homosexual.

Gender identity: “(...) the inner and individual experience in terms of gender exactly as each person feels it deep inside, that may or may not match the assigned sex at the moment of birth, including the personal experience of the body (that may involve the modification of the aspect or corporal function through medical, surgical, or other methods, as long as the same has been freely chosen) and other gender expressions, including attire, speaking manner and behavior.”

Trans Persons: “This umbrella term – that includes the subcategory transsexuality and other variations- is used to describe the different variations of the gender identity whose common denominator is the non-conformity between person’s biological sex and the gender identity that has traditionally been assigned to it. A trans person can build his/her gender identity regardless of surgical interventions or medical treatments.”

Intersex persons: “all those situations where the sexed body of an individual varies with respect to the feminine or masculine body shape standard culturally current.”

• Intersectionality

It is not possible to understand the barriers to the exercise of the LGTBI population’s rights without considering the hegemony of the heteronormative and the androcentric ways. These discrimination systems, which act simultaneously and jointly with others, bring us nearer to the notion of intersection.

According Muñoz (2011), the intersection is a tool of great theoretical, conceptual and politic use when addressing the multiplicity and simultaneity of determinants that affect the appropriation and exercise of people’s rights.

It is worth adding that this term was coined by the legal expert Kimberlé Williams Crenshaw, Afro-American scholar, in 1995, in her study on the situation of migrant afro-descendent women.

According to Muñoz, the intersectionality is the expression of a “complex system of oppression structures that are multiple and simultaneous”, which refers to situations of “multiple jeopardy” and “interlocking factors of oppression”.

género: algunos términos y estándares relevantes.
14 Ibid
15 Ibid
16 Ibid
18 Also the adultcentrism, the ethnocentrism, and the classism according to Patricia Muñoz (see next citation).
Following these authors’ contributions, it is possible to distinguish between:

- Structural intersectionality: supported by systems of discrimination: gender identity, sexual orientation, age, ethnicity, class, etc.

- Politic intersectionality: it refers to the many points of intersection that create people’s disempowerment situations.

The intersectionality is presented as an alternative model to the «additive» one, which implies considering the discrimination systems as an addition of determinants (e.g., homosexual + afro-descendant + poor); this perspective exposes the risk of fragmenting the understanding and the approach of the situations. The persons with social identities constructed as inferiors by hegemonic power systems experience this identities as a whole. This “multiple subordinated identities”, are faced with higher levels of prejudice and discrimination forms than those who have only one subordinated identity (keeping this in mind, as an example, the differences that exist between the following categories can be analyzed: man-poor, poor woman, poor female transsexual).20

Meanwhile, María Caterina La Barbera points out that the intersectionality focus itself on the indivisibility and multiplicity of each concept: sex, sexual orientation, age, race, ethnicity, culture, religion, educational level, occupation; this categories are always interrelated with the gender in such a way that disconnecting the different discrimination forms is not just absurd but also counterproductive. This author points out that to work from this perspective forces us to search for the obvious and the non-obvious dominance relationships, helping us to be aware that never a form of subordination stays isolated.21

«The way in which I try to understand the interconnection among all the subordination forms is through a method I call “make the other question”. When I see something that seems racist, I ask, where is the patriarchy in this? When I see something that looks sexist, I ask, where is the heterosexism in this? When I see something that seems homophobic, I ask, where are the class interests in this?» 22

20 Ibid
4. HUMAN RIGHTS AND SEXUAL DIVERSITY

There are abundant pronouncements of human rights bodies on the rights of lesbian, gay, trans, bisexual, and intersexual (LGTBI) persons, although there is not yet, at the international or regional level, a convention or a binding treaty that is specific on the subject.

The conceptual and normative bases on which the regulatory legal framework on the sexual and reproductive rights in the international and regional sphere is constructed are established in the V International Conference on Population and Development (Cairo, 1994) and in the IV World Conference on Women (Beijing, 1995). In the Beijing’s Action Platform it is stated: “The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.” This means, according to VILLANUEVA (2006) that “the sexual rights include at least the protection of [gender] identity, sexual orientation, election of sexual partner, and the absence of coercive sexual activity. This way, the non-procreative sexual activity and the non-heterosexual activity are protected, and the sexual violence, genital mutilation, sexual slavery, forced prostitution, and discrimination based on sexual option are banned.”

The “Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity” (YGR) were elaborated years afterwards, in 2007. The human rights (civil, political, economic, social, and cultural rights) are developed in detail from the perspective of the sexual diversity in them. The YGR constitute today a reference tool on the subject for human rights bodies. They were elaborated by a panel of specialists on the application of the Human Rights International Law on the Matter of Sexual Orientation and Gender Identity by request of the United Nations High Commissioner for Human Rights, and they are accepted as international standard by the United Nations System and the Organization of American States (OAS).

The presentation of a sexual orientation based discrimination case to the Inter-American Commission on Human Rights (IACHR) and the Inter-American Court on Human Rights (IAHR-Court), in which the daughters of a woman were separated from her because she was lesbian and was living with her female partner, lead to relevant pronouncements by these bodies in 2010 and 2012.

The Inter-American Commission on Human Rights informed that “(…) Sexual orientation constitutes a fundamental component of the private life of an individual that should be free from arbitrary and abusive interferences by the State, in the absence of weighty and convincing reasons. There is a clear nexus between the sexual orientation and the development of the identity and life plan of an individual, including his or her personality, and relations with other human beings.(…) The Commission reiterates that the right to privacy protects the right to determine one’s own identity and to establish personal and family relations on the basis of that identity, even if it is not accepted or tolerated by a majority within society.”

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25 Ob.cit, párr.95. En forma similar en Programa de Acción del Cairo, art.7.3.
27 INTER-AMERICAN COMMISSION OF HUMAN RIGHTS - Case of Atala Riffo and daughters v. Chile Case 12.502, September 17,2010, paragraphs . 111 and 116
The Inter-American Court on Human Rights issued a pronouncement on this case, regarding sexual orientation: “a person’s sexual orientation is also linked to the notion of freedom and a person’s right to self-determination and to freely choose the options and circumstances that give meaning to his or her existence, in accordance with his or her own choices and convictions” and this implies not just the obligation to respect the sexual orientation in itself “but includes its expression and the ensuing consequences in a person’s life project.” This is the right of the persons to manifest and adopt a way of life according to his/her sexual orientation.

In that judgment the Court comes to the conclusion that “no normative, decision or internal law practice, be it from the state authorities or from particulars, can in any way reduce or restrict, a person’s rights based on his/her sexual orientation”, and that “as regards the prohibition of discrimination based on sexual orientation, any restriction of a right would need to be based on rigorous and weighty reasons. Furthermore, the burden of proof is inverted, which means that it is up to the authority to prove that its decision does not have a discriminatory purpose or effect.”

The IAHR-Court, in its judgment regarding the access to assisted human reproduction techniques (2012) pointed out that “…the right to private life is related to: (i) reproductive autonomy, and (ii) access to reproductive health services, which includes the right to have access to the medical technology necessary to exercise this right” and that “that States are responsible for regulating and overseeing the provision of health services to ensure effective protection of the rights to life and personal integrity.”

The homophobic and transphobic violence is a matter of special concern for the human rights bodies. The OAS General Assembly has repeatedly expressed its condemnation of acts of violence and of violation of human rights committed against people because of their sexual orientation or gender identity. A Special Rapporteur to follow up the rights of this population was created in 2011, and it has produced reports and experts’ meetings to study the subject in deep.

The Special Rapporteur on Women’s Rights of the Inter-American Commission on Human Rights has made pronouncements in thematic reports and in reports to the countries regarding violence against women, especially in reference to the access to justice and their rights in the health sphere.

It points out, regarding the violence in the health context:

“Despite the progress made, the Commission highlights that sexual violence in educational and health-care institutions requires special procedures for filing complaints and investigation; procedures which have not been introduced in most of the countries. Apart from the problems typical of any case involving sexual violence (...) the violence that happens in (...) health-care establishments poses its own unique set of problems. Because educational and health-care institutions are milieus in which the authority wielded by professors and physicians...”

dictates the power relationships between professor and student and physician and patient, special regulations and procedures are needed to deal with violence in these settings; such regulations and procedures must take the gender perspective into account, as well as the particular needs of and dangers to the potential victims. “Given the above provisions, the Commission considers that the States must pursue and promote policies to ensure that women and girls who are victims of sexual violence have some program or service designed to protect them from re-victimization and to help them become fully reintegrated into the community. (…) The services and programs should be age appropriate and cater to the particular needs of each woman and girl, and should feature ways of involving their families and communities in their recovery.”

In the same way, the United Nations have followed very especially this problem, leading to several pronouncements and reports that are systematized in the report “Born Free and Equal” (BFE, 2012), where the position of the diverse Human Rights Bodies regarding the different aspects of the violence against LGTBI persons is expressed.

One of the forms of violence, to which the LGTBI persons have been systematically subjected, is sexual violence. In the inter-American sphere, the Convention of Belem do Pará is a fundamental treaty on violence against women. It recognizes the right of women to a life free of violence and to non-discrimination based on gender patterns that are supported by women’s inferiority and lesser value considerations, and the duty of the States to adopt measures to prevent, protect, punish and repair the violence against women. The sexual violence perpetrated or allowed by state agents is considered a form of torture, cruel, inhuman, and degrading treatment by the IADH-Court and the International Committee against Torture.

The Montevideo Consensus on Population and Development, that results from the First session of the Regional Conference on Population and Development in Latin America and the Caribbean, presents new commitments regarding sexual and reproductive rights of the LGTBI population: to promote policies that contribute to ensure that the persons exercise their sexual rights regarding their sexual orientation and gender identity without coercion, discrimination, or violence, and to eradicate discrimination based on sexual orientation and gender identity in the exercise of the sexual rights and their manifestation.

Finally, it is worth highlighting the recommendations given to Uruguay by the Human Rights Committee, Concluding observations on the fifth periodic report of Uruguay, a follow up of the International Covenant on Civil and Political Rights (2013):

“Although the Committee takes note of the progress made in respect of legislative and regulatory measures relating to the rights of lesbians and gay, bisexual and transgender persons (LGBT), the Committee is concerned by reports from non-governmental organizations which indicate

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34 Ibid, Par.168
35 Ibid, Par. 174
38 Ibid, Forn Free and Equal, page 25 and following ones.
that people are discriminated against on the basis of sexual orientation and gender identity in employment and in other areas. The Committee also wishes to express its consternation at the violent death of at least five transsexual women in 2012 under circumstances that could be regarded as indicative of a pattern of violence based on gender identity (art. 2 para. 1, art. 6 para. 1, art. 7 and art. 26)."

The State party should step up its efforts to combat discrimination against LGBT persons in all areas of life, to offer effective protection to such persons and to ensure that any and all acts of violence motivated by the sexual orientation or gender identity of the victim are investigated and that the perpetrators of such acts are prosecuted and punished. In particular, the State party should:

a) Use all means at its disposal to investigate the murders of transgender persons that occurred during the reporting period, to bring them to trial and to impose appropriate punishments upon them;

b) Introduce a statistical system that will make it possible to compile disaggregated data on this type of violence;

c) Develop awareness-raising programs to combat homophobia and transphobia."

4.1 Human Rights’ International Standards on the LGTBI People’s Right to Health

The right to health is recognized both within the United Nations system and the Organization of American States.

The International Covenant on Economic, Social and Cultural Rights states that “The States Parties (…) recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.,” and includes a series of measures that must be adopted to guarantee it.


“Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being."

Among the measures that the States agree to adopt to ensure that right, the following stand out:

- Primary health care, that is, essential health care made available to all individuals and families in the community;
- Prevention and treatment of endemic, occupational and other diseases;
- Education of the population on the prevention and treatment of health problems, and
- Satisfaction of the health needs of the “highest risk groups and of those whose poverty makes them the most vulnerable.”
Relating to these treaties, general observations, guidelines, and statements have been approved. The treaties have also led to pronouncements by national and international courts. These pronouncements establish today the minimum standards for the State to comply with the Right to Health.

We call “international minimum standards” the basic conditions to comply with the Human Rights accorded in the international and regional bodies. The international standards are not only contained in the binding treaties (ratified by the States) but also in all the general recommendations, observations, resolutions, reports, and jurisprudence of those international and regional bodies.

This is about a doctrinal and jurisprudence construction that, because of the recognition it has attained, is considered a general principle of law, customary international law or authorized doctrine, even if it does not have the binding regulation status but is included in what is called “soft law”. This authorized interpretation, seen by the light of the principle of adopting the interpretation that is most favorable to the human person, must be respected by the States according to the good faith principle when complying with the treaties (Abramovich, 2006).

They are qualified as minimum standards because they reflect the agreements obtained in that area, which do not necessarily match the maximum that is desirable. Each of the countries may have achieved a better standard than the one provided by the international instruments, and this is in fact expected.

Specifically in relationship with the Right to Health, it is fundamental the expansion made by the United Nations Committee on Economic, Social and Cultural Rights through its General Comment No. 14, in 2000 (from now on referred to as GC 14).

GC 14 interprets the Right to Health as an inclusive right that includes timely and appropriate healthcare and the main social elements that determine health, highlighting access to safe and potable water, adequate sanitation, nutrition, housing, healthy environment, and sexual and reproductive health. GC 14 gives special importance to the “participation of the population in all health-related decision-making at the community, national and international levels.”

This Comment raises four elements that make up the Right to Health and interrelate with each other: Availability, Accessibility, Acceptability, and Quality. These elements must be guaranteed, taking especially into account the inequalities in gender and age and also those that affect people with disabilities.
The contents of each of those elements are outlined in the table below:

<table>
<thead>
<tr>
<th>Availability</th>
<th>Accessibility</th>
<th>Acceptability</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>of facilities</td>
<td>to everyone without discrimination</td>
<td>ethically and culturally appropriate</td>
<td>scientifically and medically appropriate</td>
</tr>
<tr>
<td>of goods</td>
<td>physical geographical building accessibility</td>
<td>sensitive to gender and life-cycle</td>
<td>skilled medical personnel and good quality drugs</td>
</tr>
<tr>
<td>of services</td>
<td>economic accessibility (affordability)</td>
<td>respectful of confidentiality</td>
<td>hospital equipment in good conditions and adequate sanitation</td>
</tr>
<tr>
<td></td>
<td>information access</td>
<td>designed to improve the health status of the people</td>
<td></td>
</tr>
</tbody>
</table>

The contents of each of these four elements are developed according to the GC 14 and to a selection of instruments that make specific reference to sexual diversity:

- The Yogyakarta Principles: Principle 10 on the right of every person to be free from torture and from cruel, inhuman or degrading treatment or punishment, Principle 17 on the right to the highest attainable standard of physical and mental health, and Principle 18 on medical abuses. (YGK)
The International Committee on the Rights of the Child’s General Comments (CRC GC):

- CRC GC No. 3 (HIV/AIDS and the Rights of the Child, 2003),
- CRC GC No. 4 (Adolescent health and development in the context of the Convention on the Rights of the Child, 2003),
- CRC GC No. 13 (The right of the child to freedom from all forms of violence, 2011) and
- CRC GC No. 15 (The right of the child to the enjoyment of the highest attainable standard of health, 2013).


- The report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (SR) (A/HRC/14/20, 2010).

- The Reports of the Special Rapporteur on the Question of torture and other cruel, inhuman or degrading treatment or punishment (SRT) (A/56/156, 2001) and A/HRC/22/53, 2013).

- The Pan-American Health Organization (PAHO) report “Por la salud de las personas trans” (“To the Health of Trans People”). Elements to develop the comprehensive care of trans persons and their communities in Latin America and the Caribbean region, 2013.


- The Recommendations of the Council of Europe’s Commissioner for Human Rights (CE), 2009.

Availability

The availability refers to the users having enough diversity and number of goods, facilities, and healthcare services and centers.

Regarding the availability of health services, among the recommendations by the General Comment No. 14 we highlight:

- preventive, curative, and rehabilitative health services,
- prevention and treatment of HIV/AIDS,
- protection from and attention to domestic violence, and
- services to prevent vulnerability of people to trafficking.
The Yogyakarta Principles (YGK) point out the right of LGTBI persons to have available for their use:

- services that are available and without discrimination for all the persons (Principle 18).
- psychological and medical support services for victims of cruel treatment and torture (Principle 10).
- qualified treatment, attention, and support services that do not discriminate those persons that look for body modifications related with gender re-assignation, including psychological support (Principle 18).

The PAHO and the Council of Europe's Commissioner for Human Rights consider, specifically for the trans population, that it is necessary that the health services ensure the following benefits:

- emergency and primary health care friendly to trans persons (PAHO).
- cross-sex hormone therapy (PAHO y CE).
- care to body hair growth (PAHO).
- psychosocial care: management of stress due to belonging to a minority, sexual violence, and addictions (PAHO y CE).
- “sex reassignment” surgery (PAHO, CE) and other surgeries (CE).

According to the previously mentioned PAHO report, the medical specializations that are necessary to address the trans people specific problems are: gynecology, obstetrics, urology, endocrinology, plastic and reconstructive surgery, addictions management, and mental health care (to address the stress caused by belonging to a minority).

In reference to the availability of medications, particular attention should be given to:

- the availability of different birth control methods to select from (the access to contraceptives and other means of maintaining sexual and reproductive health should not be limited).\(^{42}\)
- the possibility of choosing the sex of the professional for the attention on sexual and reproductive health.\(^{43}\)
- those medications necessary for cross-sex hormone treatment.

When considering the facilities, the PAHO report “Por la salud de las personas trans” recommends the use of unisex bathrooms, to ensure the non-discrimination of trans people. It also points to the fact that beds in hospitals are assigned by sex and usually trans people are not received in the hospital rooms that correspond to their gender identity.

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\(^{42}\) Conference on Human Rights (2013). Meeting Human Rights Norms for the Quality of Sexual and Reproductive Health Information and Service.

\(^{43}\) Ibid
Accessibility

The element of accessibility includes:

- **equal and without discrimination** access,
- **economic accessibility** (affordability),
- **physical accessibility** (geographic and to the buildings), and
- **information access**.

The equality and non-discrimination principle is an immediate obligation for the States; it does not admit its progressive implementation. The equality and non-discrimination principle has led to the following recommendations by different instruments and reports in reference to LGTB people:

- To adopt the policies, and programs of education and training, necessary to enable persons working in the healthcare sector to deliver healthcare to all persons, with full respect for each person's sexual orientation and gender identity. (YGR)
- To develop and implement programs to address discrimination and prejudice. (YGR)
- To ensure that all persons have access to healthcare services and to their own medical records, without discrimination on the basis of sexual orientation or gender identity. (YGR)
- To approve trans people friendly guidelines. (OPS)
- To include in the admission form the option "trans person". (OPS)
- To ensure that the persons are named according to their gender identity. (OPS)
- To treat LGTB partners without discrimination, including with regard to recognition as next of kin. (YGR)
- To put into place measures to ensure full respect to the trans identity of people of all ages, including adults and children. (BFE)

The International Committee on the Rights of the Child's General Comments provides specific recommendations for girls, boys, and adolescents:

- To recognize the sexual orientation and gender identity of girls, boys, and adolescents. (GC CRC 4, 3, 13 y 15)
- To ensure the children access to confidential counselling and advice without parental or legal guardian consent, where this is assessed by the professionals working with the child to be in the child's best interests, including HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion. (CRC CG 15)
To ensure sexual and reproductive health education that should include self-awareness and knowledge about the body, including anatomical, physiological and emotional aspects, sexual health and well-being, reproductive health and the prevention of gender-based violence, and responsible sexual behavior. To ensure access to safe abortion and post-abortion care services to sexually active adolescents (GC 15).

Regarding physical accessibility, it must be ensured a reasonable geographic distribution of health care centers, including those where cross-sex hormone therapy and gender-reassignment surgery are provided (CE). As mentioned above, the PAHO report recommends that the facilities have unisex bathrooms.

In connection with economical accessibility, the Rapporteur against Torture states the right of couples of the sexual diversity to have access to social security in equal conditions to those of the other couples. The Yogyakarta Principles expressly mention the right of girls and boys to social security without discrimination on the basis of their sexual orientation or gender identity. The PAHO – following guidelines from the Council of Europe- recommends the coverage of: cross-sex hormone therapy, gender reassignment surgery, skin and body hair treatment, and psychosocial care to remediate the consequences of violence and exclusion. (PAHO and CE).

Both, the Rapporteur on Torture and the PAHO report- also following the Council of Europe guidelines- raise the issue of the need to guarantee the economical accessibility to gender reassignment surgery, suggesting that it should be included in the health insurance plans.

According to the GC 14, the information accessibility includes, as a minimum, education on sexual and reproductive health and family planning and expressly prohibits censoring, withholding or intentionally misrepresenting health-related information.

It must be ensured that the girls, boys, and adolescents access the information on health prevention and that the users participate in the decision making on health issues at the community, national, and international levels.

The reference about the information handling is very important when dealing with the LGTBI population given that, from homolesbotransphobic ideological positions, a link between homosexual orientation, transgender, and sickness has been promoted.

Acceptability

According to GC 14, all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned. The right to control one’s health and body must be guaranteed, including sexual and reproductive freedom and the right to be free from illegal interference, such as the right to be free from torture, humiliation, and never should non-consensual medical treatment and experimentation be enabled.

The reports and instruments analyzed complement the acceptability standards in health care in reference to the LGTBI population with the following recommendations:

- To promote autonomy, decision making in reference to treatment and medical attention, and genuinely informed consent. (YGK)
To ban forced medical interventions. (RT)

To ban forced anal exams. (OPS y RT)

To prohibit aversion therapies44 (NLI, RT)

To forbid pressuring people to conceal, suppress or deny their sexual orientation or gender. (YGK)

To prohibit having a child’s body irreversibly altered by medical procedures in an attempt to impose a gender identity without the full, free and informed consent of the child in accordance with their age. (YGK)

To prohibit the execution of irreversible and unnecessary surgeries in intersex people without the informed consent. (RT)

To prohibit forced psychiatric evaluations. (RT)

To prohibit forced sterilization. (RT)

To prohibit forced abortion. (RT)

To ban female genital mutilation. (RT)

To ban forced institutionalization in health facilities. (RT)

To forbid the denial of VIH care services and forced testing. (RT)

To forbid the requirement of medical procedures, including sex reassignment surgery, sterilization or hormonal therapy as a condition for legal recognition of their gender identity and change of name or to condition it to marriage or parenthood status. (RT, YGK)

To protect boys and girls from medical abuse. (YGK)

The patient’s free and informed consent before the interventions and medical services take place is required in all the standards.

Regarding confidentiality, the Rapporteur on Torture emphasizes that the breach of medical confidentiality must be considered an infraction. The Yogyakarta Principles make reference to the confidentiality of the sexual orientation and gender identity in the medical records, and acknowledge the need to strengthen the confidentiality criteria of those medical records regarding the sexual data.

According to CG 14, acceptable policies and healthcare services take gender into account, including prevention and corrective measures against harmful cultural practices. The Yogyakarta Principles recommend the approval of protocols against harmful medical practices based on sexual orientation or gender identity, derived from cultural stereotypes in order to ensure that sexual diversity is respected in all programs and health, educational, prevention, and care services related to sexual and reproductive health.

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44 The denominated “aversion therapy” by Psychiatry, is a form of behavioral therapy in which, to suppress a non-desirable behavior, a punishment or a stimulus is applied.
**Age** must also be taken into account, ensuring (GC 14):

- A safe environment.
- The option to participate in decision-making and negotiations in health matters.
- Confidentiality and respect to privacy in reference to sexual and reproductive health.
- Confidentiality in reference to sexual orientation and gender identity in the medical records.

The Yogyakarta Principles (YGR)\(^45\) and the International Committee on the Rights of the Child’s General Comments No. 3 and 15\(^46\) are clear regarding the respect and recognition of boys, girls, and their family members’ gender identity and sexual orientation.

### Quality

The quality element indicates that health facilities, goods and services must be scientifically and medically appropriate.

In this respect, both the United Nations report “Born Free and Equal” and the Yogyakarta Principles declare that any medical advice or treatment that implicitly or explicitly considers sexual orientation and gender identity as medical conditions that must be treated, cured, or suppressed must not be applied.

The Rapporteur on Torture and the report “Born Free and Equal” also recommend banning unnecessary surgeries on intersex people and the need to have sensitized medical personnel trained in the prevention of violence against LGTBI people.

### 4.2 National regulatory advances to guarantee the right to health and the specific needs of the LGTBI population

Uruguay has ratified the international human rights conventions, including the International Covenant on Economic, Social and Cultural Rights and –in the Americas sphere- the San Salvador Protocol. The Constitution of the Republic of Uruguay recognizes the rights and guarantees inherent to the human personality (art. 72), that are to be applied, even without a specific regulation that regulates them, resorting to the fundamentals of analogous laws, general principles of the Law, and the generally admitted doctrines (art. 332).

In Article 44, the Constitution, with a clearly tutelary perspective, refers to the Right to Health as a “duty” of all the inhabitants, mandating the State to provide for free the means for health prevention and attention to the people that are “indigent or lacking of sufficient resources”.

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\(^45\) Principle 13, the right to social security and to other social protection measures, lit.b, Principle 15. The right to adequate housing, lit.d, Principle 24, the right to found a family, lit. c y d, Paragraph 8 of CRC GC 3 and paragraph 6 in CRC GC15.
The *Sistema Nacional Integrado de Salud (National Integrated Health System)* was created in 2007, by Law No. 18.211 to guarantee the right to protect the health of all inhabitants of the country. Universal coverage, accessibility and sustainability of the attention, respect to bioethics principles and Human Rights of users, and the social participation of workers and users are among the guiding principles of the System.

The Sistema Nacional Integrado de Salud is organized as networks by levels of attention according to the needs of the users and the complexity of the services offered, prioritizing the first level of attention whose competence is the primary health care services.\(^{47}\)

Law No. 18.335 “Pacientes y Usuarios de los Servicios de Salud” (“Patients and Users of Health Centers”), from August 2008 (and amendments), expressly provide that all the patients or users of health care have the right to an equal and free of discrimination treatment, explicitly mentioning, among other discriminating categories, sex and the “sexual option or orientation”, but not the gender identity.

The principle of confidentiality in the relationship of the doctor towards the patient is not clearly defined in this law except for the confidentiality of the medical records\(^{48}\) or when the patient expressly forbids giving information to his/her relatives about his/her health state.

In the same month, the Law of Habeas Data, Law No. 18.331, is approved. It qualifies the information on sexual health or life as sensitive data, which is specially protected and confidential. No person can be forced to give these data and it can only be subject of treatment with the express written consent of the holder, when there are public interest reasons approved by law, or when the applicant organization has legal mandate to do so. The public or private health care institutions and the health sciences professionals are expressly authorized to collect and use the personal data, physical and mental, of those patients that come to them or that are or have been under their care, observing the principle of professional secret, the specific regulations, and what is established by that law.

- Two months later, in December 2008, the Law on Sexual and Reproductive Health is approved (Law No. 18.426), which establishes that it is the responsibility of the State to guarantee the conditions for the full exercise of the sexual and reproductive rights of the whole population, and in order to achieve this must promote national policies on sexual and reproductive health, design programs, and organize the services to develop them.

- This Law establishes the general and specific objectives of these policies on sexual and reproductive health. Among the first ones are noteworthy:

  - the obligation to establish universal coverage on sexual and reproductive health at the first level of attention, strengthening the services integrity, quality and opportunity with enough infrastructure, human resources skill and compromise, and appropriate information systems;
  - to ensure the benefits quality, confidentiality; and
  - the appropriate education of the health human resources in technical and information aspects as well as in communication and people skills;

\(^{47}\) The second level of attention is constituted by the set of activities for the comprehensive attention of clinical, surgical, or obstetric character, in a regime of short or medium lasting hospitalization, day or chronic hospitalization. It is oriented to satisfy low, medium, or high complexity needs. The third level of attention corresponds to the care of pathologies that require diagnostic and treatment technology highly specialized.

\(^{48}\) According to the law, only those responsible for the medical attention and the administrative staff related to them, the patient or the family, and the Ministry of Public Health (when it considers it appropriate) can have access to the medical records; anybody else would incur in the crime of revelation of professional secret (Criminal Code, Article 302).
• the incorporation of the gender perspective in all actions, ensuring the conditions for the user’s free decision-making.

• Among the specific goals and for the purpose of this work, it is worth highlighting the obligation to offer quality comprehensive attention and timely referral to any age persons that suffer physical, psychological, or sexual violence, as well as the creation of protocols of action for these interventions and their recording in the medical history.

• There is no mention in this Law of the LGTBI persons’ sexual and reproductive rights, or their specific healthcare needs, other than the reference to the incorporation of the gender perspective in the interventions and a general promotion of “the user’s free decision-making” in the general objectives.

• This law’s regulatory decree, Decree No. 293/2010, demands that all health service providers of the integrated health system have sexual and reproductive health services and universal, friendly, inclusive, equalitarian, comprehensive, ethic, multidisciplinary, qualified, and confidential access. This decree makes important progress in reference to the LGTBI population, with explicit reference to sexual diversity, mentioning:
  - trans people (when developing the concept of inclusion),
  - gender identity and sexual orientation as categories especially protected from discrimination,
  - the obligations to take into account the users population needs and expectations including those drawn from sexual orientation and “sexual identity”.

Law Nº 18.620 (October, de 2009) recognizes the right to gender identity, expressly forbidding sexual reassignment surgery as a prerequisite to change the name and sex registered in the birth certificate.

Law No. 19.167 on Assisted Human Reproduction (November, 2013), enables access to this services to homosexual and trans people, although some limitations apply. These techniques can be used on any person as main infertility treatment methodology as long as it is the most suitable medical procedure to conceive “in those couples biologically disabled to do so, and also in the case of “women, independently of their marital status”. It defines infertility as the inability to get pregnant by natural ways after twelve or more months of sexual intercourse. Although it does not explicitly mention homosexual persons or couples, it can be interpreted that all women and males have access to those treatments if they are members of a couple “biologically disabled in procreation”. Surrogacy is also accepted as an exception in the case of the woman “whose uterus cannot carry on a gestation”, so excluding the possibility of surrogacy for male-male couples or feminine trans persons.

It should be mentioned because of its importance, although outside the specific issue of the right to health, that Uruguay approved the Concubinary Union Law that recognizes same-sex couples in 2007, that according to the Law 18.590 of the Childhood and Adolescence Code same-sex couples can adopt children since 2009, and that the Law 19.075 of Equal Marriage (with modifications given by Law 19.119), that enables marriage among same sex people, was enacted in 2013.
Mechanisms of civic participation

The law that creates the Sistema Nacional Integrado de Salud (No.18.211) stipulates that every health care institution must have Department and Local Honorary Advisory Councils that are representative of its staff and users. The role of these Councils is to advise, make proposals, and evaluate in their corresponding jurisdictions, but their reports and proposals are not binding.

The same law creates the Junta Nacional de Salud (National Board of Health) as a decentralized organism, dependent of the Ministry of Public Health, and integrated by representatives from various public organisms, and by workers and users. Its area of responsibility includes ensuring the compliance of the guiding principles of the System.

Mechanisms to fill complaints.

- The national regulations provide different mechanisms to enforce the right to health, both in the institutional environment and in the independent and out of the institution bodies about which a complaint is submitted.

Intra-institutional procedures

The Junta Nacional de Salud, created by Law No. 18.211 has the power to establish a system for the reception of complaints from the users of the Sistema Nacional Integrado de Salud, and mechanisms to solve the disputes between them and the providers.

The Decree No. 395/002 (October, 2002) and the modifications added by Decree No. 15/006 (January, 2006) require the creation, in every health care entity, of User Attention Offices; they determine the process to fill a complaint. The process starts at each health care institution and can lead to the intervention of the Ministry of Public Health and the Honorary Health Commission.

Procedures outside the institution where the infringement of the rights took place.

Because the right to health is a human right, the main complaint mechanism is given by the National Human Rights Institution and Ombudsman Office, a high hierarchy independent organism that operates under the auspices of the National Parliament. It is a collegiate body that has the power to receive complaints and to recommend actions in every area of the human rights, including that of the diversity. There is no special rapporteur on this subject, so the actions that it will advance will depend on the agenda priorities that are established and the complaints that the citizens present.

At the same time, the Commission against Racism, Xenophobia and all other form of Discrimination operates in the Ministry of Education and it has the power to receive complaints from individuals and to carry on investigations and make recommendations to the involved body, and also give recommendations on how to put a complaint in the field of criminal law.
At the judicial level, the infringement of the right to health confers legitimacy for the presentation of appeals for legal protection to speedily protect these rights (Law No. 16.011), as well as for the initiation of the ordinary reparation processes and the criminal proceedings.

Articles 149bis and 149ter of the Criminal Code punish the incitement to hate, the contempt, and the violence against certain people, and they also punish the execution of these acts when the cause is sexual orientation or “sexual” identity among others.
5. SEXUAL DIVERSITY: NOTES ON THE URUGUAYAN CONTEXT

The recognition of the different dimensions included in the construction of democratic life has marked the expansion of the concept of citizenship and the debate on the right to have rights over the last decades. In this framework, the fight against discrimination and violence based on sexual orientation and gender identity has been object of work in the international and regional policies.

In the region, countries like Argentina, Brazil, and Peru were already making inroads into this subject. In Argentina, a summons to LGTB organizations and referents took place in 2010, in the Ministry of Health framework, to identify their needs and the barriers to the integration and the free exercise of sexual and reproductive rights.49 The “Proyecto para la Creación de Servicios para facilitar el Acceso a la Salud Integral y a la Prevención, Diagnóstico y Atención del VIH-SIDA para la Diversidad Sexual” (“Project for the Creation of Services to facilitate the Access to Comprehensive Health, Prevention, Diagnosis and HIV-AIDS for Sexual Diversity”) was started in 2011 as a result of the investigation done in 2010-2011 on the access to health services among people of the sexual diversity. It was coordinated by the Dirección de Sida y ETS (Directorate on AIDS and STD) of the Ministerio de Salud de la Nación (National Ministry of Health) with the technical and financial support from UNDP, UNAIDS, PAHO, and UNFPA and was implemented by five hospitals of this country along with the Provincial Programs on AIDS and one ONG specialized in sexual diversity in each place. Once the program ended, the Ministry continued offering training, support and materials to the hospitals of the country.

In Uruguay, although there is some regulatory and symbolic progress, there is a special concern over the persistence of segregation and homo/lesbophobias in different spheres.

The role of the sexual diversity movement has been a key element in the challenge of the hegemonic place of the heteronormative concept and its acceptance as natural that, together with the sexual diversity invisibilization and silencing, explains a deep inequality and democratic deficit in our society.

5.1 Background of a journey

Law No. 18.426 on the Defense of Sexual and Reproductive Health (2008), its regulation, and the implementation of the Sexual Health and Reproductive Health Services (SH&RHS) constitute a point of inflection towards the universalization and consolidation of the public policies in this field. The establishment of a Work Group on Sexual Diversity in April, 2008, achieves to bring together referents from civic society organizations and state programs. This group has promoted the elaboration of recommendations, documents, and awareness actions among other goals. The proposal to create the Chapter on Sexual Diversity in the Guidelines on Sexual and Reproductive Health was made to the Ministry of Public Health as a product of this collective work, as was the celebration, every September since 2010, of the month of sexual diversity, in the framework of the Montevideo’s 2nd. Plan for Equal Opportunities and Rights Between Women and Men.

At the beginning of the present governmental period, in 2010, the Sexual and Reproductive Program of the Ministry of Public Health presented the Guidelines on Sexual and Reproductive Health prepared by the Ministry of Public Health and the Work Group on Sexual Diversity from the Montevideo Municipality, with the support of the UNFPA. In this context, it is evident the political will to continue and to go in depth in this line of work incorporating the perspective of the Sexual Diversity.

A problem area associated to specific needs, barely or not at all provided in the set of sectorial public policies, is slowly coming into view. The acknowledgment of this reality, along with the sexual diversity inclusion deficit, have started to be reviewed in the last few years, where adding to the regulatory progress some new agendas on health, education, and social development among others are appearing.

It is in this context that the Homophobia Free Health Centers Project emerges, it does so as a consequence of the identification of voids and problem areas that affect LGTB persons; the recognition of these lacks and problems by the health staff, managers, and decision makers motivated the need to review practices and to acquire conceptual and methodological tools to approach them.

It is worth mentioning that, in this scenario of action supported by the international cooperation, the implementation of an initiative supported by the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) was also being developed; we are talking about the Project named: “Hacia la inclusión social y el acceso universal a la prevención y atención integral en VIH/Sida de las poblaciones más vulnerables en Uruguay” (“Towards the social inclusion and the universal Access to prevention and comprehensive attention of HIV/AIDS of the most vulnerable populations in Uruguay”)50, that started its implementation in 2012. This proposal aims its actions towards two target populations

- Transvestite, transgender and transsexual persons, including those who practice sex work.
- Men that have sex with men (gay, homosexual and bisexual persons), including those who practice sex work.
- It is made extensive to the population deprived of liberty.

The two institutions that were responsible for the implementation of this Project were the Ministry of Public Health (MSP, for its acronym in Spanish) as main state recipient and the National Agency for Investigation and Innovation (NAII) as main non state recipient. There were also three sub-recipients from the organized civic society organizations MYSU, Virchou Center, and Latin-American Initiative.

Although both projects focus on the health problems that affect the LGTB population, they differ in their goals, perspectives, and implementation.

### 5.2 Recent studies, progress and paradoxes: what is seen, what is not seen, and what is seen but not recognized.

In general, in our country and the region, the studies on the LGTBI population are scarce and even more so regarding their health situation.

The survey “La población ante el estigma y la discriminación: actitudes y creencias de la población uruguaya hacia la población Trans, hombres que tienen sexo con hombres y personas que viven con VIH” (“The population in the face of stigma and discrimination: attitudes and believes of the Uruguayan population on the trans population, men that have sex with men, and people that live with VIH”, SOSA, 2013)51, made in 2013, points

50 http://www.proyectovihuruguay.org/index.php/proyecto
51 SOSA ONTANEDA, Ana(2013) La población ante el estigma y la discriminación: Actitudes y creencias de la población uruguaya hacia la población Trans, hombres que tienen sexo con hombres y personas que viven con VIH. Análisis de los resultados de la encuesta sobre estigma y discriminación realizada en el marco del Proyecto: “Hacia la inclusión social y el acceso universal a la prevención y atención integral en VIH/SIDA de las poblaciones más vulnerables en Uruguay”; with the financial support of GFATM, ANII
that in our country there is:

- A high level of social recognition of the fact that these populations are vulnerable, given that their basic rights are not respected.

- Regarding the level of rejection, it places the trans population, the men that have sex with men, and the women that have sex with women in the third, fourth, and fifth place respectively.\(^{52}\)

Going on with this study, when it analyzes the situation of the trans persons – that present the highest level of rejection in the LGTB population-, regarding their opportunities in the sphere of health, education, and work, paradoxically discrimination is not registered as a problem:

“(...) regarding the opportunities that trans persons have to get health care, it is observed that to the understanding of 74% of the surveyed people this group has the same opportunities as the rest of the society\(^{53}\)

Another reference in recent studies on the trans population in Uruguay, made by MYSU\(^{54}\), points out that the knowledge about these persons health is based on a theoretical framework on prevention and treatment of sexual infections, particularly HIV/AIDS, probably because of their high incidence in this sector, which has influence in two ways: on one hand it identifies them as transmitters and recipients of transmitted diseases, and on the other it eclipses or minimizes the perception of their integral health needs.

This study contributes references to be considered in the contest of the trans people health, and most of the conclusions can be extended to the entire LGTB population. Among them we highlight:

- The attraction and assistance of LGBTI population sectors by public health care services (the survey is centered on trans people).

- The perception of stigmatization and discrimination by the health staff as a barrier to the access to the services and as a discouraging reason to seek medical advice.

- Risky health practices, especially not using preventive measures and the lack of medical supervision when undergoing procedures to have a body transformation (hormones and industrial silicones). “Those who have Public Health coverage usually do not seek its services when having body feminization treatments. Out of the 71.4% of those who had changes made to their bodies –through the intake of hormones or through surgical interventions- only 15.6% had some kind of medical supervision during or after the interventions.”\(^{55}\)

Among the trans population that practices sex work, the main link with the health system is through the mandatory controls they must have every three months to prevent STD and HIV/AIDS, in compliance with the Ley sobre Trabajo Sexual (Law on Sex Work).

\(^{52}\) In the first place it identifies “drug users” and in the second place “people that perpetrated a crime”

\(^{53}\) Ibid., p. 44

\(^{54}\) LUKOMNIK, Julia y RAMOS, Mauro (2012) Relevamiento de necesidades en personas trans, MYSU. (2012)

\(^{55}\) Ob cit.
There is no data available for Uruguay on the life expectancy of the trans population. Sempol points out that in Latin America it is 35 years “because they are kicked out of their homes at 12 or 13 years old, excluded from the educational and health systems, and forced to practice sex work as the only strategy to survive, and all this exposes them to all kind of social and state violence”.

In a different recent report, “The gender identity in social policies, a monitoring report on the inclusion policies for trans people” (LUKOMNIK, 2013)\(^{56}\), data is contributed about the trans population in Uruguay that uses the Tarjeta Uruguay Social-Trans (Social Uruguay Card-Trans)\(^{57}\). It is a mostly feminine population (97.5\%) and very young: 26\% of this population is between 18 and 29 years old, while 18\% of the total Uruguayan population is included in that age range. Almost half of the trans population (43.6\%) lives in Montevideo. In the rest of the country the departments with more resident trans persons are Canelones (11\%), Salto (5.6\%), San José (5.3\%) and Cerro Largo (5\%). The educational level achieved is typically low, most of them (71.6\%) have not completed the basic cycle. In the general population this value is 51\%. At the same time, the trans population has typically low income: 62.3\% do not get more than 5,000 (five thousand) Uruguayan pesos. 33\% of the trans population lives alone, 21.1\% with one or both parents, 12.6\% with siblings, and 11.35\% with their couple or spouse. The housing difficulties start during the adolescence, during which period, many times, exclusion from their houses takes place.

We include below the trans population “tree of problems”, prepared by Lukomnik, where the transphobic discrimination is the common element to all the subsystems.

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\(^{57}\) The Uruguay Social Card is an unconditional and non-taxable transference for indigent homes and in highly vulnerable to indigence poverty homes that can only be used to buy food, personal hygiene and cleaning products. Starting in 2012 this Card was universally extended to the trans population, that is to say: it is not limited by age, income, or the family group integration.
6. DESCRIPTION OF THE EXPERIENCE: HOMOFOBIA FREE HEALTH CENTERS PROJECT’S ORIGIN, DESIGN, AND IMPLEMENTATION

6.1 Journeys that come together and the origin of the project

The participation of institutions and different groups in this experience was built starting with a chain effect where the experience –like a snowball- gradually incorporated actors interested in the health related problems of the sexual diversity.

Through the stories of the interviewed persons it was observed how, starting at chance situations, key actors were incorporated for the construction of a synergy that moved in two directions: towards the construction of this innovative pilot experience, and towards the inside of their institutional insertion space of belonging.

6.1.1 Involved institutions and actors: the meetings and the expansive wave

The Sexual Diversity Guidelines of the Department of Sexual and Reproductive Health were presented at the beginning of the new national government administration in 2010. From the international cooperation sphere, the UNFPA felt that it was necessary to continue giving support for the incorporation of the sexual diversity in the health policies. Both institutions recognized the possibility of working together to make progress in this subject.

Summoned by a common goal, other institutions were added to develop the pilot Project: the Red de Atención Primaria de la Administración de Servicios de Salud del Estado (Network of Primary Attention of the State Administration of Health Services, RAP-ASSE for its acronym in Spanish), the Colectivo Ovejas Negras (Black Sheep Collective), the School of Medicine, the School of Psychology.

This project, although it is not formally incorporated to the Sistema Nacional Integrado de Salud, it has the political endorsement of the authorities of the health sector.

Different institutional actors participated in this initiative:

a. **Ministry of Public Health** – It participated in the “Homophobia Free Health Centers” Project in its role of governing body on health policies, through the Department of Sexual and Reproductive Health, where the Programa Nacional ITS, VIH/SIDA (STD, HIV/AIDS Program) operates.

   It is important to highlight that the implementation of the law that creates the Sistema Nacional Integrado de Salud lead to the approval of the Plan Integral de Atención de Salud en Uruguay (Comprehensive Plan on Health Attention in Uruguay, PIAS for its acronym in Spanish), in which the national health programs, the goals in health care, and the benefits/services catalog (of low and medium complexity, and of low incidence and high cost) are defined.

   The “Homophobia Free Health Centers” Project started its development at the Department of Sexual and Reproductive Health, where the National STD, VIH/AIDS Program operates.
b. The State Health Services Administration (ASSE) – First Level Attention Network. This Network is ASSE’s executive unit, and it organizes and manages the first level of medical attention in the city of Montevideo since March, 2005. Its mission is to offer comprehensive care in the first level of attention, with a prevention oriented perspective and a stress on health promotion. The health care centers “Ciudad Vieja” (South Region, Metropolitan RAP-ASSE) and the “Barros Blancos” polyclinic (Department of Canelones) are located in this framework.

c. University of the Republic (UdelaR). The UdelaR participated in this Project through two Schools: the School of Medicine and the School of Psychology.

School of Medicine. The participation in this Project of the Department of Family and Community Medicine (DMFC for its acronym in Spanish) was fundamental. This Department was created within the framework of the review and improvement of the education of undergraduates and postgraduates in 2007. Its objective is the education, assistance, outreach, and investigation in the individual, family, and community first level of attention. With its actions it aims to incorporate and strengthen a perspective that is holistic, comprehensive, and in context with the social and community reality, that will also enable it to be included in interdisciplinary and inter-sectorial intervention processes.

The Assistant Professor of the Department of Family and Community Medicine is also the Director of the First Level of Attention Network of Montevideo/ASSE; this situation facilitated the impulse and the articulation of approaches open to the inclusion of the sexual diversity in the education and practices in the first level of healthcare.

When the implementation of the Project had already started, the Cátedra de Enfermedades Infecciosas (Professorship of Infectious Diseases) joined the Project with two of its members, one of which, the Assistant Professor, has a second position where she is in charge of the National STD-VIH Program of the Ministry of Public Health.

The School of Psychology joins the Project to carry out the inter-services course for postgraduates through the Institute of Health Psychology with the “Gender, Reproductive Health, and Sexualities” Program.

d. UNFPA. The United Nations Population Fund in Uruguay works on different strategic lines: gender, sexual and reproductive health, population, and development. In this framework, it offers technical and financial assistance to governmental institutions, and social and academic organizations on different proposals and initiatives, like the “Homophobia Free Health Centers” Project, aiming to further the promotion and the full and responsible exercise of the sexuality in our context.

c. Colectivo Ovejas Negras is a non-governmental organization, established in December, 2004, an advocate for the rights of lesbians, gays, trans and bisexuals in Uruguay. One of its goals is to fight against discrimination and stigma, contributing towards the construction of a society that manages to integrate the sexual diversity as a democratic value. It deals with subjects among which issues related to the health field stand out.

58 http://www.medfamco.fmed.edu.uy/
6.1.2 The athenaeum and the sexual diversity at the “coming out of the closet”

There was an event in this process that worked as a trigger and marked the beginning of the formulation of this experience: it was an athenaeum on a situation that moved the Ciudad Vieja Health Center.

Among the activities that the Department of Family and Community Medicine (DMFC) conducts, monthly athenaeums are organized to discuss issues of interest for the education of postgraduates and resident doctors.

The point where the needs and interests of different actors met was a situation that moved the Ciudad Vieja Health Center and generated an athenaeum to which the Ovejas Negras ONG was invited.

The case seems paradigmatic although the interviewed women were reluctant to relate it, most probably to preserve confidentiality. According to the little data obtained, many discriminations and failings in the system intersected to create the situation. A teenager, mother of a girl, was distanced from the upbringing of the child because she was a lesbian (situation that has a similitude to the one that lead to the IAHR-Court’s sentence against Chile)\(^{59}\). The care of the child was given to the maternal grandmother. To be a woman, teenager, mother, with homosexual sexual orientation brought up one result: the questioning about the convenience for the child to be cared by her mother.

The sense of injustice detonated among the staff of the Health Center and motivated the interest and the need for self-review and to review the practices. The closing of the athenaeum was a moment of opening towards the continuity of a process that had started there. The team of Family and Community residents, with the Colectivo Ovejas Negras, agreed upon the need to expand the view on the approach to the sexual diversity in the health sphere.

“It was there that we started to think with some residents, who were already committed with the subject from before …. with Ovejas Negras, at the end of the athenaeum, that we had to look for strategies to change this reality, that we couldn’t start change from a small group of doctors, that we had to do so from the institutions, extra-university.”

6.2 Project development: a snow ball on the move

All conditions for the Project were given: the actors, the political will, the understanding of the problem’s relevance, an interest to ensure the maximum accessibility to the first level attention services, the availability, an opening to address the problem area, and the skills and interest of Ovejas Negras to join the process.

The search for answers to the detected LGTB population’s needs, and the will to find them in the framework of state programs that were already operating, was the driving force for the activities developed in this Project.

The following picture tries to depict the expansive wave effect that characterized this experience.
6.2.1 HFHC Project’s goals

The general objective of the project was: to jointly create a pilot learning experience by the medical community and the LTGB collective that resulted into the existence of a neighborhood polyclinic that could be characterized as “homophobia free” because of its prime levels of health care to the LGTB community, as well as working system for the posterior extension of the Project both in the levels of intervention as in the education of the health professionals.

The specific Objectives were:

- To train the health workers, community actors, and the Family Medicine residents and their teachers in a First Level Health Center.
- To bring awareness to the surrounding community on the need to use the public services with an attitude of respect towards the diversity.
- To stimulate and facilitate the LGBT population access to the health care services.
To systematize wins and mistakes in such a way that the methodology used in this experience can be duplicated in other health care services both public and private of the country.

To comply with these objectives a Managing Team is established with representatives from the DFMC/UdelaR, RAP/ASSE, MSP, UNFPA, and Ovejas Negras.

6.2.2 Giving a name to the Project

To name the Project implied to agree on the perspective and the identity of the experience. The name Homophobia Free Health Centers intended to make reference to a seal of quality that would credit that the service complies with the conditions of availability, accessibility, acceptability, and quality necessary for the protection of the right to health of the LGTB persons. Similar experiences have taken place in our country, e.g., “hospital amigo del niño” (“child friendly hospital”) when such institution complies with the guidelines that ensure breast feeding in early childhood.

In no case it was intended to transform the Health Center into a center focused on the LGTB Population, but to mainstream into the different services the sexual diversity perspective. The centers were this work took place operated as pilot centers for this training and awareness bringing experience, not as pilot centers for the focused attention of the LGTB population.

However, this name brought confusion according to some of the interviewed persons, who interpreted it as referring to health centers for the exclusive attention of the LGTB population.

Indeed, this project started because of the need to take measures to avoid stigmatization of these persons linking them to STD, HIV/AIDS; the name “Homophobia Free Health Centers” of these healthcare areas could be read as an identification of places established to put distance with and mark as different that population in a discriminatory way.

“I would give it another name, like “Centers open to diversity, whichever the diversity is.”

The tension between making the specific LGBT persons’ health rights and needs visible and including all the diversities is present.

6.2.3 Scenarios: Ciudad Vieja Health Center and Salvador Allende Civic Center (Barros Blancos)

“Ciudad Vieja” Health Center

The Ciudad Vieja Health Center is part of the First Level Attention Network. This Center was selected because it was where the aforementioned athenaeum had been promoted and because it is located in a place in Montevideo that is characterized by its diversity. In the Ciudad Vieja Center there was a “pool of diverse human resources, new people, and people with more years working in the place” and previous experiences working with different population groups: migrants, people with hearing disabilities, different religions, sex workers, Afro-descendants.
To adults, the center offers services in nursing, general medicine, cardiology, nutrition, odontology, gynecology, psychology and social work. A big portion of the consultations are addressed by Family and Community Medicine: pediatric, gynecology, and seniors.

The “Espacio Adolescente” (“Adolescent Space”) operates in the Center. It is specially prepared to address the needs of young people, including psychological, socio-educative, pediatric, nursing, and gynecological attention. The patients do not need to go to different counters to make appointments; instead the appointments are coordinated from the Espacio itself. If urologic, surgical, endocrine, or dermatologic attention is needed, they organize an “inter-consultation” with other services.

The attention and treatments related to sexual and reproductive health in general, including birth control, are among the services offered by the Center.

There is a monthly meeting to do the general coordination where all the operators participate and meetings are also organized in the different Center departments, according to the type of service.

They have implemented a system of “inter-consultation” with specialists who work at the Maciel Hospital: every week the administrative officer meets with her homologous from that hospital and they determine the date for the consultations required for the Center patients on endocrinology, surgery, and psychiatry. The inter consultation on other medical specialties “are included in the agenda”, that is to say, follow the regular process.

The building has ramps to give access to disabled persons and in it “each one uses the bathroom which they feel corresponds to their gender identity”, with no difficult detected in this area; it helps that they are individual bathrooms.

“Salvador Allende” Civic Center - Barros Blancos, Department of Canelones

The expansion of the Project into the Health Center that operates in the Salvador Allende Civic Center (Barros Blancos) followed a geographic and socio economic criterium, with the purpose of systematizing the potential of new challenges.

This Center is one of the Civic Centers in Canelones that constitute “a departmental strategy of the government of Canelones, oriented to the inclusion of the neighbors in multiple programs and services. The approach transcends old welfare policies, as it is centered in the development and promotion of the persons. It is a policy based on rights, with local identity that believes in the comprehensiveness of the local, departmental, and national services.” Canelones has five civic centers located in: Barros Blancos, Colonia Nicolich, Soca, Juanicó y Montes. Several services of the national government and the departmental government operate in the Civic Center.

The following offices and services operate in the Salvador Allende Civic Center:

The Centro de Atención al Ciudadano (Citizen Attention Center), offers personalized attention on questions and procedures related to the Canelones commune, ANTEL, Correo Banc (“Mail Banc”), Mail Post, BPS, AMGAP, MEC, and MTSS.

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61 A hospital that is crossing the street from the Health Center.
62 Annual Work Plan UNFPA 2012. Rev.A
63 Institutional handout.
64 Institutional handout.
The Civic Centers Management Unit.

The “Jóvenes en Red” Program (Young Ones in the Net Program), oriented to adolescents and young adults who are disconnected from the educational system and the formal job market, and belong to homes that are under the line of poverty.

The Library and Digital Room of the Directorate of General Culture.

CECAP, that offers education to adolescents that are outside the educational.

INTERIN Program, a service of interdisciplinary attention to children and families in vulnerable situations that affect socialization and learning processes.

OTE (Oficina Territorial, Territorial Office), constitutes the main door of access to the beneficiaries of MIDES.

SOCAT (Servicio de Orientación y Consulta, Orientation and Consultation Service), offers orientation, information and assessment on social policies actions, services, and resources.

ETAF (Equipo Territorial de Atención Familiar, Territorial Team of Family Attention), operates in the framework of the Cercanías Program (Nearness Program) and develops a comprehensive work in situ for families to guarantee a fast and efficient access to the social basic benefits.

The Centro Público de Empleo (CEPE, Public Center of Employment) facilitates the meeting between job offer and demand.

The Reference Center of INAU.

The City Hall of Barros Blancos

The Dirección General de Desarrollo y Cohesión Social, Promoción y Prevención (General Directorate of Social Development and Cohesion, Health Promotion and Prevention) of the Canelones Commune.

UDA, Unidad Docente Asistencial (Educational Health Care Unit), managed by the UdelaR under agreement with ASSE.

There is an inter-institutional committee at the Civic Center that meets periodically and has a technical secretary.

The UDA is a health care center for ASSE users, managed by Family and Community Medicine, and is part of a network of fifteen UDAS in the first level of attention, eleven of which are in the east region of Canelones. Most of its resources are contributed by the School of Medicine.

The UDA offers services in family medicine, gynecology, pediatrics, nutrition, psychiatry (including treatment), and psychology (crisis diagnostic and treatment).

### 6.2.4 Training and skills building as a strategy

The project aimed to impact – mainly through awareness and skills building actions – in different ways, in different areas and levels (individual and group interviews, workshops, courses) aiming at different actors that come together at the health care system: administration staff, service personnel, technicians, professional staff, doctors, psychologists, social workers, nurses.

The strategy was to start with the skills building of the operators inside the Health Centers as a strategy to review the practices related to the LGTB population.
There is agreement among the interviewed persons on the fact that the Family Medicine residents were a key element in the development of the Project in the centers; they worked like “motor engines” to include the subject in the different actions of the Center, spread the voice on the Project’s activities, coped with the reluctance and encouraged other actors to participate.

6.2.5 Development of the training in Ciudad Vieja

The first year of the pilot experience took place in the “Ciudad Vieja” Health Center; there, with the objective of permeating the personnel perspective, training was implemented as a key strategy, aimed to all the staff in the Center, both technical and administrative. The strategy was to train “the inside of the team” so that it could afterwards replicate knowledge and experience in its users and other teams.

In addition to two workshops targeted to the whole Center staff, fourteen individual or group meetings took place (with different degree of formality-informality), for persons belonging to the different areas of action in the Center: Espacio Asolescente, general medicine, family medicine, gynecology, pharmacy, service staff. Also, operators from the EDISA Center (Espacios Diversos de Inclusión Social y Acción, Diverse Spaces of Social Inclusion and Action, known as “Prophylaxis” Service, the service for HIV and STD detection, prevention, diagnosis, and care) were interviewed.

The police staff was not included in the workshops or the individualized spaces, although many times they are the referents in the waiting room and help people when the influx of persons is high, contributing to make things run more smoothly.

Ovejas Negras was in charge of the training, along with medicine specialists in: endocrinology, gynecology, urology, and proctology (the participation of an Argentinian professional was asked for this component).

Included among the subjects addressed during the trainings were:

- a review of the notions on sexuality,
- tools for the interaction with LGTBI population, to ensure that dialogue is inclusive and not “pushing” (e.g., how to call the trans persons when their gender identity and the name in the medical records do not match),
- information on the most frequent pathologies in this population and the necessary inter-consultations.

There were substantial taboos among the health team members in reference to the LGTB population. Some persons were willing to get information and review their practices during the training; others were reluctant. The interviewed persons think that the most committed team was that of psychology, while the general medicine staff showed very little interest.

The process of training and skill building in Ciudad Vieja culminated with its inauguration as “Homophobia Free Health Center”, meaning this as a “quality seal” in non-discrimination, on June 20, 2012.
**Impact made by the training in Ciudad Vieja.**

The interviewed persons point out that, due to the training:

- They reviewed their ideas on sexuality and sexual diversity, starting important conceptual changes.
- They felt more confident and open to the interaction with this population.
- They were able to incorporate what they learned in the general health control, taking into account the risk factors.

The most highlighted key moment, according to the interviewed persons, was when the Center closed its doors to do the training.

In the Project no monitoring or follow up of its impact on the Health Center was planned or conducted; there is also no registry of the users of the Center. Still, from the interviews, it can be inferred that in the Center today:

- The professionals that usually work with the LGTB population are those from "General Medicine".
- The most common inter-consultations are that with endocrinology, being the resources from Maciel Hospital much valued.
- While this systematization is being conducted, the staff is being trained on the performance of anal-rectal PAP.
- A family doctor that already had two trans patients was added to the medical team.
- The dermatology service is not available anymore because the professional in charge retired.
- A trans adolescent was referred to the Adolescent Space and has already had appointments with the psychologist and a socio-educational agent.
- The hormonal treatment is not performed in the Center.
- No new athenaeums have taken place.
- The Project banners are still in the facility although they are not in use because they need repair.
- The brochures were not enough. There is none at the moment.
- The sexual orientation and gender identity are registered in the medical records, with no unifying criteria. Some people write them down under "sexual history". The name by which the person wants to be called can be specified in the cover, sometimes in brackets, when it does not match the one in the identification card.
6.2.6 Development of the training in Barros Blancos

The training in Barros Blancos started one year after starting the experience in Ciudad Vieja. Ovejas Negras participated here in coordination with Family and Community Medicine and with the support of the UNFPA. The proposal was welcomed because – although they had not recognized the need in the area- they were aware of the importance of integrating the diversity perspective. Given that the Health Center is inside the Civic Center, the decision was made to expand the proposal to the other institutions that are part of the Civic Center. They did not have the posters because those had already been distributed, but they knew their contents so they were still useful as consulting material. The participation was low, except for the workshops on rights that had a big impact in the community.

Impact made by the training in Barros Blancos

The participants highlighted that the training had brought an increased accessibility for the users because it contributed towards a friendlier environment. This experience promoted interdisciplinary work and the acquired knowledge is considered useful to work with the community. In the words of an interviewed person: “It changed my head in the consultation and at the community level”.

During the implementation of the Project, one of the key operators of the experience in Ciudad Vieja (a Family Medicine resident) joined the Barros Blancos team turning out to be a strong asset to develop the Project.

As it happened in the Ciudad Vieja Health Center, no logging, monitoring or evaluations of changes were conducted in the Barros Blancos Health Center after the training.

TRAINING ACTIVITIES IN THE SALVADOR ALLENDE CIVIC CENTER – BARROS BLANCOS.

a. Awareness meeting with the Director, the Family Medicine resident, and other Family Doctors: 1 meeting.

b. Workshop aimed at the whole Civic Center: 10/4/2012.
Participants: Citizen Attention Center, CECAP, and SOCAT.

c. Training for residents and nurses on hormone therapy, specific care, anal health.

d. Series of Workshops – For the whole Civic Center and the neighbours of Barros Blancos. Weekly workshops on the LGTB persons rights. August-September 2012.

e. Meeting with SOCAT and INTERÍN: November 14, 2012
This training was offered by Family Medicine and Ovejas Negras.

f. Meeting with the Citizen Attention Center – 12/5/2012


g. Meetings/workshops with polyclinics surrounding Barros Blancos:
   Talar de Pando, 7/31/2013. With family doctors and local agents.
   Pinar Norte, 7/22/13. With family doctor and resident doctor.
   Paso Escobar 7/24/2012.”Policlínica Entretodos”. Meeting with the family doctor and the graduated nurse.
From the interviews it is inferred that:

- Users with many violence situations come to the Center. The Center coordinates its work with SI-PIAV and with the community police.
- They have little trans population but those that come say they have had bad experiences with the health system previously.
- Trans persons interested in cross-sex hormone therapy are given orientation on it and the best ways to use it.
- To this end, they inter-consult with a UDA from Montevideo, located in the Saint Bois Hospital, specifically with coworkers from Family Medicine, from whom they are also getting training to perform anal-rectal PAP. A night polyclinic was opened at the Saint Bois Center that led to more trans persons consulting and resulted in the organization of an athenaeum on a specific situation related to sexual diversity.
- They are planning to get training in hormone administration to avoid inter-consultation with professionals from other services, without losing the supervision.
- The body hair treatment for feminine trans persons is not addressed in this Health Center, and regarding sex reassignment surgery they inform the interested persons the difficulties they entail.
- The MIDES office in Pando, which is a more populated city with more services than Barros Blancos, has coordinated some situations with the Center.
- They have given health care to gay and lesbian adolescents. They have not had intersex patients.
- The access of teachers has been facilitated thanks to the coordination made by a member of Ovejas Negras who is a teacher in a local educational center.
- After the training, the Health Center is becoming a reference consulting service for other services. The health care team has periodic meetings to discuss clinical cases but none of them have been related to LGTB persons.
- They include the issues related to gender identity and sexual orientation in the medical records.
- They call the persons by the name they want to use, even if it is not the same as the one in the identification document; this practice is applied to all persons in Family Medicine.

### 6.2.7 Services to provide for the specific health needs of trans people.

The LGTB population uses the general services that are offered by the Health Centers that participated in the pilot experience. Some of the specific health needs are covered in the general framework of the services (e.g., STDs, breast cancer, cervix cancer and, soon to be available, prevention of anal cancer). There are other needs for which the coverage is insufficient or inexistent; that's the case of homophobic and transphobic violence situations both in the domestic context and in the community, working, educational, and other contexts.
The brochures created in the framework of the Project highlight the domestic violence problem area within the specific attention needs of gay, lesbians, and trans persons, but re-direct the search for answers to other institutions that are not part of the health system.

In this area, the spreading of the information on the services that exist in the framework of the Ministry of Social Development and the City Hall is still very scarce and it is aimed at lesbian and trans women while the male gays do not have this kind of services available for themselves.

According to the interviews, the specific requirements of the trans users for the adjustment of their body image are still insufficiently met.

The main difficulties pointed out are:

• **Cross-sex hormone therapy.**

It is essential to offer cross-sex hormone therapy to avoid self-administration without the necessary professional supervision:

“The population finds out about the use of hormones and sometimes they resort to veterinary drugs, they use the veterinarians’ hormones, they cause terrible damage, there is nowhere to go.”

However, the cross-sex hormone therapy and the corresponding medication are not included in the mandatory basic services:

“Some mutual health associations offer it, others don’t, it depends of the technical guidelines; they are not in the Ministry’s basic drug basket. It is not a treatment for an illness, it’s a cross-sex hormone treatment and it is not in the guidelines the Ministry asks for the baskets. It is not among the mandatory benefits. Some authorize them for me, others do not… It is not a cheap drug but it is not that expensive either.”

It is not a service all endocrinologists undertake, on the contrary, it is exceptional for them to do so:

“Any endocrinologist can do it. If you have doubts, you get the book, there are guidelines, I didn’t do any post-graduation course, it is basic level; any endocrinologist can do it.” “No, most of the endocrinologists don’t want to be in charge, I have patients that go the mutual association, I send them there with a letter asking for the tests and then they bring the results to me and I adjust the doses. Then they do the prescription, I control the patients for them, they do not want to be in charge, if they can avoid it, they do.”

The cross-sex hormone therapy could be provided by the general doctors:

“The general doctors could but they must have the guidelines, the subject is not such a mystery but they must understand the information, which hormones to provide. Some people don’t want to, they are not interested, but there are general doctors that agree that it is not so complicated.”

65 In May 2015, the President of the State Health Services Administration (ASSE) publicly announced that trans people would have access to hormone therapy in primary care. While it is not a mandatory provision for the whole National Health System, ASSE has since been implementing a specific pilot program in Pereira Rosell, Maciel and Saint Bois Hospitals.
Attention is drawn by the fact that even though this treatment is considered a health necessity, the operator can avoid treating the user, showing an acceptance of this attitude as normal. They link it with:

- lack of information on how to provide the treatment (although all the interviewed doctors agree that it is not difficult and that some basic information that is found in easy to get text books is enough) and

- the “rejection” directed towards this population:

> “There is rejection, it is a demanding population, difficult, many times they overwhelm you during the consultation… Difficult patients are avoided. There are people that do not avoid them, they do it.” “Most of them have big problems, it is like having a monster in the house, it must not be easy for the family, there are some people that cannot process it, it is like having a child, loose it and have another. They tell you everything in the consultation: the family problem, the environment, the neighborhood. There is an opening but a lot is missing. Homosexuality is more accepted, but the trans issue is worst. I would need a social worker too”

- the lack of guidelines from the Ministry of Health:

> “The main difficulty is that the Ministry doesn’t have a policy on this, then it does not give guidelines to the health care givers, (…) between the expenses it has and the prejudices, all is left is good will and craftsmanship. (…) More has to be seen about this population, a survey, how many need hormone therapy, etc. The Project has to include the medication, it has to be complemented, or else they leave.”

- **Psychosocial attention of the violence based in transphobia.** - The psychosocial attention coverage in the first level of attention does not cover the psychological treatment. If it is needed, they do inter-consultations, but sometimes it is difficult to find the right person because there are not many professionals that know the subject.

> “First they are rejected as women, but they are the ones with more incidence in gender violence, because their partners are the ones that hit more. On one hand they do not accept them, but they have the worst part of all worlds.”

- **Body hair care.** The interviewed persons did not have information on this aspect. We do not know if the service has not been asked for (because the users do not consider it an solution that has to be given by the health system) or if they have easy access to another type of solution to the problem.

- **Sex reassignment surgery.** -The procedures known as “sex reassignment surgeries” are not performed in Uruguay. There was a service from UdelaR that worked in the Clínicas Hospital till recently, but is has closed.

> “There is very little experience here, you must go train outside (…) These surgeries require lots of training, they have to go to get training. It is a mutilation and the result is not good feminine genitalia and the excitable tissues are affected.”

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66 Pereira Rossell Hospital started to perform surgery to male trans people in its first stage (genital surgery comprising hysterectomy with oophorectomy) in 2015. Mastectomy and breast implants for male and female trans people respectively have also been conducted. The Hospital is now coordinating orchiectomy for trans women.
“It is a whole issue that is not set at the legal level; it is not among the basic services…”

It is raised as a subject on which the State has to pronounce itself:

“More in the medium term, the next challenge for the next government and the Ministry is sex reassignment, because it is pending, it is not an aesthetic issue, it is a health issue and the PAHO and the WHO gave specific guidelines on this. The State has to address it.”

6.2.8 New demands

After this experience, new requests for training activities in different points of the country were made. Many of them were answered within the Project’s framework and others outside it. An “expanding wave effect” was observed.

Workshops were held as part of the activities of the Project at:

- The Clínicas Hospital, in conjunction with Medical Psychology, for psychologists, psychiatrists, and residents.
- The Hospital de Mujeres (Women’s Hospital, that operates inside Pereira Rossell Hospital), for medicine students and midwives, with the participation of the ONG “Iniciativas Sanitarias” (Health Initiatives ONG) in a teaching role.

During the interviews the fact that the students from the School of Midwives have classes on sexual education stood out; this facilitated the acquirement of new concepts on the subject: “it could be seen that the midwives know in general more (about sexuality)(…)” “There they were with (…) who is a sexual educator. She offers a course for midwives.”

The workshops organized outside the framework of the Project took place in Artigas, Salto, Florida, and Canelones. Also all residents and postgraduates of Family Medicine had an awareness activity on the subject. It is expected that it will be possible to have a workshop in each one of the regions ASSE has in the country.

It is worth adding that some of the teachers that participated in the experience were part of different health centers, both in the public and the private areas, facilitating the expansive wave effect that characterized this Project.

6.2.9 Courses developed in the framework of the Universidad de la República (UdelaR)

Course for graduates: “Health and Sexual Diversity”

The Sectorial Commission for Education of UdelaR made a summons to finance proposals for courses for graduates in 2013. The course “Health and Sexual Diversity” was presented in this framework as an initiative interservices between the School of Medicine and the School of Psychology that had the support and participation of Ovejas Negras and UNFPA. This inter-Schools course, first in the subject, is a chain effect fruit of this Project.

67 See Annex
68 Although it is a minimum financing for a course with these characteristics (300 USD, three hundred dollars of the United States of America), the legitimacy that it conferred to the course in the academic context was appreciated.
The coordinating team of the experience, together with referents from the two mentioned Schools, agreed on objectives, contents, methodology, participant’s profile, and the interdisciplinary and inter-institutional team of teachers. The seminar completed 28 in-classroom hours distributed in 7 modules; there were 30 enrolled persons of which 22 completed their training when presenting a final work articulating what was learned.

The summons was aimed at professionals with insertion in the Sistema Nacional Integrado de Salud and postgraduate students related to the sector.

The group formed, was mostly integrated by women and psychologists; among the students there were 2 health professionals from the LGBT collective that contributed with insight and experiences highly valued by participants and teachers.

“The fact that there was a trans was interesting because she contributed from her experience. She is a nurse and pointed out, for example: it’s hard for me to get the people to believe I am a nurse, people is surprised, because it is immediately linked to something related to the sexual issue. She said, for example, what happens when you go looking for a job, or when you are working at a store, when a man comes near you or you go near a man?, all the persons around you imagine that that situation has something sexual to it, no contact between a female trans and a male is thought without some intention or search for sexual contact. And what do men do? They avoid you to avoid that comment. The night shelters that, the daylight doesn’t.”

The closing of the service that provided sex reassignment surgery in the Clínicas Hospital was a recurring theme in the course. Many questions and deep critiques were made on the practices implemented there; however, since its closing no new alternatives have come up.

The contagious synergy that accompanied this experience seemed to reach some students who expressed their interest in putting to practice some ideas that came up in the course, along with other students.

“The course was thought as a political-not academic space, that is why there were people from the health area, the idea was to generate critic mass inside the health system to modify practices there and that the people would move to do things to change practices in the health system or in health areas. That was the politic intention of those who thought the course and it was made explicit along the course, here the idea is that you can modify practices.”

The course was evaluated both by the teaching and coordinating team and the participants. In the following table strengths and weaknesses are mentioned as well as some recommendations.
**Evaluation from the teaching team perspective:**

### Pointed out strengths:
- Los workshops conducted in the Health Centers allowed to think the contents of the course based on the experience.
- The teachers talked about what they knew because they had lived it, they brought examples.
- The use of materials (videos) and other group devices got a very good evaluation.
- A doctor who works in the School of Medicine, in the ethics area, participated and he said he was planning to incorporate this perspective there. “That is a political effect, that already changes something”, commented an interviewed person.
- Some teachers participated in a double role: both as students and as teachers.

### Weaknesses:
- More support and prioritization of these subjects is needed in the framework of undergraduate and postgraduate level courses.
- More articulation of the contents is needed so as to be able to perfect and articulate reference conceptual frameworks (medicine and psychology).
- More meetings among the teaching team were needed. We did not have a general teachers meeting. We couldn't have it.
- Very few resources, lots of voluntary work. Advantage: there is a social commitment in what is being done but it has the disadvantage of being done in ‘your free time’.

### Recommendations:
- From the pedagogical point of view, it would be better to distribute the course over more time to facilitate group consolidation.
- It would be important to consider the possibility of integrating other Schools, like for example the School of Odontontology: “sometimes with sexual diversity, it happened regarding HIV with a dentist, there are things to work with them”.
- It is necessary that all the involved professionals know about the subject, like for example they must know the disease indicators. There are some things everybody has to know, and in that the psychologists must update themselves…”.
- It is recommended to address the subjects of gender violence, human trafficking, and senior trans.
- It is suggested to rotate the hosting location of the course. This first course was conducted in the School of Psychology and it attracted more psychologists than doctors.
### Evaluations from the students’ perspective

- Meeting of the course goals: a clear majority of the students indicated a total compliance with the suggested goals (90%), while for the others it was “partial”.

- Meeting of the expectations: 90% of the students pointed they were accomplished and in two cases they expressed the results were over the expectations.

- About findings of the course:

  Valuated as very positive:
  - The interdisciplinary contributions: The medical approach for the psychologists and the psychological approach for the doctors.
  - Up to date information.
  - Getting to know more about the LGTBI population reality.
  - The “from experience” character of the proposal.
  - The myths and prejudices review.

- Among the subjects the students are interested in studying more in depth or incorporating in future editions are: cross-sex hormonal therapy, clinical cases, more bibliography, elaboration on different ages (childhood, adolescence, seniors), LGBTI population’s experiences.

- Most of the evaluations highlighted the personal impact of this formative experience, broadening their insight and perspective on the subject and the incorporation of these in their practices. In some cases they made explicit the importance of passing on this knowledge. Some of them mentioned they had shared the experience with coworkers and pointed out that there is reluctance to include these perspectives in their institutions.

**Suggestions from the participants:**
- To include trans teachers.
- More bibliography and citation of sources in the materials.
- A deeper analysis of the trans people problematic.
It is important to highlight that the courses had continuity with similar characteristics in 2014, and a specific training for ASSE staff of First Level Attention in the Northern Region of the country in semi-presential distance learning mode was carried out in 2015. At the same time in 2014, the same project team developed the first medical school elective health and sexual diversity course for advanced students. In 2015 this course was offered again, this time integrating students from the Schools of Medicine, Psychology, Social Work, and Midwifery and also including eight graduates from Family and Community Medicine and Gynecology. In this case, the interdisciplinary nature of the event, consequence of the diverse students and teachers’ backgrounds, as well as the exchange between students and graduates, were highly appreciated by all those involved.

Impact made by the training in the framework of UdelaR

- According to the interviewed persons it is necessary to include the subject of “the sexuality” in the Medicine program. “The new plan incorporates more on it, but it is not enough. Not even specializations like gynecology have enough, although they have the Chair of Sexual Medicine; it is a must and the sexual diversity is not addressed.”

- Regarding the audiovisual material, the interviewed persons pointed out that they were excellent educational material; their contents enabled them to recognize day to day attitudes and practices that are sensitive to the sexual diversity. The videos turned out to be an excellent material. Some participants raised their concern on having offered health care to LGBT persons without being able to “see” them. This shows the identification difficulties.

- The training process contributed with the revision of myths and prejudices that operate in the day to day health practices. Below, some testimonies from the participants state their observations:
  - “It brings that: Wow! How many times I made a mistake based on the persons’ aspect, assuming the person was heterosexual”.
  - “What Ovejas proposes is that when you get out of the closet it is not only once, you get out of it again and again. When you go to the doctor you know you have to explain that you are not heterosexual; some people do this, others think: stop, this way is harder”.
  - “Patients lie, it is not our fault”, the patients hide information and they do not tell us. The videos help to work on all this as myths”.
  - It is in the “debt column” of the psychological consultation. The subject of the diverse heterosexual (the one that does not have a typical sex life) is also addressed.

- The project contributed toward the University on how to work on and incorporate this subject.

- The repetition of the course on the following year (2014). To accomplish this, new methodology was incorporated with emphasis in role playing, the teaching team was expanded and also the contents was expanded to include new issues like the right to assisted human reproduction.

- The inclusion of the subject as an elective course in the School of Medicine in 2014.

- Beyond this project, core and elective courses that address gender, sexuality, and sexual diversity issues were included in the new curriculum of the School of Psychology.

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See Annexus

See Annexus

It is to this second course that 30 professionals from different medical specializations.
6.2.10 The Resources

**Teaching resources: the videos**

Videos were made as a teaching resource for the trainings. Their production had not been foreseen in the initial proposal. They come up as a consequence of the positive impact the real situation representations had had on the first workshop at the Ciudad Vieja Health Center. The Ovejas Negras referents and the Family Medicine residents had used the role playing technic in reference to interviews with doctors in which it was made evident the acceptance of the heteronormative as normal and the damages this can bring to the patients.

"We made the videos during the trainings. When we did the training we saw the need to have a record, something more tangible that would make an impact on the people so that they could see and realize that they needed to know more about these realities to change their work ways."

The videos were named “What’s the difference?” They present situations in which doctors interview a gay person, a lesbian person, and a trans person. An example in which the gender perspective is not acknowledged and one in which it is taken into account are contrasted in each case. The differences in the resulting communication with the user, the quality of the attention, and the better chances to prevent health risks are evinced here.

**Outreach resources: the banners and triptychs**

The banners were prepared to be placed in waiting rooms, in order to create a friendly and inclusive space.

The triptychs give information on:

- Especially important health issues; they urge the reader “to discuss them with the health team”.
- The existence of a free telephone number for consultation and complaints.
- The damage caused by the “conversion therapies”.
- The existence of a Homophobia Free Health Center (with a blank space to identify it)

The health issues addressed are different according to the targeted population: trans, gays, or lesbians. The triptychs for the last two groups are also aimed at bisexual persons. They include information on the importance of making the sexual orientation and gender identity clear in the consultation to ensure a better health care, and information on safe sex, domestic violence, and mental health (in reference to the damages caused by discrimination).

They also address specific issues that depend on whether they are aimed at gays, lesbians, or trans:

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74 Available at: https://www.youtube.com/user/UNFPAenUruguay
75 See Annex
76 The conversion therapy, also known as reparation therapy or sexual reorientation therapy, is a psychological treatment (sometimes with religious components) that promises to change an homosexual person into an heterosexual one. The professionals that practice this therapy argue that homosexuality is a disease or mental pathology and that as such can be “healed” with different practices such as behavioral modification, suppression of desires, psychoanalysis, and religious advice.
For gays: they make specific reference to hepatitis and to testicle, prostate, colon, and anal cancer.

For lesbians: they make specific reference to cervical and breast cancer.

For trans: they stress the access to health and the right to dress and behave according with the identity; there is information on the risks of using hormones without medical control, and the risk of using injectable silicon. They contain information on cancer prevention (for both female and male trans) and about healthy habits, smoking, alcohol, and drugs.

Sentences intended to challenge heterosexist stereotypes in the practice of sexual and reproductive health care are added at the back of the triptych:

• “Finally a handout that does not explain me how to use a preservative” (in the triptych aimed at lesbians).

• “Finally a handout that does not assume that if I am a male I do not go to the gynecologist” and “Finally a handout that does not order me to have a PAP done because I am a woman” (in the triptych for trans.)

• “At last a handout that does not speak only about the risk of contracting VIH” (in the triptych aimed at gays).

The training and the informational material were complemented with:

• A survey of the area to detect potential users.

• Public information activities on the existence of services committed with the subject (radio and television interviews, broadcast of the video on the social networks).
**Academic resources**

An academic material was prepared for the university environment: “Comprehensive approach to lesbian, gay, bisexual, and trans persons”. It will be introduced as a chapter in the book of the Department of Family and Community Medicine.

Its main contents are:

- Respect and inclusion of the sexual diversity in the Health Centers.
- Specific aspects to be considered in the interview.
- Homoparental families.

At this time (2015), the team is working on a publication that includes all the contents addressed in the courses of the University within the framework of this project. This will be an important tool to support training in this field. It will be published in November 2015.

**6.2.11 South – South Cooperation**

In the framework of the Project, South – South Cooperation Activities with Argentina and Perú were carried out. Cooperation with Argentina consisted in exchange activities held in the city of Buenos Aires to make advances in inclusive health policies in Uruguay and Argentina. The coordination for this was made by UNFPA country offices. In the same year, other activities were conducted with the Peruvian Organization PROMSEX, which has developed, in the last 5 years, an advocacy strategy to promote, improve and change regulatory frameworks and public policy. Beyond the present project, exchange activities on health and sexual diversity were developed within the framework of South-South cooperation between Uruguay and Cuba in 2014 and 2015.

Some of the training actions started by this project, as well as the initiatives for exchange and search of answers in the health centers, are still taking place with different degrees of intensity and coverage as far as the date of this systematization.
7. ANALISIS OF THE EXPERIENCE

7.1 Analysis of the process that lead to the development of the inter-sectorial project

- State’s obligations and commitments in the area of Human Rights and the mechanisms to put them in practice in the health area

Uruguay has a rich regulation with constitutional, legal, and regulatory status that rules the right to health of its inhabitants. There is important progress in the LGBT persons health care needs, specially through the regulation of the law on sexual and reproductive health and the Chapter on Sexual Diversity of the Ministry of Public Health’s Guidelines on Sexual and Reproductive Health.

It is still pending the elaboration of protocols on the basic quality conditions that a “Homophobia Free Health Center” must comply with, especially in reference to:

- The availability of services (e.g., health care to victims of homolesbotransphobia based violence, cross-sex hormone therapy) and the corresponding medications.
- How to log the sexual orientation and the gender identity in the medical records in such a way that it guarantees the appropriate information without a breech in confidentiality.
- The rights of trans people regarding the use of bathrooms in the health facilities.

There are no laws or regulations to rule in the health system as a whole on:

- The minimum services that can be demanded from any health provider, including health care for the consequences of homolesbotransphobia based violence, cross-sex hormone therapy, body hair care, and sex reassignment surgery.
- The handling of the sexual data in the medical records ensuring its recording in a way that is respectful to diversity.
- How to assign hospital beds in accordance with gender identity.
- Health interventions in reference to intersexual persons.

- Participation and inclusion in the design, implementation, monitoring of programs and services of the traditionally excluded groups, with emphasis on empowering these groups

The Project is innovative because it is jointly designed and implemented with a non-governmental organization of activists for the sexual diversity rights. This is a very successful experience in terms of the chances of incidence of the diversity groups and of dialogue with the state actors.

The monitoring took place informally, facilitated by the fact that the governmental organization had a direct participation in the implementation of the Project. A mechanism to guarantee the consultation and the participation of the target group of each particular health policy must be institutionalized to ensure that they happen in the short, middle, and long term policies.
Although the Project was sustained—successfully—by the co-participation of referents from different spheres (state, academy, and a non-governmental organization of persons of the diversity), no mechanism has been foreseen to ensure the continuity of their participation or that of other interested groups of users.

- Establishing mechanisms to report and monitor, with emphasis on easy access, independence, and efficiency of these mechanisms.

The HFHC Project is under the sphere of the ASSE Health Centers which has general reporting and monitoring mechanisms. No specific measures were adopted to ensure their adequacy to the objectives of the Project, mainly:

- the early detection of discriminatory practices that could hinder the LGTB persons access to health care.
- friendly ways for LGTB users to present opinions, needs, or complaints.  

The lack of a register of the performed consultations and interventions performed by the Homophobia Free Health Centers is a deficit in the implementation of the Project. A register of violence situations against the LGTB population has not been implemented either.

7.2. Analysis of the mainstreaming of the experience in the Homophobia Free Health Centers by the light of the rights standards.

- Analysis of the standards generated to secure the discrimination free and homolesbotransphobia free availability, accessibility, acceptability (including the gender belonging or claim), and quality of the services, information, and health goods.

The offered training and the outreach materials gave strength to:

- the accessibility of the services, ensures the good treatment of the users and prevents discriminatory behaviors.
- the accessibility and availability in terms of the use of the facilities in a non-discriminatory way (e.g. unisex bathrooms).
- the accesses to information, given that the knowledge can be transmitted and materials have been designed (videos, triptychs, posters, banners).
- the quality of the services from the medical and scientific point of view, regarding the persons that were trained, they have better information on risk detection, early diagnostic, prevention of diseases that this population has more chances of contracting, cross-sex hormone therapy, how to perform exams like the anal PAP.

77 In the study on “Estigma y discriminación sobre personas viviendo con VIH” by Ana Sosa Ontaneda (Proyecto PAF A – UN-AIDS PROGRAMME ACCELERATION FUNDS) Montevideo 2011, in reference to the population under study, the difficulties to obtain an answer in the justice system regarding discriminatory situations and the lack of trust in the State as a key actor to avoid and/or solve this situations are reported. (pages 21 and 23).
the acceptability from the ethic and cultural point of view, given that prejudices and stereotypes that affected the health operators' practices have been destroyed.

Basic services that are foreseen in the standards are not guaranteed, and especially important services, like the psychosocial attention to treat situations of homolesbotransphobia based violence and cross-sex hormone therapy\(^{78}\) for trans people are hindered by the lack of professionals sensitized and trained in the subject.

- **Adopted measures to guarantee the equality and the non-discrimination based on sexual orientation, gender identity, and multiple or intersectional ways of discrimination**
  - The insertion of the pilot experience in open to the public health centers (not exclusive to LGTBI people centers) shows the “intention to have an impact on spaces already present, spaces for everybody and all diversities, not for one of each of the publics”. It is a clear objective of the Project not to repeat discriminations. It must be added that there was a political will to separate the LGTB persons’ health care from the issues on STD-VIH/AIDS and from prostitution control.
  - The training in the framework of UdelaR represented a measure taken to generate a “critical mass” that is aware of the sexual diversity reality and of the need to review the homolesbotransphobic practices in the health sector.
  - The training of all the operators in two health centers, the placement of banners in those places, and the distribution of brochures that recognize the sexual diversity send messages that propitiates an environment that is ready for the inclusion and the non-discrimination.

- **Programmatic measures and services to address the specific needs of the different groups**

  Information was introduced in the framework of the trainings to promote:

  - Friendly and inclusive dialogue between the personnel and this population.
  - Early detection of specific risks.
  - Early diagnosis and treatment.
  - Specific exams like the anal PAP.
  - Information on cross-sex hormone therapy for trans people and its control.

- **Measures taken to strengthen the ability of the health staff to offer discrimination free and homolesbotransphobia free services.**

  The absence of specific training in the subjects was a known issue from the beginning of the Project. Neither information nor training is offered at the undergraduate, graduate or postgraduate levels in the School of Medicine. Based on this knowledge, the following measures were adopted in two areas:

  - Targeted and personalized trainings for all the personnel of the Health Centers were conducted where the pilot experience was implemented.
  - Specific courses for undergraduate and postgraduate students and an inter-Schools course by the Sectorial Commission of Education were conducted at the UdelaR.

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78 As stated earlier, ASSE is implementing a specific pilot program on hormone therapy in Pereira Rosell, Maciel and Saint Bois Hospitals.
The design, use, and distribution of educational devices (videos, brochures) supported these and future training actions.

### 7.3. Significance, innovation, impact, and replicability criteria

- **Obtained results**

The activities that were conducted within the framework of the Project had the following results:

- The sexual diversity perspective and the need to promote the health of LGTB persons and their care was presented and worked on by the staff of two health centers (Ciudad Vieja and Barros Blancos).

- A process to bring awareness and training was started. This process enabled the revision of myths and prejudices that are present in the practices that reproduce the discrimination and the stigma of this population by the health staff, teachers, community actors, and Family and Community Medicine residents.

- Members of the community that surrounds the health centers where the experience took place received information on the purpose of the pilot experience to support the process and to attract the LGTB population of the area.

- The right conditions were generated to include the subject as an optative course at the UdelaR (a way to institutionalize subjects that are not included in the curricula).

- The identification of the LGTB population with the issue of VIH/AIDS, that ignores other health needs, was challenged.

- The lacks in the health coverage for the LGTB population, mainly the cross-sex hormone therapy and the sex reassignment surgery, were made visible.

- The first steps were given to train the operators to answer the health needs of the trans population and the inclusion of this subject in the health policies agenda.

- An inter-sectorial work alliance was built: State, academia, civil society, and international cooperation. This resulted into a synergy that generated motivation, commitment, multiplication of the experiences, opening to learning, and other ways of understanding the diversity.

- The interdisciplinary approach was included in the perspectives presented, the contents, the teaching teams, and, generally speaking, the participants.
Main challenges and success factors

- **Challenge:** The inclusion of the subject and the problem area in the health agenda.

  **Success factors:**
  - The framework of legitimacy offered by the involved actors:
    - The governing body on health policies,
    - The board of first level of attention (that were prioritized in the Sistema Nacional Integrado de Salud reform),
    - The academia, represented by the University of the Republic,
    - The international cooperation through UNFPA, an agency with recognized experience in the subject,
    - The Black Sheep Collective, also well recognized for its work.
  - The commitment and leadership of referents with the power of decision making in the MSP, in ASSE, and at the UdelaR.
  - The permeability and openness to recognize the problem, detect the needs, and contribute with the building of solutions.
  - The progress in the policies on gender equality as a favorable framework for the recognition of the sexual diversity’s rights.
  - A special context: the regulatory developments, such as equal marriage, the change of the registered name and sex in the birth certificate, the law on cohabiting couples, and the mobilization of the civil society to achieve these, as well as the debate on VIH/AIDS, constituted a context that enabled the debate on cultural stereotypes that create discriminatory situations against the LGTB population.
  - The construction of alliances between the actors that were sensitive to the subject and had the power of execution produced a synergy that multiplied the number of opportunities and skills.

- **Challenge:** The effective mainstreaming of the sexual diversity into the health policies.

  **Success factors:**
  - The participation of teachers and residents from the Department of Family and Community Medicine, which in turn has presence in several areas in the country, enabled the amplification of the experience and the exchange of information and initiatives that can be replicated.
  - The need for information and training created new demands for workshops and activities.
  - The flexibility to adapt the actions to the new demands, opportunities, and realities of the different organizations.
  - This chain effect potentiated the Project and made it possible to continue the activities beyond the initiative.
  - The adoption of a quality seal that identifies a respectful work perspective towards the diversity.
Challenge: The continuation and deepening of the study of the subject of the sexual diversity in the academic context and its extension to other Schools.

Success factors:

- The will and commitment of: the Department of Family and Community Medicine and the Professorship of Infectious Diseases from the School of Medicine, and the Institute of Health Psychology from the School of Psychology.
- The commitment and the communication skills of the referents from the Collective Ovejas Negras that participated in the experience.
- The positive evaluation of the inter-Schools course and its repetition in the form of an optative seminar the following year.
- The relevance of the contents, elaborated on the basis of the practical and strategic needs of the operators that had been surveyed in the workshops conducted in the health centers.
- The “novelty” and the topical character of the contents contributed by the referents of the Ovejas Negras Collective.
- The process of opening to the teaching to teachers of UdelaR who participated both as teachers and as students.
- The rotation of the hosting place for the inter-School courses that specially attract the students and teachers from the hosting institution.

Challenge: To ensure the effective access of the LGTB population to the services.

Success factors

- To be able to count on committed people from the LGTBI collective itself and their local formal and informal networks.
- To conduct workshops with the community to inform and bring awareness to the environment of the health centers.
- Giving answers to specific needs of the LGTB population, like the appropriate attention to sexual health and the cross-sex hormone therapy.
- The participation of persons that belonged to different areas (e.g., the participation of professionals that work for different health providers).
- The extension of the opening times of other services related to the Department of Family and Community Medicine (night polyclinic at Saint Bois Hospital).

Challenge: The acknowledgment of diversity within the LGTB collective

Success factors

- The elaboration of materials (videos, brochures, banners) differentiated according to the targeted population (lesbians, gays, or trans), and also mentioning bisexuality.
- The presentation of the specific needs of the trans people as a problem to be solved and the search for answers that are respectful of their rights.
- The contents of the training.
**Challenge:** *Allotment of national resources for the sustainability and replicability of the experience.*

**Success factors**

- The insertion of the Project within Programs and Services that were already operating.
- The funding model of the *Sistema Nacional Integrado de Salud*, through the National Health Found and complemented by the National Resources Found.

**Learned lessons**

The lessons that are highlighted by the analysis of the main results and success factors are the following ones:

- The actions that interact with the health policies agreed upon and in place, that involve key actors (interested, decision making, influential, and with the power to act), facilitated the expansive wave that characterized this project.

- The absence of a document organizing the proposal, recording and monitoring the activities makes it difficult to systematize and evaluate the impact of the experience to then replicate it.

- Training is a valid strategy to have an impact on changes in the short, medium, and long term.

- The training of the whole staff of the health centers facilitated the affiliation and the sense of belonging to the initiative, a key aspect for the sustainability of the proposal.

- The involvement of the University of the Republic gave legitimacy to the knowledge and potentiated the possibility of having an impact on the training and education of professionals and on present and future health services.

- The investment of the resources in a training strategy that enabled the review of stereotypes and practices had an impact on the individual and institutional processes that goes beyond the life of the Project.

- The access of the LGTB population to the health services is facilitated when this persons are involved, actively participate (including in the reporting aspect), and have the chance to demand answers to their needs and interests.
8. CONCLUSIONS

- Uruguay has a vast normative framework that integrates in it the international standards as standing human rights principles in the country. This legislation exists hand in hand with another one in which there still are heteronormative and sexist models, with lacks and holes, especially in the area of implementation to guarantee the effective exercise of the rights, the mechanism of enforceability being fragile (monitoring, reporting, evaluation, complaining, and reparation mechanisms).

- Some answers that seek to make visible and to offer care for the specific needs of the LGTB population have gradually been incorporated in the health context. Some of these answers stand up: the Chapter on Sexual Diversity of the Guidelines On Sexual and Reproductive Health, the “Hacia la inclusión social y el acceso universal a la prevención y atención integral en VIH Sida de las poblaciones más vulnerables en Uruguay” Project (“Towards social inclusion and universal access to comprehensive prevention and attention of VIH/AIDS of the most vulnerable populations in Uruguay” Project), supported by the Global Fund to fight AIDS, Tuberculosis and Malaria, the transgender people Healthcare in the UDA (Training and Treatment Unit) of the First Level Attention Network / ASSE at the Saint Bois Hospital and this Project, “Homophobia Free Health Centers”. This process was accompanied by a debate on addressing perspectives and approaches centered on the tension integrality vs. focus of the answers.

- This Project started with the acknowledgment by the public actors, the civil society, the academia, and the international cooperation of the need for training, and their interest on addressing the problem area. This meeting of interests generated a chain effect that enabled the permeation of actions both in local health centers and in academic educational spaces.

- The key strategy was the training of the operators, where the specific knowledge of the LGTB population was included through its own involvement in the design and execution in an associative and collaborative way with the state, the academia, and the international cooperation.

- The methodology used in the trainings was innovative and successful in the health care context in terms of involvement of all the actors that are part of the staff of the centers, its interdisciplinary character, the use of life portraying dynamics, and the elaboration of written material by the LGTB population. The positive impact of the experience has led to many actions to replicate it.

- The implementation of this Project in already operating systems and in a manner consistent with the programmatic lines prioritized by the sector, mainly sexual and reproductive health and primary health care, facilitates the sustainability and institutionalization of the proposal.

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79 Find more information of this experience in UNFPA Dissemination Series, Book No. 8 available at: www.unfpa.org.uy
9. RECOMMENDATIONS

1. To acknowledge and make visible the diversities and specificities within the LGTBI collective, deconstructing a certain hierarchy of the gay population over lesbians and trans and the taking into account the intersex persons.

2. To review the name given to the centers that mainstream the sexual diversity in their actions:
   - to overcome the confusion brought by the reference to a homophobia free health “center” that can be misinterpreted as a center – attention facility- exclusive for the discriminated population.
   - to extend the “homophobia” denomination to include all the sexual diversity.

3. To continue and expand the process of mainstreaming of the sexual diversity in the health services:
   - Including all the health care providers of the Sistema Nacional Integrado de Salud.
   - Prioritizing the first level of attention and the emergency services.
   - Requiring the training on sexual diversity of all the human resources, including medicine specialists, the technicians in general, administrative staff, service staff, security staff, etc., adapting it to the needs of the offered service.
   - Ensuring a comprehensive approach that takes into account:
     - The dimensions (individual, family, community, cultural, organizational) and the extended social context (politics, regulations, media).
     - The involved fields: disciplines, sectors, institutions.
     - The levels of: prevention (primary, secondary, tertiary) and attention (first, second, and third).
     - The stages of the process: detection, first attention, follow up, reparation, rehabilitation.

4. To incorporate education and training strategies on sexual diversity, violence, and health rights within the University context, taking especially into account those careers related to the health area (medicine, odontology, nursing, midwives), the psychosocial area (social sciences, psychology), and law.

5. To produce academic material for the different subject areas, validated from the perspective of the sexual diversity rights advocacy organizations, and taking into account the recommendations given by the international and national organisms specialized on the subject.
6. To strengthen the participation and involvement of the LGTBI population in the management, the monitoring, and the evaluation of the health centers. For that purpose it is suggested to initiate a process of exchange through dialogue with the non-governmental organizations, commissions of users, and the LGTBI persons.

7. To elaborate a protocol of the minimum conditions that a first level health service must comply with to be qualified as free of sexual discrimination. Among others, the aspects related to the following matters should be considered:

- The use of non-discriminatory language in the health service in general and in the consultation in particular, overcoming the heteronormativity assumptions and ensuring respect to the person's right to be called according to their gender identity.
- The permanent and up to date training to the whole personnel of the health center, including those who do not directly depend of the sector (e.g. police officers that work in the facilities).
- The availability of information on sexual diversity for the users.
- The availability of good quality services, medication, and services (e.g., cross-sex hormone therapy, anal PAP, and cross-sex hormone therapy).
- The availability of health care services carried out by specialized personnel on situations of violence based in homolesbotransphobia.
- Registration and systematization of the situations of violence based on homolesbotransphobia.
- The adoption of registering criteria according to sexual orientation, gender identity, and other sensitive data related to sexuality in the medical record guaranteeing the right information without breaching confidentiality.
- The establishment of criteria regarding the use of the bathrooms in the restrooms of the facility and their adaptation to the sexual diversity.
- The availability of participation and complaining mechanisms for the users.

8. To investigate, collect information, train on the health rights and needs of the intersex population, taking especially into account the international standards on the subject.

9. To determine and develop prevention actions against gender and homolesbotransphobia based violence. For this purpose it is suggested:

- To implement awareness raising campaigns on the rights of the LGTBI population, including specific aspects on health.
- To expand the application of the quiz on Domestic Violence to the persons of the Sexual Diversity.
- To incorporate the perspective of sexual diversity in the services against domestic and gender violence.
- To incorporate the gay, trans and intersexual persons as users of the services against domestic and gender violence, including that which takes place in the educational, working, health, residential, recreational, cultural, and political spaces.
- To keep a registry of the discrimination and homolesbotransphobic based violence situations that become known by the health system.
10. To regulate, for all providers of the *Sistema Nacional Integrado de Salud*:

- The use of the name chosen by the person according to his/her gender identity, even when no modification has been done in the identity documents.
- The mandatory services in the three levels of attention, including the health care of the consequences of the violence based on homolesbotransphobia, and those specific for the trans population (cross-sex hormone therapy, body hair care, body adaptation surgery).
- The handling of the sexual data in the medical record guaranteeing its recording in a respectful of diversity way.
- The way hospital beds and wards are allotted according to sexual identity, even when no modification has been made in the identity documents.
- The health interventions regarding the intersex persons.

11. To obtain quantitative and qualitative information on the LGTBI population that contributes with a baseline for the formulation of comprehensive public policies.

12. To provide accessible and efficient mechanisms for the enforceability of the health rights of the LGBTI population, overcoming the different barriers (bureaucratic, cultural, social) that are cause of the non-utilization of the processes that are currently available.

13. To incorporate in the National Institution of Human Rights a special rapporteur on Sexual Diversity.

14. To ensure the inclusion of the sexual diversity perspective, including health rights, in the training of the operators of the justice system and other decision makers on individual or collective conflicts (administrative conflicts intra or extra institution).
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UNFPA (s/f) Desarrollo de los marcos para apoyar las actividades de las INDH en el área de los derechos sexuales y reproductivos.


a. Banners

Left banner:

TO LIVE A FULL LIFE TAKE YOUR HEALTH OUT OF THE CLOSET
ASK YOUR HEALTH TEAM OPENLY AND WITHOUT FEARS

Right banner:

HERE WE CONGRATULATE ALL FAMILIES WHERE LOVE RULES
1. Visibilidad
Antes que nada, saca a tu salud del closet. Quien que te atienda debe saber que sos gay o bisexual. Es un dato importante que hará que pueda brindarte una mejor atención, más sensible a tus intereses y necesidades. ¿Por qué?

2. Sexo seguro
Los varones que tenemos sexo con varones no estamos libres de contraer Infecciones de Transmisión Sexual (ITS), como la Sifilis, Gonoreea o el Virus de Inmunodeficiencia Humana (VIH). La mayoría pueden resolverse o evitar que avancen si se detectan a tiempo, pero si tardamos en consultar podemos invertir en disfatar nuestra vida sexual, ver deteriorada nuestra calidad de vida, exponernos al cáncer genital.

3. Prevención de hepatitis
Los varones gays y bisexuales tenemos riesgo de contraer hepatitis virales (A, B y C). En tu centro de salud existe un área de vacunaciones donde podés imunizarte contra la Hepatitis A y B. Consulta.

4. Autoexamen testicular
Es importante conocer nuestro cuerpo y realizar el autoexamen testicular de forma periódica para prevenir el cáncer testicular. Para otros tipos de cáncer, como de próstata o colon, los varones gays y bisexuales debemos controlarnos regularmente. Las formas de prevención y estudios requeridos son diferentes en cada etapa de la vida. Hablalo con tu médico/a de referencia.

5. PAP anal
El Virus del Papiloma Humano (HPV) es una ITS que puede aumentar el riesgo de cáncer anal. Los varones que mantenemos sexo anal podemos hablar de este tema con nuestra/a médico/a general o de familia, y preguntar sobre la disponibilidad del Papilomocultivo (PAP) anal.

6. Vida sin violencia
En una pareja de varones también puede existir la violencia doméstica o de género. Si te estás viendo, busca apoyo en tu centro de salud. Animate, hablalo.

7. Salud mental
La discriminación siempre nos vuelve más proclives a la depresión y la angustia. Animate a hablarlo. En los servicios de salud hay profesionales que pueden ayudarte tanto a cuidar tu salud mental, como a denunciar casos en que sientas que estás siendo discriminado en tu trabajo, tu centro de estudios, etc. Esos sí, no aceptes que te ofrezcan terapias de “cura” de tu homosexualidad (en este caso podés denunciar a la Administración de Salud Pública y al Colectivo Ovejas Negras), ni trate este aspecto como el único relevante o problemático. Si sientes que tu terapeuta está cuestionando tu orientación sexual, PLANTEÁLO.

8. Adopción
Actualmente las leyes de nuestro país permiten que un varón pueda adoptar independientemente de su orientación sexual y su estado civil. Asimismo, puede ser que actualmente convivas con un/a niño/a y vos o tu pareja quieran hacer el trámite para regularizar la adopción, o puede que ambos quieran adoptar. Dentro del equipo de salud hay profesionales que pueden orientarte para cada caso.


Las personas lesbianas, gays, bisexuales y trans tenemos derecho a la salud, al igual que todos y todas quienes vivimos en Uruguay.

El Colectivo Ovejas Negras junto a varias instituciones realiza talleres y capacitaciones con equipos de salud para que los profesionales conozcan y puedan atender nuestras necesidades específicas. Nos toca a nosotros/os plantear abiertamente nuestra orientación sexual e identidad de género en la consulta.

¡Sémos a nuestra salud del closet!
Garantizar y promover el acceso a la salud en el territorio, pero además responsabilidad de todos y todas.
Si no sos gay, lesbiana, bisexual o trans pero tu hija, tu hermano, tu amiga, o alguien cercano a ti lo es, comparte esta información con ella/él.

RECORDÁ:
Tanto en los Servicios de Atención al Usuario de cada centro como llamando al 0800 4444 podrás asesorarte y denunciar una atención incorrecta en cualquier centro de salud público o privado del país (NÚMERO GRATUITO).

Elaborado por el Colectivo Ovejas Negras

www.ovejasnegras.org
The previous poster reads:

**Front page (up):**

*Left up corner:* FINALLY A HANDOUT THAT DOES NOT SPEAK ONLY ABOUT THE RISK OF CONTRACTING VIH!

*Center:* FINALLY A HAND OUT THAT TALKS TO ME!

GRAPHIC CAMPAIGN TO PROMOTE HEALTH FOR LESBIANS, GAYS, INTERSEXUALS, AND TRANS.

*Right up corner:* HEALTH FOR GAYS.

Seven things we gays should discuss with our health team.

*Left down corner:* Published with the support of the Global Program on Reproductive Health commodity Security (UNFPA).

**Back page (down):**

*Left column:*

1. **VISIBILITY.** First of all, take your health out of the closet. The professional that is taking care of you must know that you are gay or bisexual. It is important information that will let him offer you a better attention that is sensitive to your interests and needs. Why?

2. **SAFE SEX** We, males that have sex with males, have the risk to contract Sexual Transmitted Infections (STD), like Syphilis, Gonorrhea, or the Human Immunodeficiency Virus. Most of them can be healed or avoided if detected in time, but if we delay the consultation, we can lose the opportunity to enjoy our sex life, see our quality of life deteriorate, or expose ourselves to genital cancer.

3. **HEPATITIS.** The gay and bisexual males have a greater risk to contract hepatitis. There is a vaccination area where you can get vaccinated against this illness in your health center. Ask.

4. **TESTICULAR, PROSTATIC, AND COLON CANCER.** Gay and bisexual males must have regular controls to prevent these and other types of cancer. The prevention measures and the required studies are different at different stages of life. Talk about it with your health provider.

*Middle column:*

5. **ANAL CANCER.** The Human Papilloma Virus (HPV) is an STD that can increase the risk of anal cancer. The men that have sex with men prevent it by practicing safe sex and periodically consulting our general or family doctor.

6. **DOMESTIC VIOLENCE** We are not free of repeating gender violence because we are a a male couple. If you are living this situation, look for help in your health center. Go ahead and talk about it.

7. **MENTAL HEALTH** Discrimination always makes us prone to depression and anguish. Be encouraged to speak with your health provider when you need so. However, do not accept offerings of therapies to "cure" your homosexuality, or that he/she deals with this aspect as the only one that is relevant or problematic. If you feel that your therapist is questioning your sexual orientation, RAISE THE SUBJECT.
**REMEMBER:** Calling number **0800 4444** you can get advice and complain about an incorrect attention in any health center, whether public or private of the country. (FREE NUMBER)

Source: Vincent M. B. Silenzio, MD, MPH, Former Member of the Board of Directors of the GLMA and Former Co-Editor of the Journal of the Gay and Lesbian Medical Association, [www.glma.org](http://www.glma.org)

Elaborated by the Collective Ovejas Negras

[www.ovejasnegras.org](http://www.ovejasnegras.org)

*Right column (yellow background):*

*Upper white bubble:*

The therapies of conversion or “cure” of homosexuality or transsexuality that are carried out by some professionals or people related to health care and some religions cause a lot of damage to the people targeted by them.

If somebody tries to offer you these treatments report him/her to the Ministry of Public Health and to the Collective Ovejas Negras.

*Middle, on yellow background:*

There is a Homophobia Free Health Center in Montevideo that will be able to give attention to your health needs:

*Lower section on yellow background:*

Requirement: Valid ASSE Assistance Card.

If you have FONASA (you are paying the Social Security) and you have chosen to consult in ASSE (Public Health system) you can go to this health center with your usual card.

If at the moment you do not have health coverage at all, neither public nor mutual, you can get your Card at any health center or public or Municipal Polyclinic.
1. **Visibilidad**

Antes que nada, saca a tu salud del closet. Quen que te atienda debe saber que sos lesbiana o bisexual. Es un dato importante que hará que pueda brindarte una mejor atención, más sensible a tus intereses y necesidades. ¿Por qué?

2. **Sexo seguro**

Las mujeres que tenemos sexo con mujeres no estamos libres de contraer Infecciones de Transmisión Sexual (ITS). La mayoría pueden resolverse fácilmente si se detectan a tiempo, pero si tardamos en consultar podemos estar perdiéndonos de disfrutar de nuestra vida sexual, o exponernos al cáncer genital.

3. **Consulta ginecológica**

Es importante ir regularmente a la consulta ginecológica y solicitar el Papanicolaou (PAP) al menos cada dos años. Así podremos, por ejemplo, detectar a tiempo el Virus del Papiloma Humano (HPV), que puede aumentar el riesgo de desarrollar cáncer de cuello de útero.

4. **Cuidado de las mamas**

Autoexaminar las mamas una vez al mes e ir a consulta ginecológica para un examen clínico son algunos de los cuidados que necesitamos. Las mujeres que no hemos amamantado tenemos mayor riesgo de desarrollar cáncer de mama. La mamografía está recomendada para algunas mujeres, de acuerdo a su edad y sus antecedentes familiares. Consulta a tu equipo de salud.

5. **Vida sin violencia**

En una pareja de mujeres también puede existir la violencia de género. Si la estás viviendo, es importante que el servicio de salud al que vas regularmente esté al tanto de la situación. También podrás acudir a alguna de las cinco Comunas Mujer que existen en Montevideo, o en el interior a las Opciones del MIDES para asesoramiento de víctimas de violencia doméstica.

6. **Salud mental**

La discriminación siempre nos vuelve más proclives a la depresión y la angustia. Anímese a hablar. En los servicios de salud hay profesionales que pueden ayudarte tanto a cuidar tu salud mental, como a denunciar casos en que sientas que estás siendo discriminada en tu trabajo, tu centro de estudios, etc. Eso sí, no aceptes que te ofrezcan terapias de “cura” de tu homosexualidad (en este caso podrás denunciar al Ministerio de Salud Pública y al Colectivo Ovejas Negras), ni trate este aspecto como el único relevante o problemático. Si sientes que tu terapeuta está cuestionando tu orientación sexual, PLANTEÁLO.

7. **Reproducción asistida y adopción**

Actualmente las leyes de nuestro país permiten que una mujer pueda adoptar o acceder a técnicas de fertilización asistida independientemente de su orientación sexual y su estado civil. Asimismo, puede ser que actualmente convivas con un niño/a y vos o tu pareja quieran hacer el trámite para regularizar la adopción, o puede que ambas quieran adoptar. Dentro del equipo de salud hay profesionales que pueden orientarte para cada caso.

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Las personas lesbianas, gays, bisexuales y trans tenemos derecho a la salud, al igual que todas y todos quienes vivimos en Uruguay.

El Colectivo Ovejas Negras junto a varias instituciones realiza talleres y capacitaciones con equipos de salud para que los profesionales conozcan y puedan atender nuestras necesidades específicas.

Nos toca a nosotros/as plantear abiertamente nuestra orientación sexual e identidad de género en la consulta.

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**RECORDA:**
Tanto en los Servicios de Atención al Usuario de cada centro como llamando al 0800 4444 podrás asesorarte y denunciar una atención incorrecta en cualquier centro de salud público o privado del país (NÚMERO GRATUITO).

Elaborado por el Colectivo Ovejas Negras

[www.ovejasnegras.org](http://www.ovejasnegras.org)
HOMOFOBIA FREE HEALTH CENTERS: SYSTEMATIZATION OF PILOT EXPERIENCES

The previous poster reads:

_Front page (up):_

_Left up corner:_ FINALLY A HAND OUT THAT DOES NOT EXPLAIN ME HOW TO USE A PRESERVATIVE!

_Center:_ FINALLY A HAND OUT THAT TALKS TO ME!

GRAPHIC CAMPAIGN TO PROMOTE HEALTH FOR LESBIANS, GAYS, INTERSEXUALS, AND TRANS.

_Right up corner:_ HEALTH FOR LESBIANS.

SIX THINGS WE LESBIANS SHOULD DISCUSS WITH OUR HEALTH TEAM.

_Left down corner:_ Published with the support of the Global Program on Reproductive Health commodity Security (UNFPA).

_Back page (down):_

_Left column:_

1. **VISIBILITY** First of all, take your health out of the closet. The professional that is taking care of you must know that you are lesbian or bisexual. It is important information that will let him offer you a better attention that is sensitive to your interests and needs. Why?

2. **SAFE SEX** We, women that have sex with women, are not free of contracting Sexual Transmitted Infections (STD). Most of them can be healed or avoided if detected in time, but if we delay the consultation, we can lose the opportunity to enjoy our sex life, or expose ourselves to genital cancer.

3. **CERVIX CANCER** It is very important to go to the gynecologist and have a Papanicolau (PAP) done at least every two years (or every one year if you have changed your sex partner). This way you will, for example, detect the Human Papilloma Virus (HPV) in time. HPV can increase the risk for this type of cancer.

4. **BREAST CANCER** Lesbian and bisexual women that have not breast-fed a baby are in higher risk of developing this type of cancer; we must have regular controls, go to the gynecologist for a clinical breast exam, conduct self-examinations once a month, and periodically ask for mammograms after we are forty.

_Middle column:_

5. **DOMESTIC VIOLENCE** We are not free of repeating gender violence because we are a female couple. If you are living this situation, you can go to any of the Comunas Mujer (Women Communes) that exist in Montevideo, or outside Montevideo, in the MIDES Offices for advice for victims of domestic violence.

6. **MENTAL HEALTH** Discrimination always makes us prone to depression and anguish. Be encouraged to speak with your health provider when you need so. However, do not accept offerings of therapies to “cure” your homosexuality, or that he/she deals with this aspect as the only one that is relevant or problematic. If you feel that your therapist is questioning your sexual orientation, RAISE THE SUBJECT.
REMEMBER: Calling number **0800 4444** you can get advice and complain about an incorrect attention in any health center, whether public or private of the country. (FREE NUMBER)

Source: Katherine A. O’Hanlan, MD, Former President of GLMA, Co-Founder, Lesbian Health Fund, Gynecologist, Portola Valley, CA.  www.glma.org

Elaborated by the Collective Ovejas Negras

**www.ovejasnegras.org**

*Right column (orange background):*

*Upper white bubble:*

The therapies of conversion or “cure” of homosexuality or transsexuality that are carried out by some professionals or people related to health care and some religions cause a lot of damage to the people targeted by them.

If somebody tries to offer you these treatments report him/her to the Ministry of Public Health and to the Collective Ovejas Negras.

*Middle, on orange background:*

There is a Homophobia Free Health Center in Montevideo that will be able to give attention to your health needs:

*Lower section on orange background:*

Requirement: Valid ASSE Assistance Card.

If you have FONASA (you are paying the Social Security) and you have chosen to consult in ASSE (Public Health system) you can go to this health center with your usual card.

If at the moment you do not have health coverage at all, neither public nor mutual, you can get your Card at any health center or public or Municipal Polyclinic.
The previous poster reads:

*Front page (up):*

*Left up corner:* FINALLY A HAND OUT THAT DOES NOT ASSUMES THAT IF I AM A MALE I DO NOT GO TO THE GYNECOLOGIST!

FINALLY A HAND OUT THAT DOES NOT FORCE ME TO HAVE A PAP DONE BECAUSE I AM A WOMAN!

*Center:* FINALLY A HAND OUT THAT TALKS TO ME!

GRAPHIC CAMPAIGN TO PROMOTE HEALTH FOR LESBIANS, GAYS, INTERSEXUALS, AND TRANS.

*Right up corner:* HEALTH FOR TRANS.

TEN THINGS WE FEMININE TRANS AND MASCULINE TRANS SHOULD DISCUSS WITH OUR HEALTH TEAM.

*Left down corner:* Published with the support of the Global Program on Reproductive Health commodity Security (UNFPA).

*Back page (down):*

*Left column:*

1. **VISIBILITY.** First of all, take your health out of the closet. You must know that it is important that you take care of your health, not just your sexual health, but the whole of it. Do not keep yourself from going to your health center, and tell the professional that is taking care of you that you are trans. Do not omit this, and do not change the way you dress or behave for the consultation. It is important information that will let him offer you a better attention that is sensitive to your interests and needs. Why?

2. **RIGHT TO HEALTH** As a human being, independently of our gender identity or sexual orientation, the law guarantees us the access to health care. Do not let anybody take that right away from you.

3. **YOUR MEDICAL RECORDS** It is important that we see the professional who is taking care of us as somebody we can trust. Telling him/her about surgeries that we have had, hormones that we have used or are using, or other treatments is important for him to be able to offer us a better attention. For example:

4. **HORMONES AND INJECTABLE SILICON** The use of hormones has associated risks and requires medical control. We must also take into account that the irregular or not controlled use of hormones can bring us alterations in our mood and symptoms that can look like depression. Both girl and boy trans must talk about this with our general doctor to get his/her advice or to be referred to another doctor if it is necessary. The feminine trans that have injected ourselves with silicon or similar products must talk about this with who is providing health care to us to prevent possible damages to our health.
5. **CANCER PREVENTION** Neither feminine nor masculine trans are free of breast cancer. Even if you are a boy trans who has had a mastectomy, you must go on having checkups, although the risk is lower. The risk is even lower for girl trans but it exists and it can go up if we are using hormones. Let’s talk with our general or family doctor! Talk about this cancer and about the risk to contract other types of cancer, especially the genital ones. The masculine trans must ask for a Papanicolau (PAP), and the feminine trans must prevent the testicle and the prostate cancer.

6. **CARDIOVASCULAR HEALTH AND HEALTHY HABITS** The annual controls are a form of prevention that must be present in our lives, especially if we have risk factors (e.g., overweight, tobacco use, hormone use). Regular exercise and a balanced diet help us to decrease the risks.

7. **SAFE SEX** It is important to practice safe sex to prevent the Sexual Transmitted Infections (STD), like Syphilis, Gonorrhea, the Human Papilloma Virus (HPV), or the Human Immunodeficiency Virus (VIH). Most of them can be healed or avoided if detected in time, but if we delay the consultation, we can lose the opportunity to enjoy our sex life, see our quality of life deteriorate, or expose ourselves to genital cancer.

8. **TOBACCO, ALCOHOL AND DRUGS USE** There is a space to stop the use of tobacco where you get health attention. Ask about it. Also, if you are having problems because of alcohol and/or drugs, talk about it in your health center or call 1020 (Free Number from any land or cell phones).

9. **DOMESTIC VIOLENCE** We, trans persons, are not free of suffering domestic or gender violence. If you are living this situation, you can go to the Comunas Mujer Centro (Downtown Woman Commune) on Wednesdays from 15 to 16 in Montevideo or, outside Montevideo, in the MIDES Offices for advice for victims of domestic violence.

10. **MENTAL HEALTH** Discrimination always makes us prone to depression and anguish. Be encouraged to speak with your health provider when you need so. However, do not accept offerings of therapies to “cure” your transsexuality, or that he/she deals with this aspect as the only one that is relevant or problematic. If you feel that your therapist is questioning your gender identity, RAISE THE SUBJECT.

*Right column (green background):*

**REMEMBER:** Calling number **0800 4444** you can get advice and complain about an incorrect attention in any health center, whether public or private of the country. (FREE NUMBER)

Source: Rebecca A. Allison, MD Board of Directors, Gay and Lesbian Medical Association American Medical Association, Advisory Committee on GLBT Issues Interventional Cardiologist, Phoenix, Arizona www.glma.org

Elaborated by the Collective Ovejas Negras

[www.ovejasnegras.org](http://www.ovejasnegras.org)

*Upper white bubble:*

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### b. Invitation to the inauguration of the Homophobia Free Health Center

*The above poster reads:*

We invite you to celebrate the inauguration of the First homophobia free health center

Wednesday, June 20, 2012, 1:30 p.m.

Ciudad Vieja Health Center

183 28 de Mayo Street and Maciel
c. Summons poster for the Graduates’ Course

Poster 2013

The poster reads:

Course for graduates
Sexual health and diversity
Tuesdays, from 6 to 10 p.m.
Starts: October 15, 2013
Teachers Team:

- School of Medicine: Dr. Susana Cabrera, Dr. Alicia Sosa, Dr. Zaida Arteta, Dr. Raúl Cepellini.

UNFPA: Mg. Valeria Ramos

Location:

CICP athenaeum, School of Psychology (Annex)

1737 Mercedes Street and Gaboto

Inscriptions up to Thursday, October 10
Course for graduates “Sexual Health and Diversity”

Organized by:

School of Psychology – School of Medicine – MSP – UNFPA – Colectivo Ovejas Negras

Objective: The course seeks to generate a training space for health professionals on the integration of the sexual diversity perspective in health promotion and attention of LGTB persons.

Target: Professionals, preferably those who are working in the SNIS. Postgraduate students related to health care.

Length: 24 in class hours. Every Tuesday from 6:00 to 22:00 p.m. (5 credits)

Starting Date: October 15, 2013

Location: CIC-P athenaeum, School of Psychology (Annex). 1737 Mercedes Street and Gaboto

Teachers Team:

- **School of Medicine**: Dr. Susana Cabrera, Dr. Alicia Sosa, Dr. Zaida Arteta, Dr. Raúl Cepellini.
- **Ovejas Negras**: Lic. Valeria Rubino, Lic. Florencia Forrisi, Lic. Nestor Rodriguez, Dr. Pablo Arean, Dr. Karina Roselli
- **UNFPA**: Mg. Valeria Ramos

Places: Up to 30 enrolled participants.

Enrollment: it will be done by e-mail between October 1st and 10th (the acceptation of the participants will be confirmed on October 14th). The enrollment form must be downloaded and sent to formacionpermanente@psico.edu.uy. For more information you can write to the same e-mail.
The poster reads:
Course for graduates
Sexual health and diversity
Saturdays from 9 to 12 a.m.
From 10/11 to 11/22

Teachers Team:
- School of Medicine: Dr. Susana Cabrera, Dr. Alicia Sosa, Dr. Zaida Arteta, Dr. Daniel Marquez, Dr. Victoria Frantchez.
d. Course for Graduates’ Program

General Objectives:

- To promote the integration of the sexual diversity perspective based on sexual and reproductive rights into the health promotion and attention of LGTB persons by the health professionals.

Specific Objectives:

- To update health professionals on the new perspectives on health promotion and attention of LGBT persons.
- To create a space for exchange among health professionals where they can share experiences and promote good practices regarding the attention of the LGBT population.
- To facilitate that professionals of different health areas learn about the basic elements of the approaches used in other disciplines favoring this way a comprehensive attention.

Targets:

Practicing professionals that are part of health teams in all attention levels.

Module 1: Sexuality, Gender, and Diversity.

Module 2: Sexual diversity and health.

- Sexual diversity and health. The situation in Uruguay. Legal and normative aspects in sexual diversity and sexual and reproductive health.

- The impact of heteronormativity on the social determinants of health. Actions to promote health from the perspective of the sexual diversity.

- The health consultation. Barriers to access it: cultural, geographical, economic, and functional from a sexual diversity perspective.

Module 3: Approach to sexuality from a diversity perspective in the health consultation.

- Sexuality, sexual health, and reproductive health. The sexual and reproductive rights regarding the Human Rights.

- Comprehensive health promotion and attention with a diversity perspective by the health teams: analysis of the actions of different professionals with emphasis on graduated nurses, psychologists and medicine doctors. References and counter-references.

- The sexual and reproductive health with a diversity perspective in the three levels of attention.

f. Elective Subject

Advanced Level elective course

1. Course title: Health and sexual diversity

2. Educational objectives:

General objective:

- To promote the development of skills in the students of the Health Area services of UdelaR in the area of sexual health and sexual diversity from an approach on integrality, gender, and rights.

Specific objectives:

- To provide undergraduate health students the development of skills for health promotion and attention to all the persons according to their sexual orientation and gender identity.

- To contribute to the strengthening of the incorporation of the aforementioned subjects to the education offered by the UdelaR.
3. Subject detail and bibliography:

Module 1: Sexuality, Gender, and Diversity.


Module 2: Sexual diversity and health.

- Sexual diversity and health. The situation in Uruguay. Legal and normative aspects in sexual diversity and sexual and reproductive health.

- The impact of heteronormativity on the social determinants of health. Actions to promote health from the perspective of the sexual diversity.

- The health consultation. Barriers to access it: cultural, geographical, economic, and functional from a sexual diversity perspective.

Module 3: Approach to sexuality from a diversity perspective in the health consultation.

- Myths and realities of women’s sexuality. Myths and realities of male sexuality.

- Comprehensive health promotion and attention with a diversity perspective by the health teams: analysis of the actions of different professionals with emphasis on graduated nurses, psychologists and medicine doctors. References and counter-references. The main role of the health team in the breaking down of the barriers to the health attention of the persons.

- The sexual and reproductive health with a diversity perspective in the three levels of attention.

Module 4: Clinical aspects and specificities in the medical consultation with LGBT population (lesbians, gays, bisexuals, and trans people).

- Anal, oral, and vaginal conditions related to sexual practices.

- HPV infection and associated neoplasms, relevant aspects to the LGTB persons health, general information on HPV, transmission mechanisms and prevention in LGBT, treatment principles.
- HIV and other STD: Relevant aspects to the LGBT health. Situation in Uruguay, epidemiology, perspective in diagnosis, follow up, relationship with the health system, treatment, treatment as prevention.

- Consultation with trans persons: psychological elements in the consultation with trans population. Cross-sex hormone therapy processes: principles and general guidelines of diagnosis and treatment. Surgical interventions and silicone implants, aspects related to the general procedure and main complications that are handled by the health team.

BASIC BIBLIOGRAPHY (APA format):

- Fundación Ecuatoriana Equidad (2008): Guía de orientaciones básicas para la atención clínica de hombres gays, bissexuales, personas trans y hombres que tienen sexo con hombres (GBTH) en los servicios de salud. Quito: FEE
- PROMSEX (2011). Guía de vigilancia a establecimientos de salud que brindan servicios de salud sexual y reproductiva. Lima: PROMSEX

4. Course coordinating teachers -Contact Educators Department:

Prof. Agda. Alicia Sosa. Family and Community Medicine. nuezcuarto@gmail.com, 099690508

Prof. Adj. Zaida Arteta. Cátedra de Enfermedades Infecciosas. zaidaarteta@gmail.com, 099631516
5. Periodicity of the course.

Semester course, to be held twice a year, dates to be determined. First course: November 2014.

6. Teaching methodology:

A mixed methodology will be used, where the workshop modality and interactive lectures will be integrated. The workshop space is presented to facilitate the participation of the students, enabling the ownership of the addressed subjects in a context of jointed production where they will work based on audiovisual material, clinical cases, subjects prepared by the students, etc. After this, the study of the contents will be continued with lectures on the theory of the subject.

The students will go to the policlinics twice, with the teachers to perform clinical work related to the attention of LGBT persons. The modality of standardized patient will also be used in 2 meetings (the type of interview of a member of the health team in a policlinic consultation)

7. Time load discriminated according to the type of foreseen activities (lectures, workshops, seminars, hands on work, clinical practice, field work, work in EVA, etc.)

The total time load is 75 hours.

There will be 9 meetings 4hours long each, making a total of 36 in class hours, plus the visits to the policlinic (6hours), work submitted by the students at the end of the course (16 hours), and home study (17 hours).

8. Credits: 75 hours that correspond to 5 credits

9. Evaluation procedure:

The evaluation will be based on the assistance to the class sessions (10%), a multiple choice written test (60%), and the grade based on the continuous evaluation during the meetings (30%). The continuous evaluation will be done using the scale 1-12.

10. Target public, required or recommended pre-requisites to attend the course:

Medicine student: should be student of the CCGI or higher level.

Regarding students from other health careers, each case will be analyzed independently. The last year of the career is recommended for Sociology students, the 4th year of the career for nurse students, and the last year of the career for students of schools that report to the School of Medicine and the School of Nutrition.
11. **Student places:**

30 places for medicine students per course.
10 places for students of other health careers per course.
The place allotment can be changed if they are not filled.

12. **Mechanism of selection (if there is place).**

Open enrollment. If there are more enrolled persons than places, a drawing will be done to define who can attend the course.
e. List of Interviewed persons

Leticia Rieppi – Ministry of Public Health
Susana Cabrera – Ministry of Public Health
Alicia Sosa – ASSE-RAP and School of Medicine- Department of Family and Community Medicine
Florence Forrissi – Ovejas Negras
Valeria Ramos – UNFPA
Juan José Meré - UNFPA
Mariana Giraldoni – ASSE- Ciudad Vieja (ex Director)
Carmen Martinez – ASSE – Ciudad Vieja
Jaqueline Ponzo - Barros Blancos
Pablo Arean – Ciudad Vieja/Ex Family and Community Medicine resident
Karina Rosselli - Ciudad Vieja/Ex Family and Community Medicine resident
Lucía Valdez – Ciudad Vieja/Health Team
Leonel Briozzo – Subsecretary of the Ministry of Public Health
Elizabeth Ibarra – Endocrinologist, Hospital Maciel - Teacher
Pablo López – School of Psychology
Zaida Arteta – Chair of Infectious Diseases