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BROADENING OUR UNDERSTANDING OF DIVERSITY

SEXUAL HEALTH AND SEXUAL DIVERSITY
TRAINING MANUAL FOR PRIMARY HEALTHCARE
PROFESSIONALS

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

JULY 2015

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PREFACE

It has been AIDSTAR-One's great pleasure to collaborate with partners in Central America in the creation of these training materials for health workers who provide critical services to sexual minorities. For many people, how they are perceived and received by their health care provider is tremendously important and determines the likelihood that they will engage and remain in care. When a client and a provider can establish a trusting and respectful relationship, information about sexual behavior and other risks can be discussed openly, without judgment and plans to address and minimize risk can be developed. That conversation has to be founded on an understanding of the diversity of individuals and their needs, and the application of the right tools and messages that address their circumstances. We hope that these materials will help guide providers in their efforts to provide comprehensive health services to their gay and trans clients.

Andrew M. Fullem

Project Director

AIDSTAR-One

PROLOGUE

Recognizing that sexual health is an essential element of comprehensive health has been gaining traction in recent years. We have increasingly moved away from a limited focus with a fragmented view of health towards a multidimensional approach that includes the many elements that constitute sexual health. In the same manner, traditional views that only emphasize disease prevention are being replaced by broader rights based perspectives that promote and support human development.

According to the World Association for Sexual Health (WAS), sexual rights are universal human rights based on liberty, dignity, and equality inherent to all human beings. These rights support and champion individual security, sexual autonomy and privacy, gender equality and equity, and go beyond simply protecting against stigma and discrimination. They recognize diversity as a core element of the human condition.

In this spirit, WAS initiated a collaboration with the AIDSTAR-One project, to support the capacity building of health professionals in Latin America. AIDSTAR-One conducted assessments in Central America with trans women and health providers to explore the health needs of trans women, available services, and barriers to access. According to findings health providers had very limited skills to identify and address the needs of sexually diverse populations. Thus, a capacity building strategy was designed that included a sexual health and diversity perspective that allowed for a deeper understanding of human sexuality, how it's influenced by the family, society, and culture, and how humans are bound by common elements regardless of sociocultural differences. Understanding sexuality through this lens contributes to normalizing a subject that is often considered taboo, and enables people to analyze their gender and sexual identities and expressions, orientations, desires, and sexual practices.

Recognizing the high levels of stigma and discrimination within health services, heavily influenced by patriarchal cultures and classism that marginalize and exclude individuals based on ethnicity, class or for not conforming to traditional gender roles associated with the sex assigned at birth, the capacity building strategy does not simply offer a theoretical framework, it provides health workers the opportunity to reflect on their attitudes and values and understand how these manifest in their work and affect the communities they serve. A strategy that does not seek to transform health services to view users as clients with rights instead of "patients" is not conducive to an integrated health model.

Equally important is the need to address the lack of clinical skills among health providers to adequately respond to the sexual health needs of clients, especially trans persons. Therefore to truly strengthen the quality of health services for LGBTI persons, it is paramount that capacity building strategies also expose health staff to the latest state of the art clinical information and procedures.

The validation of the capacity building strategy designed by AIDSTAR-One demonstrated that health staff are interested in learning about sexual health and see the value in applying these new concepts to improve the services they provide to sexually diverse populations. We hope that this experience will encourage others to integrate sexual health as part of their quality improvement efforts.

Esther Corona

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World Association for Sexual Health

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ACRONYMS

CERITS	Centros Especializados de Referencias de Infecciones de Transmisión Sexual y VIH/SIDA [Sexually Transmitted Diseases and HIV Healthcare and Referral Centers]
DSD	disorders of sexual development
DSM	Diagnostic and Statistical Manual of Mental Disorders
GLMA	Gay and Lesbian Medical Association
LAC	Latin America and the Caribbean
LGBT	Lesbian, gay, bisexual and transgender
LGBTI	Lesbian, gay, bisexual, transgender and intersex
NGO	nongovernmental organization
PAHO	Pan American Health Organization
PEPFAR	US President's Emergency Plan for AIDS Relief
STI	sexually transmitted infections
SWOT	strengths, weaknesses, opportunities and threats
USAID	US Agency for International Development
WAS	World Association for Sexual Health
WHO	World Health Organization

INTRODUCTION

Recently, the number of physicians,¹ nursing staff, social workers and other healthcare professionals who have received training on HIV-related topics, the use of antiretrovirals, epidemiological information, counseling on the subject and other technical matters has increased. However, very few have received any training with a comprehensive approach to sexual health, which also allows them to deal with a series of problems such as teenage pregnancy, sexual violence, stigma and discrimination, issues related to sexual and reproductive rights, and in particular, sexual diversity.

This is related to the fact that it is even difficult for healthcare professionals themselves to talk about sexuality in a comprehensive way. Healthcare professionals, in general, do not receive any training on sexuality during their professional education, and there are very few opportunities for continuous education or on-the-job training, although they are increasingly expected to appropriately address situations that require a full understanding of human sexuality. Often, they do not even possess basic knowledge and may share the same prejudices and biases of the communities with which they work.

This Workshop Training Manual has been designed to address these needs as part of a training strategy: providing up-to-date knowledge that offers the opportunity to review attitudes and values and which leads to action. This workshop falls within a vision of Sexual Health as part of Comprehensive Health, which, in the words of the working definition by the World Health Organization (WHO), is a general state of physical, emotional, mental and social well-being in relation to sexuality and associated with the respect and protection of sexual rights. This perspective implies recognition of sexual diversity as part of the wealth of human experience and within it, the broad spectrum of gender identity.

As the topic of sexuality is still taboo to a certain extent, it must be addressed from several levels, among which the following are recognized: first, that related to the position that each person has regarding his/her own sexuality and the sexuality of others; second, the commitment we have to professional work in this field of healthcare; and third, the enormous responsibility involved in working with sexual diversity from a rights perspective.

The workshop is addressed to primary healthcare professionals who are preferably members of healthcare teams. The Manual is designed for the workshop's facilitator(s).

It can also be used to train future trainers, who can then replicate the strategy proposed herein.

¹ Unless otherwise specified, in this text, when we refer to participants, physicians, patients, facilitators, providers, researchers and others, we are alluding to men as well as women. This decision responds to the need for fluent reading.

SUGGESTIONS FOR USING THE MANUAL AS A TRAIN-THE-TRAINERS TOOL

This Manual may be used as a train-the-trainers tool, for which we offer you the following suggestions:

1. Carefully review the Manual and prepare objectives that match the training activity you are going to conduct.
2. Choose a structure that allows you to deliver information and knowledge while at the same time reviewing attitudes and clarifying values. Sessions that are fundamental for the analysis of new information are:
 - a. Session 1. Healthcare professionals and sexual health and those related to development, Sessions 5 and 7.
 - b. Sessions 2, 3 and 4 refer to healthcare systems as well as professionals in the field, and that is where participants generally have greater knowledge and experience.
 - c. Sessions 8 and 9 work more on clinical approaches. It is possible to begin the workshop with Sessions 2, 5 and 7 to allow future trainers to develop a “simulation” of at least Sessions 2, 3 and 4 later, following the Manual’s instructions, and then go back and cover Sessions 8 and 9 again, and of course, finish with Session 10 and the Final Session.
3. All participants must have copies of the Manual.
4. Facilitators may organize a PowerPoint® presentation with information on the facilitator’s role, which is part of this Manual.
5. It is a good idea to offer participants a tool to comment on and evaluate the sessions facilitated by the participants.
6. A system must be in place to monitor and follow up on the training activities conducted by the participants.

I. OBJECTIVES

FIRST-LEVEL HEALTHCARE PROFESSIONALS SHOULD:

1. Approach and treat sexual health in all its diversity in an informed manner, free from prejudice and within a framework of respect for human rights.
2. Gain a broad and scientific vision of some of the fundamental aspects of sexual health.
3. Acquire tools so that they can provide better treatment for their patients in areas involving sexual health.
4. Be aware of the health problems that affect the lesbian, gay, bisexual, transgender and intersex (LGBTI) community and obtain resources to serve them in a positive and respectful way.
5. Provide their services considering the sexual health needs of the sexually diverse populations that they treat and protect the sexual rights of these groups.
6. Acquire the ability to replicate some of the Manual's elements, acting as facilitators in activities and workshops within their professional field.

If conducting a Train-the-Trainers Workshop, add the following objective:

Acquire the basic ability to replicate the Workshop presented in the Manual within professional and community areas.

II. STRUCTURE OF THE MANUAL

APPROACH

The Manual adheres to a vision of the training as a process that focuses on the development of skills that enable healthcare service providers to reflexively, responsibly and effectively carry out the various tasks they face that pertain to sexual health and diversity. The development of such skills involves a dynamic combination of knowledge, values, abilities, attitudes and principles, which will be built on the experience of the participating individual or group.

An integral part of this training is to promote human rights, gender and interculturality approaches, in order to empower the participating groups and break down social, gender, cultural and attitude barriers to provide adequate care in this field.

Trans persons should fully participate in this workshop, not only so they can relate their experiences, but also act as facilitators and, if possible, manage and review the workshop before it begins.

METHODOLOGY

The Manual's educational proposal falls within an active learning paradigm that integrates the participant's previous experiences, incidents surrounding the situation, analysis of the information, approach to and resolution of questions, establishment of relationships and associations, decision-making and development of action strategies. It is not limited to transmitting blocks of information that, although necessary, is only part of a more complex process of creative interactions that will allow participants to develop a diversity of skills including, among others, situation analysis, problem-solving, critical thinking, and communication and information management.

An interactive, constructivist-type methodology is used, which promotes the development of skills and not simply the accumulation of information.

The person responsible for facilitating the workshop will find a guide with detailed instructions on the learning activities, which will help him/her stay on track with the process and help the participating group master the main concepts of each session. It might also be useful for some of the participants to replicate activities and workshops in their professional environments.

Each session contains educational activities that are described in detail, step by step. These activities are based on the principles of interactive learning and include case discussions, working in small groups, dramatizations and other exercises, which call upon the individuals involved in the learning process to actively participate. They likewise encourage group work and exchange of knowledge among the workshop's members. To go along with the reading, the trainer will be able to create an active educational session, at times animated and fun. The person doing the training will not be doing all the speaking, but instead will be part of a dynamic learning process.

Interactive methodologies are a framework for creating and carrying out instruction that promotes shared reflection, critical analysis, in-depth questioning and group problem-solving. This enables the participants to broaden their knowledge and come to a better understanding of the actual human rights issues they are facing, and to define proposals and strategies for change.

The learning made possible by interactive methodologies, firmly rooted in the life experiences, realities, hopes and aspirations of the participants, is in line with the principles of adult education and is often called “experiential learning.”

Taking into consideration the implications of broad but limited group participation, an interaction that gathers the participants’ experience and analyzes it in light of new concepts and other scientific evidence, working efficiently to reach conclusions that lead to viable actions for participants and the importance of integrating diverse training skills, it is highly recommended that the Manual be used by a team of facilitators and not just by one individual.

FORMAT

The Manual is consistent with a training workshop’s structure and format. The workshop format is quite suitable for encouraging group thinking processes on a topic of interest and reviewing ways in which the lessons can be applied. It is a complex yet flexible format that promotes group knowledge-building, primarily by combining interactive activities.

This format allows a set of skills to be combined, channeling the understanding of problem situations – their difficulties and consequences – into a framework of human rights, and from a perspective of gender, seeking skillful management of methodological and communication-based tools to integrate sexual health into the provision of healthcare services.

ORGANIZATION

The Manual consists of an introductory session, a final evaluation session and ten educational sessions, which are broken down into three steps:

1. **Observing the circumstances:** the group participants should start by reflecting on their own experiences or everyday situations that allow them to put the topic into context. They will use this reflection on their real-life experiences to come up with information for later discussion. This first step serves as a mirror for observing individual and group images that will account for situations that occur and that should be reviewed.
2. **Reinforcing concepts:** at this time, discussion begins in order to analyze the topic in question, beginning with the multiple viewpoints of the participants in attendance. New knowledge on the subject will also be incorporated. The intention is to connect the group analysis to other points of view in order to supplement, expand on and/or review the information available to the group. This step promotes a broader reflection on how one thinks, how one feels and what one does when facing a given situation.
3. **It’s clear to me that...:** with the help of the facilitating individual or team, the group is encouraged to reach conclusions. We are looking for repercussions of some customary practices in our community and professional environment that lead to opportunities to transform healthcare services. Individual and group conclusions are used by the facilitator team to assess the processes and review the lessons learned.

Each step corresponds to an educational activity. All proposals are encompassed in a perspective of learning that allows the participating groups to develop a diversity of skills including, among others, situation analysis, problem-solving, critical thinking, communication and information management.

The following aspects are specified in each session:

Objective: indicates the abilities that are to be developed through the learning activities; thus, they may refer to knowledge, skills or attitudes.

Time: specifies the minimum amount of time required.

Activity: indicates the name and type of exercise proposed for the group process.

What you need to have in advance: specifies the prior arrangements required.

To learn more: includes basic supporting texts and indicates useful sources to expand on information about each topic.

Resources: indicates some links to online documents that pertain to the topic.

PowerPoint presentation images are also included in the session. Sometimes these images are slightly different from the slides since they are a guide for facilitators to prepare their own presentations.

III. WORK PLAN

The workshop is structured to be carried out in 20 hours. These hours can be distributed in different ways. A **sample agenda**, for two-and-a-half days, is shown below. This agenda can be adapted to group needs and times, provided the hourly intensity is maintained.

Broadening Our Understanding of Diversity Workshop Agenda

Time	DAY 1	DAY 2	DAY 3
8:30	Initial Session (1.5 hours)	Session 5: Healthcare professionals and sexuality in the lifecycle. Infancy and childhood (2 hours)	Session 10: Professionals and specialized sexual health (1.5 hours)
9:00			
9:30			
10:00	Session 1: Healthcare professionals and sexual health (3 hours)	Session 6: In the first person (1 hour)	BREAK
10:30			
11:00		Session 7: Healthcare professionals and sexuality in the lifecycle. Adolescence and youth (1.5 hours)	Final Session: Workshop evaluation and closing (1.5 hours)
11:30			
12:00			
12:30			
1:00			
LUNCH			
2:00	Session 2: I already have...but I still need (1 hour)	Session 8: Healthcare professionals and sexuality in the lifecycle. Adulthood (1.5 hours)	
2:30			
3:00	Session 3: Human rights as core elements of the healthcare team's work (1.5 hours)		
3:30			
4:00	Session 4: The healthcare professional as a member of a culture (2 hours)	Session 9: Healthcare professionals and sexual healthcare. Special needs of key populations (3 hours)	
4:30			
5:00			
5:30			
6:00	Summary and evaluation of the day (10 minutes)		
6:30			

IV. FACILITATION PROCESSES

REQUIREMENTS AND ROLE OF FACILITATORS

Being a facilitator is not easy, and that is why it is important that you be clear on what your role is and what your responsibilities are. Whenever possible, it is desirable for the workshop process to be in the hands of more than one facilitator. Two may always be present, and alternate in the facilitation and co-facilitation roles.

So, as one person facilitates a session, the other person can record the information on the printed flipchart, flipchart or computer, keep track of times, help the discussion adhere to the session's objectives, support the work of small groups, provide additional summaries or clarifications, collect or distribute material. If it is not possible to have two or more facilitators, the participation of a volunteer from among the participants may be requested for simple tasks such as recording information or distributing materials.

It is essential that facilitators know how the services are provided, in general, since training should help *link* their different areas. Furthermore, the trainers' experience should complement each other as much as possible. In some cases, "experts" could be invited to provide the information in step 2: Reinforcing concepts.

Although the Manual contains information to guide you during a workshop and help you make decisions that enrich the learning experience, trainers should understand the principles of adult education, know how to use a variety of interactive training methods and techniques, and be able to adapt materials to meet participants' needs. We must always remember that the Manual is a guide and is in no way set in stone; adaptations can be made, provided that its basic elements are maintained.

The facilitator's work begins before the workshop and ends after the training.

FUNCTIONS OF FACILITATORS²

BEFORE TRAINING

Administrative Functions

- Along with the managers of customer service, ensure that the following is clear: the training's objectives, the time required, the importance of participants' uninterrupted attendance, the selection of a multidisciplinary group, etc.
- Along with those in charge of the programs, reflect on the individual and group profiles of the training attendees.
- State the need for the size of the group to not be too large (maximum 35 participants), since this is what the interactive methods require.

² The terms "facilitator" and "trainer" are used interchangeably since both refer to an enabling action in an experience focused on individuals and their ability to generate learning. It is worth clarifying that the terms coach and/or instructor are to be avoided, since their functions are at odds with the interactive and constructivist learning approaches promoted in the Manual.

- Agree on the systems to follow up on the training, assigning deadlines and people in charge.
- Ensure that the hall or location where the training will take place allows for interactive activities to be carried out, move the furniture, organize subgroups, carry out dramatizations, etc. Auditorium-type venues are not recommended.
- Visit, and if necessary, prepare the hall or location where the training is going to take place. The facilitator may not be able to do much about where the workshop is going to take place. However, it is important that he/she be aware of how the hall may affect the participants' ability to learn. Distractions, lack of natural light, lack of ventilation, outside noise, among others, are factors that disrupt attention.

Technical Functions

- Research potential participants' backgrounds with regard to the tasks they perform and training needs. If possible, trainers should chat with participants about their experiences in the provision of services and ask questions that allow them to discern some existing attitudes and knowledge.
- Make it clear that an approach other than theoretical explanation is going to be used. This means that participants carry out their own learning process in an environment that is comfortable and suitable for mutual enrichment and exchange of experiences and knowledge. The group must keep in mind that its members are responsible for their own learning process.
- Familiarize yourself with the process and sequence of activities that make up the sessions or learning modules, the material and other teaching resources that will be used, to give yourself an idea of the type of sessions that are going to be carried out and understand the objectives, content and approaches (thematic and methodological). At the start of each session, the required materials are indicated.
- Gather all the materials that the group is going to need to carry out the planned tasks, and assign one place for them: printed flipchart or flipchart, large, different-colored markers, adhesive tape, scissors, glue, Post-its and other materials.
- Adapt the sessions, especially the cases and suggestions for dramatizations, so they reflect the participants' needs and standard local practice. These adaptations may be as simple as changing the names of the characters in the case studies, or as complex as developing new suggestions for dramatizations, or even coming up with new exercises.
- Have visual aids prepared in advance and in a suitable format. When you are going to need projection equipment, verify the power sources, the location of the screen and the proper functioning of the equipment.

DURING TRAINING

The facilitator has to perform different functions during the workshop:

- **Opening the session:** consists of explaining the objectives of the session to the group and presenting the topic to be addressed in such a way that the participants are able to personally relate to it. Describe how each session is related to other previous or future sessions.
- **Guiding the process:** includes presenting the concepts of each set of topics, using the interactive techniques suggested in each case. Avoid leaving ideas "up in the air," encourage

their recording and support participants so that they understand them and can relate them to their jobs and personal situations. Assist in the “idea discovery” process and in raising the group’s awareness.

- **Giving instructions:** clearly and accurately indicate precisely what task the group is going to carry out, what each member of the group must do, what result must be obtained from the activity and how much time the group has to complete it.

During the workshop, there are times when the participants must all work together and other times when they are divided into subgroups. When the large group is divided into subgroups, the final instructions must not be given until the subgroups have been formed. Otherwise, the participants may forget the instructions while forming the subgroups.

- **Managing tasks:** involves the ability to carry out the activities within the established timeframes as well as the flexibility to make quick adjustments when the time, group or activity so require. Tell participants how much time they have and announce the time remaining to complete the activity. The pace of the activity must be maintained. Discretely review the work of the group or subgroups to verify that the work is being done correctly and in order to make decisions regarding time adjustments.
- **Promoting group participation:** consists of fostering an environment of respect in which everyone can express him-/herself without fear of being judged or disparaged. Encourage participation from the shyest or quietest people and do not let the most “talkative” people take over the process.
- **Managing time:** involves complying with and enforcing the schedules. Start the session on time and resume on time after each break. Keep the groups’ statements and discussions focused. On the one hand, it is very important to grant enough time for the educational processes, and on the other, it is also very important not to lose time unnecessarily due to tangents that are not always directly related to the activities.
- **Clarifying communications:** verify that participants understand the ideas you wish to communicate; summarize and emphasize the most important aspects every so often.
- **Maintaining interest and motivation by asking open-ended questions** (which cannot be answered with a “yes” or “no”) so that participants reflect individually and as a group. It should be noted that various sample questions have been included in the Manual to guide the facilitator when required. However, it is not necessary to ask all the questions that are suggested. Each facilitator, at his/her discretion, must choose the ones he/she deems most appropriate to support the process of reflection that the group is undertaking in the workshop. It is also expected that the facilitator understand the meaning of the questions and reword them in a way that best suits the group of participants.
- **Closing the sessions:** ensure that all questions have been answered. Provide guidance on how the lessons should be applied or put into practice. End the sessions by ensuring that all pending issues have been resolved. Leave enough time for the evaluations.
- **Evaluating your work:** periodically review, usually at the end of each day, how the sessions were carried out, in order to identify successes and areas of opportunity in conducting the workshop (organization, facilitation, topics, activities, materials, breaks, time and logistics issues).

AFTER TRAINING

- Process the evaluations of each workshop and prepare reports.
- Make adjustments to scheduling and/or materials when necessary.
- Maintain open communication with participants in order to receive feedback and be able to master the facilitation process.

V. SESSIONS AT A GLANCE

Sessions	Objectives	Activities	Time
Initial Session	<ul style="list-style-type: none"> • Create a suitable environment for the exchange of ideas and experiences in a context of respect and dialog. 	<ol style="list-style-type: none"> 1. Initial diagnosis 2. Introductions and expectations 3. Objectives, schedule and procedure 4. Workshop agreements and rules 	1.5
Session 1. Healthcare professionals and sexual health	<ul style="list-style-type: none"> • Review the role of healthcare service providers regarding sexual health and the basic needs of sexually diverse populations that are not being met. • Review some basic terms on sexuality and sexual diversity and create a glossary that facilitates communication. • Analyze the skills and knowledge that healthcare personnel possess to provide care pertaining to the sexual health of the general population. 	<ol style="list-style-type: none"> 5. Presentation: When healthcare services don't provide care 6. Let's agree 7. Group work: The role of healthcare personnel 	3
Session 2. I already have...but I still need	<ul style="list-style-type: none"> • Review the role of healthcare personnel in terms of sexual healthcare. • Compare expected functions to actual skills and identify gaps that must be closed. 	<ol style="list-style-type: none"> 8. Creating a typical character 9. Presentation 10. Brainstorming 	1
Session 3. Human rights as core elements of the healthcare team's work	<ul style="list-style-type: none"> • Provide up-to-date knowledge on sexual diversity and promote the elimination of prejudices associated with it, enabling healthcare personnel to protect sexual rights, as applicable to them. • Facilitate the understanding of different expressions of sexuality as part of respect for sexual and human rights. 	<ol style="list-style-type: none"> 11. Looking back and looking ahead 12. Presentation 13. Plenary discussion 	1.5

Sessions	Objectives	Activities	Time
Session 4. The healthcare professional as a member of a culture	<ul style="list-style-type: none"> Gain basic knowledge to identify stigma and discriminatory actions. Understand the relationship between stigma and discrimination and the negative impact they both have on the right to healthcare. Recognize that we are all part of the problem and are involved in stigmatization even when we don't realize it. Envision ways to establish phobia-free spaces. 	<p>14. Guided discussion on the "Where is the Difference?" video</p> <p>15. Collective construction – strengths, weaknesses, opportunities and threats (SWOT) analysis</p> <p>16. Creation of signs</p>	2
Session 5. Healthcare professionals and sexuality in the lifecycle. Infancy and childhood	<ul style="list-style-type: none"> Review the main characteristics of child sexual development in infancy. Analyze the role of healthcare providers within the scope of child sexual health. Foster a comprehensive vision of child sexuality as a set of ongoing processes in which biological, psychological and sociocultural aspects are not separate, but rather complementary dimensions. 	<p>17. Tales and truths</p> <p>18. Presentation: Child sexuality</p> <p>19. Role play</p>	2
Session 6. In the first person	<ul style="list-style-type: none"> Understand the letter T in the lesbian, gay, bisexual and transgender (LGBT) abbreviation. Come up with a direct approximation, orally, of the most pressing healthcare needs of trans persons. Pave the way for direct communication between services and trans groups that allows prejudices and mistrust to be set aside during interactions and seek broader participation from these groups in decisions regarding their sexual health. 	<p>20. Gathering of questions</p> <p>21. Panel</p> <p>22. It is relevant to consider</p>	1
Session 7. Healthcare professionals and sexuality in the lifecycle. Adolescence and youth	<ul style="list-style-type: none"> Address adolescents' reality from a perspective of historical and cultural change. Learn about some of the problems and challenges in addressing sexual health in adolescence and youth in today's world. Think about the importance of reviewing strategies for promoting sexual health in adolescents at the first level of care, from a perspective of gender and rights. 	<p>23. Adolescence, yesterday and today</p> <p>24. Presentation</p> <p>25. Prioritizing problems</p>	1.5
Session 8. Healthcare professionals and sexuality in the lifecycle. Adulthood	<ul style="list-style-type: none"> Reflect on the need to accept diversity in adults as a fundamental aspect for those working in healthcare, from a perspective of gender and human rights. Reflect on the importance of initial contact and approach, 	<p>26. Thinking outside the box</p> <p>27. Presentation</p> <p>28. We are already doing this, but we need to be doing that</p>	1.5

Sessions	Objectives	Activities	Time
	<p>suggesting aspects that must be taken into account.</p> <ul style="list-style-type: none"> • Raise awareness about some prejudices that exist among healthcare workers regarding sexual orientation and identity that lead to an inadequate approach to the consultation and/or to rejecting the opportunities for solving problems affecting adults' health. • Question prejudices regarding sexual diversity that allow healthcare practices in violation of people's dignity to be changed and go on to eliminate differences so that no one requires "special treatment." 		
<p>Session 9. Healthcare professionals and sexual healthcare. Key populations' needs</p>	<ul style="list-style-type: none"> • Acquire basic knowledge about the healthcare needs of trans persons. • Identify and analyze factors associated with services and trans persons' perceptions of these services that limit the possibilities for comprehensive care of these groups. • Review strategies for comprehensive treatment of trans persons and come up with recommendations for the respective services. 	<p>29. Brainstorming 30. Open discussion 31. The news</p>	<p>3</p>
<p>Session 10. Professionals and specialized sexual health</p>	<ul style="list-style-type: none"> • Emphasize actions by primary care professionals to meet LGBTI health needs. • Analyze the scope and limitations of primary care as part of comprehensive care of LGBTI persons. • Go over the situations in which it is appropriate to make referrals and how they should be made. • Identify actions to be taken that allow the lessons learned in this workshop to be put into practice. 	<p>32. Collective construction 33. Interactive talk 34. My task is...</p>	<p>1.5</p>
<p>Final Session. Workshop evaluation and closing</p>		<p>35. Overall evaluation 36. Post-workshop tests 37. Future planning 38. Closing</p>	<p>1.5</p>

VI. SESSIONS

INITIAL SESSION

The success or failure of any educational activity starts with the initial contact between the group of participants and the facilitator. The following elements are key: being aware of needs, defining objectives, knowing the context in which actions will be taken and having a clear agreement on the type of work to be done, its scope and requirements. The purpose of this session is to put the work into context, to facilitate the exchange of knowledge between the facilitator and the participants and to clarify expectations. The goal is to create an environment of significant, reflexive, respectful, creative, motivational and interactive learning. All of these elements result in a better work dynamic.

Initial Session		Time: 1.5 hours
Objective Create a suitable environment for the exchange of ideas and experiences in a context of respect and dialog.		
Activities		Minutes
1. Diagnosis and initial evaluation		20
2. Introduction of participants and their expectations of the workshop		20
3. Explanation of the objectives, schedule and procedure to be followed		10
4. Workshop agreements and rules		10
What do you need to have in advance?		
		Material 1: Riddle Scale Material 2: Lists for matching terms and definitions Material 3: Case Slide 1: Objectives Slide 2: Agenda
To learn more		Interpretation of Riddle Scale responses

Activity I	Group diagnosis
Educational material	Copies of the following for each participant: Material 1: Riddle Scale (Attitudes toward diversity) Material 2: Lists for matching terms and definitions Material 3: Case

PROCEDURE

1. Take a few moments to welcome the group and introduce the facilitator team.
2. Explain the need to obtain some answers before beginning discussion on the topic. Explain that they are going to be asked to complete three forms, that it is very important to adhere to the time schedule, that the forms must be filled out individually and that any questions that arise will be answered at another time during the workshop. You can assign a number to each participant and ask that he/she put it on his/her forms, pointing out that this same number will be used in the post-workshop evaluation. This is being done to ensure the anonymity of responses, while at the same time allowing the initial responses to be compared to the final responses.
3. Give each participant a set of forms that includes the **Riddle Scale** (Material 1), the **lists for matching terms and definitions** (Material 2) and **the case** (Material 3).
4. Make it clear that they have 20 minutes to complete the three forms; once this time has elapsed, collect the materials.
5. Be sure to collect all the materials and make sure they have all been completed. These evaluations may be reviewed by the facilitator team to formulate a preliminary diagnosis of the group's existing knowledge and opinions.

Activity 2	Introduction of participants and their expectations of the workshop
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PROCEDURE

1. Explain the procedure for introducing participants: using the standard Twitter message format (140 characters including spaces, in about 17 words), put together a direct message to communicate your name, where you are from and your expectations or interest in participating.
2. Each participant shares his/her message in the plenary session.
3. Emphasize the group's most outstanding qualities and the existing potential for undertaking this workshop.

Activity 3	Explanation of the objectives, schedule and procedure to be followed
Educational material	Slides in PowerPoint® or on flipchart sheets: 1. Objectives 2. Agenda
Equipment	Computer Projector Screen

PROCEDURE

1. Present the slides corresponding to the workshop's objectives and the work schedule.
2. Point out that the topic is very broad and that this workshop is a general overview that does not exhaust the topic or resolve all training needs.
3. Mention that carrying out this work requires active participation from the group.
4. Clarify any doubts about participants' expectations.

Activity 4	Workshop agreements and rules
Equipment	Flipchart Color markers

PROCEDURE

1. Interactively establish some rules so the workshop will run smoothly.
2. Write the group's input on the flipchart and put it in a visible place.
3. Let the group know that it is possible to modify these rules as the workshop progresses.

In general, there are agreements such as the following:

- All participants have the right to speak, to share our experiences and express our opinions. Therefore, teasing or disparaging criticism is not allowed.
- When sharing experiences, we will talk about our own experiences in the first person. We will say, "This happened to me," "I did..." etc.
- It is not appropriate to interrupt when someone is speaking. You should ask to speak.
- Interventions must be brief so as to not monopolize time and take away other people's opportunity to speak.
- It is not appropriate to make moral judgments with regard to what each participant expresses in the group.
- What is discussed within the group is confidential and should not be discussed outside of the group.
- The facilitator will remind the group of these rules whenever necessary.

INITIAL SESSION MATERIALS

Activity	Educational Material
1. Group diagnosis	Material 1: Riddle Scale Material 2: Lists 1 and 2 for matching terms and definitions Material 3: Case
2. Introduction of participants and their expectations of the workshop	
3. Explanation of the objectives, schedule and procedure to be followed	Slide 1: Workshop Objectives Slide 2: Agenda
4. Workshop agreements and rules	

MATERIAL 1. ATTITUDES TOWARD DIVERSITY – RIDDLE SCALE

<i>Check off all statements with which you agree</i>		Agree
1.	Only heterosexuality is natural and moral.	
2.	LGBTI persons are psychologically and emotionally sick.	
3.	LGBT persons must seek conversion therapy or any other available treatment that helps them change their sexual orientation and identity.	
4.	LGBT persons did not choose their condition. If they could choose, they would be heterosexuals.	
5.	Homosexuality and the trans identity are phases people go through and most overcome them.	
6.	LGBTI persons require our support and guidance to overcome the problems associated with their lifestyle.	
7.	The fact that people are LGBTI doesn't bother me, but I don't believe that they should flaunt their identity or orientation.	
8.	What LGBTI persons do in their private lives is their business.	
9.	LGBTI persons deserve the same privileges and rights as other people.	
10.	Society needs to reject discrimination and prejudices against LGBTI persons.	
11.	LGBTI persons require courage and strength to show themselves as they are.	
12.	It is important to me to examine my own attitudes to actively support LGBTI persons' struggle.	
13.	Human diversity is of great value and LGBTI persons are part of this diversity.	
14.	It is important to me not to accept homophobic or transphobic attitudes.	
15.	LGBTI persons are an indispensable part of our society.	
16.	I would be willing to advocate for the full inclusion of LGBTI persons in our society.	

MATERIAL 2. LIST I

Sexual Orientation	A. Ways in which a person communicates his/her gender identity through his/her physical appearance.
Sex	B. Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical.
Sexual Identity	C. A central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.
Gender Role	D. Each person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender (e.g. heterosexual) or the same gender (e.g. homosexual) or more than one gender (e.g. bisexual).
Sexuality	E. Includes how the individual identifies as male, female, masculine, feminine, or some combination; and the individual's sexual orientation. It is the internal framework constructed over time that allows an individual to organize a sexual self-concept based on his or her sex, gender and sexual orientation, and to perform socially in alignment with his or her perceived sexual capabilities.
Intersex Traits or Conditions	F. Biological characteristics (genetic, endocrinal, and anatomical) used to categorize humans as members of either a male or female population. While these sets of biological characteristics are not mutually exclusive (they naturally occur in various degrees or combinations), in practice, they are used to differentiate humans as supposedly opposite extremes within a polarized binary system.
Gender Identities	G. The ensemble of social and behavioral norms and expectations associated with different categories of sex and gender identity in a given culture and historical period.
Gender Expressions	H. A person's sense of being a man, a woman, or some alternative gender or combination of genders.

MATERIAL 2: LIST 2

Trans	1. Adjective to describe a diverse group of individuals whose gender identity differs to varying degrees from the sex they were assigned at birth. It refers to persons who have not altered or do not desire to alter their natal primary sexual characteristics.
Transgender	2. Term used to refer to trans persons who identify as female (i.e., persons who were assigned male at birth and identify as women).
Transsexual	3. Adjective used as an umbrella term to refer to persons whose gender identity and/or gender expression does not correspond with the social norms and expectations traditionally associated with their sex assigned at birth.
Transvestite	4. Individuals who are changing, or have changed, their primary and/or secondary sex characteristics by means of medical interventions (hormones and surgery) to masculinize or feminize the body. Generally these individuals also permanently change their gender role.
Trans Woman or Transfeminine	5. Term used to refer to persons who wear clothes and adopt other forms of gender expression culturally associated with the other sex.
Trans Man or Transmasculine	6. Term used to refer to trans persons who identify as male (i.e., persons who were assigned female at birth and identify as men).

MATERIAL 3: CASE NUMBER _____

You have the file of Carlos Álvarez, who requires a medical examination as a requirement for starting a new job. The person who answers your call appears to be female.

1. How do you address this person?
2. What do you initially ask?
3. What steps do you take based on this person's responses?
4. What final guidance do you give this person?

Slide 1. Broadening Our Understanding of Diversity

Sexual health and diversity training workshop for primary healthcare professionals

Objectives

First-level healthcare personnel should:

1. Approach and treat sexual health in all its diversity in an informed manner, free from prejudice and within a framework of respect for human rights.
2. Gain a broad and scientific vision of some of the fundamental aspects of sexual health.
3. Acquire tools so that they can provide better treatment for their patients in areas involving sexual health.
4. Be aware of the health problems that affect the LGBTI community and obtain resources to serve them in a positive and respectful way.
5. Provide their services considering the sexual health needs of the sexually diverse populations that they treat and protect the sexual rights of these groups.
6. Acquire the ability to replicate some of the Manual's elements, acting as facilitators in activities and workshops within their professional field.

Slide 2

Broadening Our Understanding of Diversity Workshop Agenda			
Time	DAY 1	DAY 2	DAY 3
8:30	Initial Session (1.5 hours)	Session 5: Healthcare professionals and sexuality in the lifecycle. Infancy and childhood (2 hours)	Session 10: Professionals and specialized sexual health (1.5 hours)
9:00			
9:30			
10:00	Session 1: Healthcare professionals and sexual health (3 hours)	Session 6: In the first person (1 hour)	BREAK
10:30			
11:00		Session 7: Healthcare professionals and sexuality in the lifecycle. Adolescence and youth (1.5 hours)	Final Session: Workshop evaluation and closing (1 hour)
11:30			
12:00			
12:30			
1:00			
LUNCH			
2:00	Session 2: I already have...but I still need (1 hour)	Session 8: Healthcare professionals and sexuality in the lifecycle. Adulthood (1.5 hours)	
2:30			
3:00	Session 3: Human rights as core elements of the healthcare team's work (1.5 hours)	Session 9: Healthcare professionals and sexual healthcare. Special needs of key populations (3 hours)	
3:30			
4:00			
4:30	Session 4: The healthcare professional as a member of a culture (2 hours)		
5:00			
5:30			
6:00			
6:30	Summary and evaluation of the day (10 minutes)		

SESSION I

This session is extremely important because it sets the overall tone for the entire workshop. It must define the workshop’s core ideas: sexual health will be the main topic of the training, and will be further broken down into diversity and, more specifically, the health needs of trans persons.

This workshop also seeks to broaden the vision of healthcare professionals in order to recognize the aspects that must be addressed, changed or strengthened to improve the quality of care in areas pertaining to sexual health for everyone, regardless of one’s sexual orientation or gender identity.

One of the most important parts of this session is to establish a common language as well as to clarify the concepts that will be used throughout the workshop.

Visualizing and respecting sexual diversity in the healthcare system is to protect all citizens’ right to have access to healthcare.

Session I		Time:
Healthcare professionals and sexual health		3 hours
Objectives		
<ol style="list-style-type: none"> 1. Review the role of healthcare service providers regarding sexual health and the basic needs of sexually diverse populations that are not being met. 2. Review some basic terms on sexuality and sexual diversity and create a glossary that facilitates communication. 3. Analyze the skills and knowledge that healthcare personnel possess to provide care pertaining to the sexual health of the general population. 		
Steps	Activities	Minutes
Observing the circumstances	5. Presentation	20
Reinforcing concepts	6. Let’s agree	120
It’s clear to me that...	7. Group work: The role of healthcare personnel	40

What do you need to have in advance?	PPT® 1: When services don't provide care PPT® 2: Diversity and identities: concepts and terminology Material 4: Glossary of basic terms on diversity (printed for distribution)
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To learn more	Overview of sexuality Terminology and definitions
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Step 1	Observing the circumstances
Activity 5	Presentation
Educational material	PPT® 1: When services don't provide care
Equipment	Computer Projector Screen

PROCEDURE

1. Introduce the topic of the session, indicating that the workshop's emphasis is placed on a comprehensive vision of health that, in general, is seldom present in healthcare services due to various circumstances.
2. Brainstorm about the following question: Why is comprehensive healthcare difficult in our context?
3. Recognize the difficulties and obstacles that the group indicates and point out that this has consequences.
4. Make a presentation using PPT® 1: **When healthcare services don't provide care.**
5. Invite the group to participate by expressing their concerns and/or providing examples.
6. Avoid monologues.

Step 2	Reinforcing concepts
Activity 6	Let's agree
Educational material	PPT® 2: Diversity and identities: concepts and terminology Material 4: Glossary of basic terms on diversity (printed for distribution)

PROCEDURE

1. Conduct a general review of terminology-related difficulties encountered in the initial test.
2. Explain that in this workshop, we will be working with terms that are often used in very different ways by various people, which may lead to confusion and misunderstandings. It is very important to use a common language and clarify, from the start, the main terms that we will be using. Add that there is a need for the common language to be correct, free from prejudices.
3. Indicate that inappropriate and/or biased language results in unproductive communication and an approach that does not benefit the population's sexual healthcare needs.

4. Using PPT® 2 (**Diversity and identities: concepts and terminology**), review each term one by one.
5. Ask the group which terms are easiest for them and which are the most complicated.
6. Ask questions or ask for examples to verify that each concept that was reviewed has been made clear.
7. Whenever possible, hand out a copy of Material 4 (**Glossary of basic terms on sexuality and diversity**) so participants can reinforce their knowledge and ask questions.

Step 3	It's clear to me that...
Activity 7	Group work: The role of healthcare personnel
Equipment	Flipchart Color markers Post-its

PROCEDURE

1. Form four groups.
2. Each subgroup must choose one of the following categories and write down, on the Post-its, the areas that must be strengthened in order to improve its work in areas of sexual health.
Categories:
 - Prevention
 - Care
 - Interpersonal communication
 - Community diagnosis
3. On a flipchart sheet, draw a table with the categories as columns and ask that each subgroup, during the plenary session, place their conclusions in the applicable columns.

Prevention	Care	Interpersonal Communication	Community Diagnosis

4. Organize a plenary session so that each group can provide a conclusion.
5. Take the group's contributions into account in order to tie them in to other topics later on.
6. Summarize the group work and try to identify areas of improvement among healthcare personnel in order to provide people with adequate care pertaining to sexual health.

SESSION I MATERIALS

Activity	Educational Material
5. Presentation: When healthcare services don't provide care.	PPT® 1: When services don't provide care
6. Let's agree	PPT® 2: Diversity and identities: concepts and terminology Material 4: Glossary of basic terms on sexuality and diversity
7. Group work: The role of healthcare personnel	

Material 4: Glossary of basic terms on sexuality and diversity³

Sex

Biological characteristics (genetic, endocrinal, and anatomical) used to categorize humans as members of either a male or female population. While these sets of biological characteristics are not mutually exclusive (they naturally occur in various degrees or combinations), in practice, they are used to differentiate humans as supposedly opposite extremes within a polarized binary system.

Typically, a distinction is made between primary sexual characteristics (i.e. an individual's reproductive organs) and secondary sex characteristics (i.e. other, non-genital physical traits that differentiate males from females).

Sexuality

“Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors” (WHO, 2002).

Sex Assigned at Birth (or Natal Sex)

“Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex (Grumbach, Hughes, & Conte, 2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender-nonconforming individuals, gender identity or expression differ from their sex assigned at birth” (Coleman et al., 2011, p. 97).

³Taken from: PAHO (2012). *Elementos para el desarrollo de la Atención Integral de personas trans y sus comunidades en Latinoamérica y el Caribe [Blueprint for the Provision of Comprehensive Care for Trans Persons and their Communities in Latin America and the Caribbean]*. Washington, DC.
https://www.dropbox.com/s/prg7qelulfkz9s/DEFINITIVO%20FINAL%20FINAL%20Por_la_salud_de_las_personas_trans-version_digital%281%29.pdf

Intersex Traits or Conditions

In certain contexts, they are also called “disorders of sexual development” (DSD). Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the “disorder” label and instead view these conditions as a matter of diversity (Diamond, 2009), preferring the terms intersex and intersexuality” (Coleman et al., 2011, p. 95).

Gender Identities

A person’s sense of being a man, a woman, or some alternative gender or combination of genders. A person’s gender identity may or may not correspond with natal sex.

Gender Expressions

An individual’s way of communicating gender identity through physical appearance (including clothing, hair styles, and the use of cosmetics), mannerisms, ways of speaking, and behavioral patterns.

Gender Role

The ensemble of social and behavioral norms and expectations associated with different categories of sex and gender identity in a given culture and historical period. A person’s behavior may differ from the gender role or gender identity traditionally associated with sex assigned at birth, and may transcend the system of culturally established gender roles altogether.

Sexual Identity

Sexual identity includes how the individual identifies as male, female, masculine, feminine, or some combination; and the individual’s sexual orientation. It is the internal framework constructed over time that allows an individual to organize a sexual self-concept based on his or her sex, gender and sexual orientation, and to perform socially in alignment with his or her perceived sexual capabilities (Pan American Health Organization [PAHO]; WAS, 2002).

Sexual identity includes physical characteristics, gender identity, gender expression and sexual orientation. This encompasses a constellation of possibilities, including homosexual trans woman; heterosexual cis (i.e., non-trans) male; heterosexual trans man, and others.

Sexual Orientation

Sexual orientation is understood to refer to each person’s capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender (e.g. heterosexual) or the same gender (e.g. homosexual) or more than one gender (e.g. bisexual) (The Global Fund, 2009, p. 29) or regardless of gender (pansexual). Sexual orientation represents a personal characteristic that is independent of gender expression and identity. Therefore, an individual’s gender expression or identity does not allow inferences to be made regarding his/her sexual orientation.

Gender Non-Conformity

The extent to which a person’s gender self-concept and expression differs from the social norms and expectations traditionally associated with her or his sex assigned at birth or gender identity.

Transition

“Transition is the period of time when individuals change from the gender role associated with their sex assigned at birth to a different one. For many people, this involves learning how to live socially as a person of that gender. For others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized” (Coleman et al., 2011, p. 97).

Trans

Adjective used in this document as an umbrella term to refer to persons whose gender identity and/or gender expression does not correspond with the social norms and expectations traditionally associated with their sex assigned at birth.

Transgender

Adjective to describe a diverse group of individuals whose gender identities differ to varying degrees from the sex they were assigned at birth (Bockting, 1999). The term is sometimes distinguished from the term “transsexual.” In this case, “transgender” refers to persons who have not altered or who do not desire to alter their natal primary sexual characteristics. Various groups of transgender women in different Spanish-speaking countries have started to demand to be recognized as “transgender female,” a neologism signifying the female nature of their identity. This is a significant affirmation, since the Spanish language uses gender in very strict terms.

Transsexual

“Adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through feminizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role” (Coleman et al., 2011, p. 97).

Travesti

This term is one of the most varied terms in the region. In some Latin American countries, it is used to refer to persons assigned male at birth who go to great length feminizing their body and appearance and prefer female pronouns, without typically considering themselves women or desiring to alter their natal primary sexual characteristics through genital surgery (Kulick, 1998). In other countries, this term is simply a synonym of transvestite.

Transvestite

Term used to refer to persons who wear clothes and adopt other forms of gender expression culturally associated with the other sex. Cross-dressing may be the initial stage of transition, but not all cross-dressers experience anguish and suffering due to their sex assigned at birth. Many persons periodically wear clothing and adopt a gender expression associated with the other sex as part of performances, though their gender identity generally corresponds with their sex assigned at birth. Some terms that are used include: drag queens, transformers, drags, or cross-dressers (in the case of men assuming a female role) and drag kings or painted women (in the case of women assuming a male role).

Trans Woman or Transfeminine

Term used to refer to trans persons who identify as female (i.e., persons who were assigned male at birth and identify as women).

Trans Man or Transmasculine

Term used to refer to trans persons who identify as male (i.e., persons who were assigned female at birth and identify as men).

Female-to-Male (FTM)

“Adjective to describe individuals assigned female at birth who are changing, or have changed, their gender identity and gender expression from birth-assigned female to a more masculine body or role” (Coleman et al., 2011, p. 96).

Male-to-Female (MTF)

“Adjective to describe individuals assigned male at birth who are changing, or have changed, their gender identity and gender expression from birth-assigned male to a more feminine body or role” (Coleman et al., 2011, p. 96).

Other Gender Categories

Other identity labels may be used by individuals whose gender identity and/or expression does not conform to a binary, mutually exclusive understanding of gender in terms of man or woman, male or female (Bockting, 2008). These may comprise terms such as queer and transqueer, and may include individuals who identify as both man and woman (bigender, pangender, omnigender), as a third or other gender (intergender), or as without gender (genderless, agender, or neutral).

Alternative Genders/Third Genders

Among some aboriginal and native peoples, gender systems may not be binary (for example, masculine-feminine), but include additional categories, such as muxes among Zapotecs in Mexico or tidawinas among Warao in Venezuela.

PPT® I: When healthcare services don't provide care

When healthcare services don't provide care

- ppt® 1
- Session 1
- Activity 5

Exclusionary models

- Based on a series of exclusionary or discriminatory practices or ideas and on prejudices with a certain degree of social consensus, against individuals' fundamental rights.

Types of exclusionary models

- Neutrality
- Avoidance
- Segregation
- Exoticization

Neutrality

- Considers individuals' sexual orientation and gender identity to be irrelevant information in the provision of healthcare services, and thus do not generate any kind of reaction in their providing care.
- Identifies LGBT individuals as people who are equal to others who deserve the same health services anyone else receives when seeking non-specific care.
- Claims that "routine treatment" is provided, but hides the patient's individual and specific characteristics, which in many cases is key to having an appropriate clinical history as well as providing a proper diagnosis and treatment.

Avoidance

- There is fear of offending or shaming the individual and therefore, topics or questions that address sexuality are avoided.

Segregation

- Identifies LGBT groups as dangerous and "high-risk" individuals.
- Acknowledges sexual orientation and gender identity as relevant information for approach. However, on this basis, makes a series of assumptions about the individuals' lives and their moral character as persons.
- In providers, this generates attitudes of fear, discomfort and rejection.
- Individuals are treated with suspicion and distrust.

Exoticization

- Has stereotypical ideas of LGBT persons, considering them to be exceptional, gay, frivolous, strange, "misexual", promiscuous and uncommitted in their relationships.
- They are characterized as being "artificial," "open-minded" or, explicitly or not, as likely to be sex workers.
- The topic of sexual orientation and/or gender identity is taken "highly" taken as a case, and it is assumed that they are individuals who are used to being the butt of jokes. It is also assumed that their sex lives are public or are an open topic of conversation, with out modesty.

This happens because...

- There are no clear criteria for providing care to individuals with non-majority gender identities or sexual orientations.
- The meaning of respect for privacy is interpreted arbitrarily.
- Guidelines for the provision of services do not take into account the implications and needs associated with an individual's gender identity and sexual orientation.
- There is a fear of asking questions, as they do not know how to react or respond as healthcare professionals.

This results in

- Barriers to accessing healthcare
- Impersonal care
- Impact on overall health
- Violation of human rights

PPT® 2: Diversities and identities: concepts and terminology

DIVERSITIES AND IDENTITIES

- PPT® 2
- Session 1
- Activity 6

Ideas about the "Trans" Concept

Here, include examples of sources from healthcare service providers in your country. They may come from different fields such as the diagnosis made by a doctor (the left) or social, cultural, religious and political, or from other sources.

EXAMPLES

- Most of the sources, transform the body to change the sex with which the individual was born. They do this by using hormones, surgery to reassign the body, undergoing surgery and hormone therapy for their bodies, to have a female body.
- Some linked themselves to a change in external appearance to them is a male who dresses like a female.

Ideas about the "Trans" Concept

Other examples:

- Subversion of the natural order of gender: "From Creation, God made men and women, so defyingly, if a person is created like a man or a woman, that does not take sexual role or gender away from that person."
- Trans status is irrelevant for equal treatment: "That is a normal person."

"The world is not to be divided into sheep and goats. Not all things are black, nor all things white. It is a fundamental of humanity that nature rarely deals with discrete categories. Only the human mind invents categories and tries to force facts into separate pigeon-holes. The living world is a continuum in each and every one of its aspects. The sooner we learn this concerning human sexual behavior, the sooner we shall reach a sound understanding of the realities of sex."

—Jiddu Krishn, 1950

Sexual Diversity

It is the ever-changing result of the combination, in each culture and in each person, of inherited biological factors, the dictates of the culture in which one is born and how that individual and that individual's society adapt to the environment and evolve, fusing anything in its meaning of life and in relation to what that individual's culture considers to be sexual.

Sexuality

- Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.
- Sexuality is experienced and expressed in thoughts, feelings, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

WHO, International Guidelines for the Clinical Management of Transsexual Gender, 2014

Sex

Biological characteristics (genetic, chromosomal, and anatomical) used to categorize humans as members of either a male or female population. While there are many biological characteristics that are used to identify sex, many are not used to determine biological sex. In practice, they are used to determine biological sex. In practice, they are used to determine biological sex. In practice, they are used to determine biological sex.

Sexual, a difference in male between primary sexual characteristics (i.e. an individual's reproductive organs and associated structures) and secondary sexual characteristics (i.e. an individual's body hair, facial hair, and other sex-related features that develop from the testes or ovaries).

WHO, International Guidelines for the Clinical Management of Transsexual Gender, 2014

Gender

The sum of cultural values, attitudes, roles, practice, and characteristics based on sex

- refers to a set of characteristics, responsibilities, roles and behaviors assigned by societies to men and women.
- Differs from one cultural environment to another and is dynamic.

Sex assigned at birth or birth sex



"Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. However, the internal genitalia, chromosomes, and hormones may not match the external genitalia. In some cases, the sex assigned at birth may not match the sex assigned at birth. In some cases, the sex assigned at birth may not match the sex assigned at birth."

WHO, International Guidelines for the Clinical Management of Transsexual Gender, 2014

RESOURCES

- Chávez, S. and Liendo, G. (2008). *Concertando Diversidades. [Harmonizing Diversities.] Guía de apoyo para facilitadores y facilitadoras. [Support Guide for Facilitators.]* Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos, PROMSEX. [Center for the Promotion and Defense of Sexual and Reproductive Rights, PROMSEX.] Peru. Available at: www.promsex.org
- PAHO. (2012). *Elementos para el desarrollo de la Atención Integral de personas trans y sus comunidades en Latinoamérica y el Caribe. [Blueprint for the Provision of Comprehensive Care for Trans Persons and their Communities in Latin America and the Caribbean.]* Washington. https://www.dropbox.com/s/prg7qeluolfkz9s/DEFINITIVO%20FINAL%20FINAL%20Por_la_salud_de_las_personas_trans-version_digital%281%29.pdf
- Proyecto Todo Mejora. [Everything Improves Project.] *Más allá del rosa y el azul. [Being Trans: Beyond Pink and Blue.]* At: <http://www.youtube.com/watch?v=TbJYzX0UIEs&list=WLCAEC7A87499324A8>

SESSION 2

The purpose of this session is for healthcare personnel to explore their needs in depth to be able to provide adequate care that meets the needs of sexually diverse persons. This review covers the use and practice of concepts such as sexual diversity, human rights, gender and quality of care. It likewise involves going over the need to have open, professional, empathetic, understanding and respectful attitudes, which add value to communication and effectiveness in the resolving the purpose of the consultation.

Session 2 I already have...but I still need		Time: 1 hour
Objectives		
<ol style="list-style-type: none"> 1. Review the role of healthcare personnel in terms of sexual healthcare. 2. Compare expected functions to actual skills and identify gaps that must be closed. 		
Steps	Activities	Minutes
Observing the circumstances	8. Creating a typical character	20
Reinforcing concepts	9. Presentation	20
It's clear to me that...	10. Brainstorming in subgroups: What we have and what we need	20

What do you need to have in advance?	PPT® 3: First-level care for sexually diverse populations
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To learn more	Conceptions of care quality
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Step 1	Observing the circumstances
Activity 8	Creating a typical character
Equipment	Flipchart sheets Color markers

PROCEDURE

1. Indicate that the group will be split into two teams.
2. Each team must create a typical character, i.e., identify a character that is representative of healthcare service providers. To create this character, aspects such as name, age, place of work and duties he/she performs should be considered.
3. The skills, knowledge and attitudes the typical character possesses to promote the population's sexual health should be considered.
4. Emphasize that this is not about creating ideal characters. The exercise is about recognizing strengths and areas of opportunity for improvement.
5. Tell them that they should put as much creativity into their characters as possible through the use of drawings, sculptures and portrayals, and that they will have ten minutes to do so.

6. After the ten minutes have passed, ask a representative from each team to come up and introduce their typical character.
7. Lead a general discussion about needs based on the characteristics of the typical characters.
8. With help from the participants, prepare a summary that identifies a few general categories to itemize the needs that have been indicated (for example: related to attitude, communication, information, organization, etc.).

Attitudes	Communication	Information	Organization

9. Go over the most important points identified by the teams and point out those that have not been mentioned.
10. Tell them that it is important that they recognize two aspects: first, social expectations about their role in terms of sexual health; and second, the skills and knowledge they must develop and strengthen to be able to adequately fulfill these expectations. Even though they will be reviewed throughout the workshop, it is important that each person identify those on which he/she needs to work.

Step 2	Reinforcing concepts
Activity 9	Presentation
Educational material	PPT® 3: First-level care for sexually diverse populations
Equipment	Sheets Tape (masking)

PROCEDURE

1. Discuss some of the qualities that are essential in primary care services when the needs of LGBTI groups must be appropriately met and addressed. Use PPT® 3 (**First-level care for sexually diverse populations**) as an aid.
2. Make sure that each of the factors is made clear. If necessary, provide examples.

Step 3	It's clear to me that...
Activity 10	Brainstorming in subgroups

PROCEDURE

1. Divide the group into four subgroups. Ask groups 1 and 2 to write down, on a flipchart sheet, what each of them already has to meet the needs mentioned; ask groups 3 and 4 to write down what each of them still requires to meet their needs.
2. Ask them to write their answers down on a flipchart sheet or printed flipchart sheet or by answering the two questions asked: groups 1 and 2, **what we have** and groups 3 and 4, **what we need**.
3. Ask the groups to present their conclusions and ask the group for its input when necessary.

SESSION 2 MATERIALS

Activity	Educational Material
8. Creating a typical character	
9. Presentation	PPT® 3: First-level care for sexually diverse populations
10. Brainstorming in subgroups	

PPT® 3: Primary care for sexually diverse populations

<p>Primary care for sexually diverse populations</p> <p>Desirable scenarios</p> <ul style="list-style-type: none">• PPT® 3• Session 2• Activity 9	<p>All members of the healthcare team, including administrative staff, are essential for ensuring quality service in caring for the health of patients.</p>	<p>PRIMARY CARE Ideal Features</p> <p>Primary care is the gateway to healthcare services for LGBTI groups whose needs have not been met .</p>
<p>Healthcare personnel have been trained on:</p> <ul style="list-style-type: none">• Local cultural frameworks, values and attitudes of local groups, languages and conceptualizations on sexual and gender diversity and rights.• Comprehensive specialized healthcare from a sexual and gender diversity and human rights perspective.	<p>When healthcare personnel have empathy and understanding along with an inclusive language and environment, it opens access to healthcare and comprehensive, effective, humane, timely and decisive care.</p>	<p>As part of healthcare services, patients are guaranteed rights to confidentiality, privacy and informed consent, explaining to the patients, in clear and simple language, what that means.</p>
<p>When sexual diversity is recognized and respected, the health-care system guarantees the right to access healthcare for all citizens.</p>	<p>It is fundamental to have a communication framework that allows an open, professional, empathetic, understanding, confidential and private attitude regarding diverse identities, behaviors and sexual practices to be effective in resolving consultations.</p>	<p>When inquiring about a couple, multiple possibilities will be considered so as to avoid assuming that the individuals that make up the couple are heterosexual.</p>

RESOURCES

Bernal, M. (2010). Provisión de servicios afirmativos de salud para personas LGBT. [Provision of Affirmative Healthcare Services for LGBT Persons.] Colombia Diversa. [Diverse Colombia.] Bogotá. Available at:
http://colombiadiversa.org/colombiadiversa/images/stories/que/CAPACITACION/salud/Provision_de_servicios_afirmativos_de_salud_para_personas_LGBT.pdf

SESSION 3

The purpose of this session is for healthcare workers to go over situations of discrimination against and exclusion of LGBTI persons by the healthcare services. When some of those situations come to light, it is clear that the right to health, along with many other rights, are being taken away from this population, which goes against all international human rights standards.

In this session, it is important for the facilitator to include data on the status of human, sexual and reproductive rights in his/her own country and to encourage participants to share their own experiences.

Session 3		Time:
Human rights as core elements of the healthcare team's work		1.5 hours
Objectives		
<ol style="list-style-type: none"> 1. Provide up-to-date knowledge on sexual diversity and promote the elimination of prejudices associated with it, enabling healthcare personnel to protect sexual rights, as applicable to them. 2. Facilitate the understanding of different expressions of sexuality as part of respect for sexual and human rights. 		
Steps	Activities	Minutes
Observing the circumstances	11. Looking back and looking ahead. Review of situations	30
Reinforcing concepts	12. Presentation: Sexual rights as part of Human Rights	30
It's clear to me that...	13. Plenary discussion: The importance of sexual rights	30

What do you need to have in advance?	Material 5: Situation cards PPT® 4: Human, sexual and reproductive rights Material 6: WAS Declaration of Sexual Rights Material 7: Summary <i>Born Free and Equal</i>
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To learn more	Ten rights of LGBT patients
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Step I	Observing the circumstances
Activity II	Looking back and looking ahead
Educational material	Material 5: Situation cards

PROCEDURE

1. Cut and randomly distribute the **situation cards** (Material 5) among some of the participants.
2. Ask them to read the cards out loud.
3. Ask the group to comment on the situations described and go over the human rights situation in each case: Was there a violation of rights? If so, of which rights?
4. Encourage participants to share other similar cases of which they are aware.

5. Go over the participants' contributions again and ask them to analyze the topic in greater depth in the following activity.

Step 2	Reinforcing concepts
Activity I2	Presentation: Sexual rights as part of Human Rights
Educational material	PPT® 4: Human, sexual and reproductive rights

PROCEDURE

1. Make a presentation on human rights and on sexual and reproductive rights, focusing on some of the situations LGBTI groups experience. Point out, in particular, how the rights relate to some guidelines issued by governments and ministries such as those that refer to the prevention of discrimination. Use PPT® 4 (**Human, sexual and reproductive rights**) as an aid.
2. Expand on the content of the slides and draw a connection between the topics and the discussions from the previous activity.
3. Use local examples that allow you to better put the topic into context.
4. Avoid monologues and promote group participation.

Step 3	It's clear to me that...
Activity I3	Plenary discussion: The importance of sexual rights
Educational material	Material 6: WAS Declaration of Sexual Rights
Equipment	Flipchart Color markers

PROCEDURE

1. After the general discussion on human rights, point out that significant efforts have been made to “ground” these rights in a code or compendium of sexual rights. Mention that although there are those who say that these rights are not officially recognized, it is true that they are not at all new because they derive from the Universal Declaration of Human Rights signed by all countries.
2. Make reference to the existence of several sexual rights declarations or statements, which do not vary in their foundation of respect for human rights, but which can put some specific emphasis on the situation of a vulnerable group, for example: adolescents, women, LGBT, persons living with HIV, migrants and others. For this purpose, some sexual rights declarations or codes have been drawn up.
3. Indicate that one of the most well-known and inclusive declarations is that of the World Association for Sexual Health (WAS).
4. Give each participant a copy of the **WAS Declaration** (Material 6) for them to read and comment on later.
5. Organize a plenary discussion on how healthcare services can contribute to the exercise of LGBT groups' sexual rights.
6. Ask a co-facilitator or participant to write a summary of the participants' suggestions on the flipchart.
7. With the group's help, identify which tasks are pending in order for them to put their suggestions into practice.

8. Emphasize that sexual and reproductive rights pertain to adults as well as to groups of adolescents and children.
9. If possible, hand out copies of the **Born Free and Equal** document to participants (Material 7).

SESSION 3 MATERIALS

Activity	Educational Material
11. Looking back and looking ahead	Material 5: Situation cards
12. Presentation	PPT® 4: Human, sexual and reproductive rights Material 6: WAS Declaration of Sexual Rights
13. Plenary discussion	Material 7: <i>Born Free and Equal</i> Summary

MATERIAL 5. SITUATION CARDS

A man said that once he identified himself as gay, he was forced to wait for long periods of time before receiving treatment.

A transgender woman states: "I don't even want to go to the healthcare center because at the entrance, the security guards harass and intimidate us."

An activist from the LGBTI community states: "We have to hide our identity for them to treat us well; if we don't, they offend us, they make us wait longer, and they even deny us care."

The Director of an HIV/AIDS program said that one time, when patients identified themselves as homosexuals on a form to receive antiretroviral drugs, they were placed on the waiting list for the drugs, while people who identified themselves as heterosexuals were not.

A nurse who administered drugs to a lesbian woman for a sexually transmitted infection advised the patient to repent of her sins.

Transgender persons, who cannot legally change their names or sex on identity documents to reflect their gender identity, say that healthcare personnel addressed them by the name and sex on their document instead of the name and sex with which they identify themselves. A transgender man commented: "When you go to the healthcare units, they look at you and in front of everybody, they say in a loud voice, 'Mrs. Fernández, come in.' Once I get up, everyone looks and automatically points at me and starts to stigmatize. Or they make you wait until the last shift."

A transgender man indicated the lack of access to certain types of specialized healthcare. For example, he said that they laughed at him when he asked for an appointment with the gynecologist and he was denied access to that healthcare provider.

When a woman filled out the admission form, she mentioned that she lived with another woman. The social worker told her that before doing anything else, she would send her to the psychiatrist "so that he helps you cure yourself."

LGBTI community activists have reported that, at some healthcare centers, appointment cards for HIV treatment are marked in red with the "HIV" abbreviation. So when patients entered clinics and hospitals, they were harassed by the security guards.

A woman explained: "Why is the guard interested in what I'm going to do at the hospital?...He's not a doctor...he has nothing to do with the healthcare sector."

PPT® 4: Human, sexual and reproductive rights

<p>Human, sexual and reproductive rights</p> <ul style="list-style-type: none">▶ PPT® 4▶ Session 3▶ Activity 12	<p>Human rights</p> <p>Are the powers, freedoms and prerogatives inherent to each person due to the mere fact of being human.</p> <p>The Universal Declaration of Human Rights (1948) encompasses all rights that are considered to be basic and are found in the International Charter of Human Rights.</p> <p>The Declaration indicates that all human beings are born free and equal in dignity and rights.</p>	<p>Characteristics</p> <ul style="list-style-type: none">▶ Inalienable▶ Independent▶ Irrevocable▶ Non-transferable▶ Unwaivable
<p>Inalienable</p> <p>No one, under any circumstances, can deprive another person of these rights beyond the existing legal code.</p>	<p>Independent</p> <p>Of any particular factor (race, sex, nationality, religion, sexual preference).</p>	<p>Irrevocable</p> <p>Cannot be abolished.</p>
<p>Non-transferable</p> <p>One person cannot transfer these rights to others.</p>	<p>Unwaivable</p> <p>Basic rights cannot be waived by anyone.</p>	<p>Holders</p> <ul style="list-style-type: none">▶ HOLDERS of rights: + 7,000,000,000 people▶ Each individual, man, woman or child, of any race, ethnic group or social status, of any religious belief and sexual orientation.

MATERIAL 6. DECLARATION OF SEXUAL RIGHTS

Declaration of Sexual Rights of the World Association for Sexual Health (WAS)⁴

Sexuality is an integral part of the personality of every human being. Its full development depends upon the satisfaction of basic human needs such as the desire for contact, intimacy, emotional expression, pleasure, tenderness and love.

Sexuality is constructed through the interaction between the individual and social structures. Full development of sexuality is essential for individual, interpersonal, and societal wellbeing.

Sexual rights are universal human rights based on the inherent freedom, dignity, and equality of all human beings. Since health is a fundamental human right, so must sexual health be a basic human right.

In order to assure that human beings and societies develop healthy sexuality, the following sexual rights must be recognized, promoted, respected, and defended by all societies through all means. Sexual health is the result of an environment that recognizes, respects and exercises these sexual rights.

1. The right to sexual freedom

Sexual freedom encompasses the possibility for individuals to express their full sexual potential. However, this excludes all forms of sexual coercion, exploitation and abuse at any time and situations in life.

2. The right to sexual autonomy, sexual integrity, and safety of the sexual body

This right involves the ability to make autonomous decisions about one's sexual life within a context of one's own personal and social ethics. It also encompasses control and enjoyment of our own bodies free from torture, mutilation and violence of any sort.

3. The right to sexual privacy

This involves the right for individual decisions and behaviors about intimacy as long as they do not intrude on the sexual rights of others.

4. The right to sexual equity

This refers to freedom from all forms of discrimination regardless of sex, gender, sexual orientation, age, race, social class, religion, or physical and emotional disability.

5. The right to sexual pleasure

Sexual pleasure, including autoeroticism, is a source of physical, psychological, intellectual and spiritual wellbeing.

6. The right to emotional sexual expression

Sexual expression is more than erotic pleasure or sexual acts. Individuals have a right to express their sexuality through communication, touch, emotional expression and love.

7. The right to sexually associate freely

This means the possibility to marry or not, to divorce, and to establish other types of responsible sexual associations.

8. The right to make free and responsible reproductive choices

This encompasses the right to decide whether or not to have children, the number and spacing of children, and the right to full access to the means of fertility regulation.

⁴Declaration of the 13th World Congress of Sexology, 1997, Valencia, Spain, reviewed and approved by the General Assembly of the World Association of Sexology, WAS, on August 26, 1999, at the 14th World Congress of Sexology, Hong Kong, People's Republic of China.

9. The right to sexual information based upon scientific inquiry

This right implies that sexual information should be generated through the process of unencumbered and yet scientifically ethical inquiry, and disseminated in appropriate ways at all societal levels.

10. The right to comprehensive sexuality education

This is a lifelong process from birth throughout the life cycle and should involve all social institutions.

11. The right to sexual health care

Sexual health care should be available for prevention and treatment of all sexual concerns, problems and disorders.

Sexual Rights are Fundamental and Universal Human Rights.

MATERIAL 7. SUMMARY

Born Free and Equal⁵

The legal obligations of States to safeguard the human rights of LGBT and intersex people are well established in international human rights law on the basis of the Universal Declaration of Human Rights and subsequently agreed international human rights treaties. All people, irrespective of sex, sexual orientation or gender identity, are entitled to enjoy the protections provided for by international human rights law, including in respect of rights to life, security of person and privacy, the right to be free from torture, arbitrary arrest and detention, the right to be free from discrimination and the right to freedom of expression, association and peaceful assembly.

The protection of people on the basis of sexual orientation and gender identity does not require the creation of new rights or special rights for LGBT people. Rather, it requires enforcement of the universally applicable guarantee of nondiscrimination in the enjoyment of all rights. The prohibition against discrimination on the basis of sexual orientation and gender identity is not limited to born Free and Equal II international human rights law. Courts in many countries have held that such discrimination violates domestic constitutional norms as well as international law. The issue has also been taken up by regional human rights systems, most notably by the Inter-American Commission on Human Rights and the Council of Europe.

It is recommended that States:

1. Protect people from homophobic and transphobic violence. Include sexual orientation and gender identity as protected characteristics in hate crime laws. Establish effective systems to record and report hate-motivated acts of violence. Ensure effective investigation and prosecution of perpetrators and redress for victims of such violence. Asylum laws and policies should recognize that persecution on account of one's sexual orientation or gender identity may be a valid basis for an asylum claim.
2. Prevent the torture and cruel, inhuman and degrading treatment of LGBT persons in detention by prohibiting and punishing such acts and ensuring that victims are provided with redress. Investigate all acts of mistreatment by State agents and bring those responsible to justice.
Provide appropriate training to law enforcement officers and ensure effective monitoring of places of detention.
3. Repeal laws criminalizing homosexuality, including all laws that prohibit private sexual conduct between consenting adults of the same sex. Ensure that individuals are not arrested or detained on the basis of their sexual orientation or gender identity, and are not subjected to baseless and degrading physical examinations intended to determine their sexual orientation.
4. Prohibit discrimination on the basis of sexual orientation and gender identity. Enact comprehensive laws that include sexual orientation and gender identity as prohibited grounds of discrimination. In particular, ensure non-discriminatory access to basic services, including in the context of employment and health care. Provide education and training to prevent discrimination and stigmatization of LGBT and intersex people.

⁵ United Nations Office of the High Commissioner for Human Rights (2012). *BORN FREE AND EQUAL. Sexual Orientation and Gender Identity in International Human Rights Law*. New York-Geneva.

5. Safeguard freedom of expression, association and peaceful assembly for LGBT and intersex people. Any limitations on these rights must be compatible with international law and must not be discriminatory. Protect individuals who exercise their rights to freedom of expression, association and freedom of assembly from acts of violence and intimidation by private parties.

RESOURCES

Citizenship, Cultural Activism and Human Rights. At:

<http://www.ciudadaniasx.org/?Campanas>

Lesbian, Gay, Bisexual and Trans Federation of Argentina. *Gender Identity Law*. Buenos Aires. Available at:

<http://www.lgbt.org.ar/00-derechos,09.php>

United Nations Office of the High Commissioner for Human Rights. (2012). *BORN FREE AND EQUAL. Sexual Orientation and Gender Identity in International Human Rights Law*. United Nations. New York-Geneva. Available at: <http://acnudh.org/2013/02/nacidos-libres-e-iguales-orientacion-sexual-e-identidad-de-genero-en-las-normas-internacionales-de-derechos-humanos/>

University of California (2012). *Sexual Diversity in El Salvador. A report on the human rights situation of the LGBT community*. International Human Rights Law Clinic. University of California, Berkeley, School of Law. Available at: http://www.law.berkeley.edu/files/LGBT_Report_Spanish_Final_120705.pdf

SESSION 4

In this session, situations of rejection and aversion to LGBT persons are questioned, exposing this repudiation as the result of an ideology that, when internalized, translates into prejudices that attribute negative characteristics to LGBT persons and is expressed through different forms of violence (physical, moral or symbolic), linked to sexual orientation or gender identity.

Session 4		Time:
The healthcare professional as a member of a culture		2 hours
Objectives		
<ol style="list-style-type: none"> 1. Gain basic knowledge to identify stigma and discriminatory actions. 2. Understand the relationship between stigma and discrimination and the negative impact they both have on the right to healthcare. 3. Recognize that we are all part of the problem and are involved in stigmatization even when we don't realize it. 4. Envision ways to establish phobia-free spaces. 		
Steps	Activities	Minutes
Observing the circumstances	14. Guided discussion on the "Where is the Difference?" video	30
Reinforcing concepts	15. Collective construction – SWOT analysis	60
It's clear to me that...	16. Creation of "Discrimination-free spaces" signs	30

What do you need to have in advance?	<i>Where is the Difference?</i> video, Parts 1 and 2 (21 minutes) Internet connection https://youtu.be/yXNSvGSoqXg SWOT matrix diagram
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To learn more	"Discrimination exists when we deny other individuals or groups of people the equality of treatment which they may desire" (UN, 1949).
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Step I	Observing the circumstances
Activity I4	Guided discussion
Educational material	Where is the Difference? video, Parts 1 and 2. Available at: https://youtu.be/yXNSvGSoqXg
Equipment	Screen Projector Internet connection Computer Flipchart Color markers

PROCEDURE

1. Introduce the activity by indicating that the video they are going to watch was produced by a nongovernmental organization (NGO) called *Colombia Diversa [Diverse Colombia]*.
2. Ask the group to keep the video's title in mind throughout the presentation and at the end, they will have the opportunity to express their opinions in a discussion.
3. Present the video *Where is the Difference? (Parts 1 and 2)*.
4. Before starting the discussion, outline the topic and propose some general guidelines: speak one at a time, do not repeat what has already been stated, let everyone express themselves, limit the time of each intervention.
5. Have some open-ended questions ready. Yes or no questions should be avoided since that cuts off discussion and does not encourage analysis. Some examples of open-ended questions are:
 - In your communities, what ideas about sexual diversity prevail? How is everyone affected: LGBT persons, families, institutions?
 - Why does society label differences?
 - Why do you believe that stigma is so strongly associated with gender identity and sexual orientation?
 - Why do stigma and discrimination occur without there being much awareness about this?
 - What problems are created in a society that discriminates?
 - Which groups are most significantly affected by stigma and discrimination related to sexual diversity?
 - What are the effects of these discriminatory practices on the affected persons?
 - -What is behind these ideas and manifestations?
 - What consequences does this have on the lives of the persons mentioned?
 - How do they affect or endanger people's freedom?
 - How do people feel when they are discriminated against?
6. If the discussion strays, it is better to briefly summarize what was addressed and redirect the activity through some new questions.
7. Write down the main ideas stated to formulate a final summary on the flipchart.
8. Do not commit to the participants' points of view; just contribute elements of information, stimulate and summarize every so often. Maintain a cordial attitude and do not reject any opinions.
9. Keep in mind that it is important to reach a conclusion on what was discussed.
10. Prepare a summary and ask the group to approach this situation in a more limited context, such as healthcare services.

Step 2	Reinforcing concepts
Activity 15	Collective construction – SWOT analysis
Educational material	SWOT matrix diagram
Equipment	Flipchart Color markers

PROCEDURE

1. Start by mentioning that on the one hand, the strengths and weakness that the healthcare system has to address these issues, and on the other hand, the opportunities and threats that arise on a personal level in this same sense will be analyzed.
2. Form four subgroups and assign them a task in the following manner:
 - Group 1 – Strengths of the system
 - Group 2 – Personal opportunities
 - Group 3 – Weaknesses of the system
 - Group 4 – Personal threats
3. Ask each subgroup to identify at least three factors, under their heading, that affect the ability to carry out sound and decisive work that addresses the sexual health needs of LGBT groups.
4. Give each subgroup some blank cards and ask them to write down the factors they identified so they can put them into the matrix, similar to the one below, that you had prepared in advance:

The System	Personal
Strengths	Opportunities
Weaknesses	Threats

5. Have the entire group look at the set of responses and express their comments.
6. Prepare a summary.

Step 3	It's clear to me that...
Activity 16	Creation of signs – Discrimination-free spaces
Equipment	Posters Color markers Tape (masking)

PROCEDURE

1. Mention that the previous session demonstrated that sexual rights must be the basis to safeguard against homophobia, lesbophobia and transphobia; however, they are institutionalized and are experienced in the daily provision of services.
2. Ask the group to think about the importance of having spaces that are free of these types of phobias. For this purpose, have them organize themselves into four subgroups and prepare a sign with a message that addresses the phenomena shown previously.
3. Each group presents its sign and explains its contents.
4. A member of the group summarizes all the proposals.

SESSION 4 MATERIALS

Activity	Educational Material
14. Guided discussion	<i>Where is the Difference?</i> video, Parts 1 and 2.
15. Collective construction – SWOT analysis	SWOT matrix diagram
16. Creation of signs – Discrimination-Free Spaces	

RESOURCES

Gender and Health. At: <http://www.genderandhealth.ca/en/portfolio/index.jsp>

International Lesbian, Gay, Bisexual, Trans and Intersex Association, ILGA. At: <http://ilga.org>

Spanish Government network for the depathologization of trans identities. (2010). *Guide to good practices for trans persons' healthcare within the framework of the National Health System*. Available at: <http://stp2012.files.wordpress.com/2010/10/stp-propuesta-sanidad.pdf>

SESSION 5

The purpose of this session is for healthcare personnel, especially primary care personnel, go over the construction of sexuality in the infancy and childhood stage, clarify issues in this regard and become aware of the responsibility to be well informed and to develop open attitudes due to the influence they may have on others, given their credibility.

Session 5		Time:
Healthcare professionals and sexuality in the lifecycle. Infancy and childhood		2 hours
Objectives		
<ol style="list-style-type: none"> 1. Review the main characteristics of child sexual development in infancy. 2. Analyze the role of healthcare providers within the scope of child sexual health. 3. Foster a comprehensive vision of child sexuality as a set of ongoing processes in which biological, psychological and sociocultural aspects are not separate, but rather complementary dimensions. 		
Steps	Activities	Minutes
Observing the circumstances	17. Tales and truths	45
Reinforcing concepts	18. Presentation: Sexuality in infancy and childhood	30
It's clear to me that...	19. Role play We identify opportunities to teach about sexual diversity	45
What do you need to have in advance?	Tale for a childhood on the edge. At: http://www.mujeresalborde.org/spip.php?article109 PPT® 5: Child sexuality Material 8: The role of healthcare providers within the scope of child sexual health	
To learn more	Development of sexuality in infancy and childhood	
Step 1	Observing the Circumstances	
Activity 17	Tales and Truths	
Educational material	Tale for “a childhood on the edge.” At: http://www.mujeresalborde.org/spip.php?article109	
Equipment	Internet connection Projector Computer, screen Flipchart Color markers	

PROCEDURE

1. Begin the session by showing the story “a childhood on the edge.”
2. Point out, as previously mentioned, that sexuality is present throughout the entire lifecycle and that it is important to learn about its manifestations in the first stages because sexuality in infancy and childhood lays the foundation for adolescent and adult sexuality.
3. Form four subgroups and randomly assign an age bracket:
 - -From ages 0 to 2
 - From ages 2 to 4
 - From ages 5 to 8
 - From ages 9 to 12
4. Ask them to write down, on flipchart sheets, some of the manifestations of sexuality in the age bracket they were given. Ask them to indicate if there are differences between boys and girls.
5. After 15 minutes, ask the participants to present, in chronological order, their conclusions.
6. Comment on the conclusions with the group, clarifying ideas when necessary. Tell them that the next step will expand even more on this stage.

Step 2	Reinforcing concepts
Activity 18	Presentation
Educational material	PPT® 5: Child sexuality Material 8: The role of healthcare providers within the scope of child sexual health

PROCEDURE

1. Explain that the objective of this talk is to present a general overview of sexual development in infancy and childhood.
2. To provide additional information on the group’s reflection, review the information in the *To Learn More* section in advance.
3. Mention that, given the broad nature of the topic, the focus will be on aspects related to the development of sexual identity.
4. For your presentation, use PPT® 5: **Child sexuality**.
5. During the presentation, intervene to ask questions that help the group clarify ideas. To provide additional information and when appropriate, ask for examples.
6. At the end, give each participant a copy of Material 8: **The role of healthcare providers within the scope of sexual health**. Ask them to take five minutes to read it, and make sure that all questions have been answered.

Step 3	It’s clear to me that...
Activity 19	Role play We identify opportunities to teach about sexual diversity

PROCEDURE

1. Organize four subgroups and assign each one an age bracket in the childhood stage: ages 0 to 2, ages 3 to 5, ages 6 to 8, and ages 9 to 12. Ask the subgroups to choose a question, concern or fear that fathers and mothers have expressed to them about the sexuality of a son or daughter.
2. Tell them that, in accordance with the topic chosen, they must organize a social drama or role play (dramatization) in which they interact with fathers and/or mothers of boys or girls as service providers. This can take place at the doctor's office, the waiting room or in the community.
3. Instruct the group to prepare a short script (no longer than three minutes) and to distribute roles as they deem fit.
4. Ask the subgroups to perform their skits and after each skit, ask the group in general to comment, with you making the final conclusion with the relevant clarifications.

SESSION 5 MATERIALS

Activity	Educational Material
17. Tales and truths	Tale for "a childhood on the edge." At: http://www.mujaresalborde.org/spip.php?article109
18. Presentation	PPT® 5: Child sexuality Material 8: The role of healthcare providers within the scope of child sexual health
19. Role play	

MATERIAL 8. THE ROLE OF HEALTHCARE PROVIDERS WITHIN THE SCOPE OF CHILD SEXUAL HEALTH

Parents often seek the guidance and advice of professionals (child caregivers, psychologists and psychiatrists, pediatricians, counselors, etc.) to try to resolve their questions and concerns in relation to child sexuality and in general, to verify if certain sexual behaviors they observe in their children are within the limits of “normality” or, on the contrary, should generate suspicion or alarm. The recommendations and opinions provided by professionals in response to these questions, therefore, may determine, to a great extent, the parents’ reaction to their children’s sexual behavior. For example, if these assessments are not well-founded and erroneously label a sexual behavior as problematic or “deviant,” they may foster an inappropriate or excessive response.

Furthermore, it must be advised that existing social and scientific controversies on sexual abuse may contribute to professionals’ indecision when counseling parents or even come to favor the adoption of extreme attitudes with very pernicious effects. On the one hand, professionals who exaggerate the frequency and consequences of sexual abuses may consider any sexual reference by a child suspect and therefore, foster denial and the pursuit of healthy child sexuality. On the other hand, professionals who ignore or minimize the incidence and severity of abuses may consider all sexual behaviors of children to be appropriate and thus be unable to identify cases of abuse, even in the presence of alarming signals.

Therefore, when carrying out this type of task, the beliefs and opinions of professionals carry great relevance because children’s sexual behaviors are usually a faithful reflection of the values and beliefs that are demonstrated by the adults in their immediate environment in relation to child sexuality.

Above all, it is important that professionals be aware of their own biases and prejudices in matters of child sexuality and that they try to avoid, at all times, allowing these biases and prejudices to contaminate the counseling work they carry out with minors.

Professionals should also keep in mind the weight that prevailing sexual mores, social customs and means of communication can come to bear on the sexuality of some minors, and take a critical stance when the guidelines and values transmitted by these ideological and social powers promote sexual behaviors that are clearly incompatible with health.

PPT® 5: Sexuality in infancy and childhood

Sexuality in infancy and childhood

- PPT 5
- Session 5
- Activity 18

Recapping... Sex

Biological (genetic and anatomical) characteristics which define humans as female or male. Although these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they do tend to differentiate humans as men and women." (The Global Fund, 2009, p. 22)

Sexuality

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, behaviours, practices, desires, and anatomy.

Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships, while aspects of it such as those concerning sex or others are always experienced or expressed.

Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

<http://www.who.int/news-room/fact-sheets/detail/sexual-health>

PAHO/WAS: Sexual identity

Sexual identity includes how the individual identifies as male, female, masculine, feminine, or some combination, and the individual's sexual orientation. It is the internal framework constructed over time that allows an individual to organize a sexual self-concept based on his or her sex, gender and sexual orientation, and to perform socially in alignment with his or her perceived sexual capabilities.

Intersex traits or conditions

Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. They are designated by the terms intersex or intersexuality. (Coleman et al.)

Components of Sexual Identity

(Moayyedi & Burnett)

Sex at birth

- Apparent sex at birth
- Generally determined by the external genitalia.
- At times, the genitals are ambiguous
 - Neither male nor female
 - Simultaneously masculine and/or feminine
 - Some form of intersex

Sex assigned at birth or birth sex

"Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormone sex) are considered in order to assign sex (D'Augelli, Hughes, & Conley, 2008; MacLachlan & Donahoe, 2004; Murray & Enhardt, 2012; Viner, 2005). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender-nonconforming individuals, gender identity or expression differs from their sex assigned at birth." (Coleman et al., 2011, p. 97)

Gender identity

- A person's sense of being a man, a woman, or some alternative gender or combination of genders. A person's gender identity may or may not correspond with natal sex.
- The fundamental conviction of being male and/or female or transgender.
- Individuals vary in the intensity of their identification as male, female or a different identity, and in the permanence and completeness of their feelings.
- Feelings may fluctuate; identities may co-exist or the person may feel neither male nor female.

RESOURCES

Sexuality Information and Education Council of the United States, SIECUS. At: www.siecus.org/

SESSION 6

The purpose of this session is to have an informal conversation, yet one that follows a consistent and orderly path without digressing outside of or far from the topic, or into overly subjective assessments. The facilitator must encourage open communication among the panelists through a conversation that covers the group’s main concerns, always within an environment of respect and cordiality.

Starting with individual experiences, we are looking to challenge certain conceptions about gender identity and delve into the need for healthcare services and personnel from these institutions to develop new ideological and methodological tools for the addition and inclusion of excluded sexualities, which contribute to comprehensive care and, above all, to the recovery of rights infringed upon by discriminatory actions.

Session 6 In the First Person		Time: 1 hour
Objectives <ol style="list-style-type: none"> 1. Understand the letter T in the LGBT abbreviation. 2. Come up with a direct approximation, orally, of the most pressing healthcare needs of trans persons. 3. Pave the way for direct communication between services and trans groups that allows prejudices and mistrust to be set aside during interactions and seek broader participation from these groups in decisions regarding their sexual health. 		
Steps	Activities	Minutes
Observing the circumstances	20. Gathering of questions	10
Reinforcing concepts	21. Panel	30
It’s clear to me that...	22. It is relevant to consider	20
What do you need to have in advance?	<p>Contact trans persons who wish to express their needs within the scope of healthcare.</p> <p>The facilitator, together with the organizing team, should ensure that the people they invite:</p> <ul style="list-style-type: none"> – can easily express themselves and are not “inhibited” by professional arguments; – can contribute ideas that are more or less original and diverse; – approach the different aspects of the topic; – possess critical judgment and a certain sense of humor to enliven a conversation that could at times become somewhat tiresome. <p>The coordinator should hold a meeting beforehand with all the members who will serve on the panel, to exchange ideas and establish a rough outline for the development of the session, explore the topic in depth, organize the subtopics and specific aspects, set times for interventions, etc.</p> <p>Although the Panel should later appear to be a spontaneous conversation, for it to be successful, some preparations such as those stated are required.</p>	

Step 1	Observing the circumstances
Activity	20. Gathering of questions
Equipment	Blank cards Color markers Flipcharts

PROCEDURE

1. Refer to the session's purpose and introduce the panelists.
2. Briefly explain the strategy that is going to be followed: time for questions, presentations and conclusions; features of the interventions by panelists and participants.
3. Invite participants to relay their questions **in writing**, in the following minutes. They may continue relaying their questions throughout most of the panel's duration.
4. Meanwhile, the facilitator and the panelists can organize the questions by topic, examine the most common concerns, and best identify what they will be emphasizing in their presentations.

Step 2	Reinforcing concepts
Activity	21. Panel

PROCEDURE

1. Begin the session by introducing the panel members and asking the first question about the topic that is going to be addressed.
2. Any one of the panel members begins the conversation, although the person who does so may be planned, and the dialog is initiated that will be developed according to the scheduled plan.
3. Intervene to ask new questions about the topic, guide the dialog toward aspects that are not mentioned, focus the conversation on the topic when it strays too far from it, overcome a possible situation of tension that may occur, etc.
4. Stimulate dialog if it lags, but without intervening with your own opinions.
5. About five minutes before the end of the dialog, ask members to very briefly summarize their ideas.

Step 3	It's clear to me that...
Activity	22. It is relevant to consider
Equipment	Blank cards Color markers Flipcharts

PROCEDURE

1. Emphasize the most important conclusions, based on notes you have taken.
2. If time permits, ask the group to exchange ideas on what was stated, informally, in the style of a forum.

3. At this stage, the presence of the panel members is not entirely necessary, but if they would like, they can answer questions from the group, in which case the facilitator will act as a moderator for these questions, directing them to the applicable panelist.

SESSION 7

This session reviews the role that healthcare workers may have in helping adolescents protect their sexual health, understanding their sexuality, actively taking responsibility and making informed decisions, based on clear and timely guidance. This intervention not only allows for discussion, but it is also essential for adolescents to be able to assume their gender identities and sexual orientations without discrimination and to enjoy their sexual rights.

Session 7		Time:
Healthcare professionals and sexuality in the lifecycle. Adolescence and youth		1.5 hours
Objectives		
<ol style="list-style-type: none"> 1. Address adolescents' reality from a perspective of historical and cultural change. 2. Learn about some of the problems and challenges in addressing sexual health in adolescence and youth in today's world. 3. Think about the importance of reviewing strategies for promoting sexual health in adolescents at the first level of care, from a perspective of gender and rights. 		
Steps	Activities	Minutes
Observing the circumstances	23. Adolescence, yesterday and today	40
Reinforcing concepts	24. Presentation: Sexual development in adolescence	20
It's clear to me that...	25. Prioritizing the problems of adolescence today	30

What do you need to have in advance?	<p>Material 9: Questions about adolescence</p> <p>PPT® 6: Sexual development in adolescence</p> <p>Material 10: Adolescents' sexual and reproductive rights charter.</p> <p>Review the latest national surveys on the youth in the country where the workshop will take place, and add data that pertains to the topic, the presentation and other activities in this session.</p>
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To learn more	Construction of sexuality in adolescence
Step I	Observing the circumstances
Activity 23	Adolescence, yesterday and today
Educational material	Material 9: Questions about adolescence
Equipment	Flipchart sheets Color markers

PROCEDURE

1. Divide the group by gender into two or four groups, depending on the total number of participants.
2. Give each group a printed flipchart sheet with the questions from Material 9: **Questions about adolescence**. Prepare the sheets you are going to need in advance.
3. Ask the groups to take ten minutes to think about their adolescence and answer the questions that appear on the sheets they were given. Also ask each group to sing a song that is from “their era.”
4. Ask the groups to present their answer sheets and indicate that each group has a maximum of five minutes to do so. Ask them to explain why they chose their song.
5. Observe and compare the work done and try to identify points of agreement and disagreement.
6. Ask for some comments or reactions from the group.
7. End the activity by commenting on the differences between genders, and among the participants and today’s adolescents. Also point out that the group conclusions depend on the place and time they have as a reference.
8. Emphasize that the adolescents they once were are not a homogeneous group, just as today’s adolescents are not, either.

Step 2	Reinforcing concepts
Activity 24	Presentation
Educational material	PPT® 6: Sexual development in adolescence

PROCEDURE

1. Explain that the objective of the presentation is to present a general overview regarding adolescence. Use PPT® 6 as an aid.
2. Mention that due to the broad nature of the topic, emphasis will be placed on aspects related to the development of sexual identity (including gender identity and sexual orientation).
3. Use the information for the facilitator that appears in the *To Learn More* section as a guide.
4. Encourage the group to ask questions and verify that all questions have been answered.

Step 3	Considering the implications
Activity 25	Prioritizing the problems of adolescence today
Educational material	Material 10: Sexual and reproductive rights charter
Equipment	Stickers in three colors

PROCEDURE

1. Point out that, according to the PAHO, “The ‘right to health’ of young people is the same as for other groups, such as ‘adults’ although young people may be constrained in its exercise for the only reason of being young, for example with respect to ‘medical consent’...”
2. Go over the conclusions of the previous exercise’s section regarding **healthcare and general topics that are most concerning for today’s adolescents**, and make a list on a large sheet (a flipchart sheet). Ask the co-facilitator or a member of the group for help.
3. Make sure that the following topics are included in the list:

- Unwanted pregnancies
 - Access to condoms
 - Access to contraceptives
 - sexually transmitted infections (STIs) (HIV)
 - Sexual diversity
 - Homophobic *bullying*
 - Gender violence
 - Violence between partners
4. Give the participants three “points” (sticker labels that can easily be found at stationery stores) in three different colors. Indicate that each color represents a value. For example, the red points refer to the most important problem according to the participant, blue refers to the second most important, and green to the third most important.
 5. Ask the participants to place the points on the most important problems in their communities. This does not mean that the other problems are not important.
 6. At the end, the participants will have created a map of the problems they identify as the most important. Point out, however, that there are problems that are less visible, but that seriously affect adolescents and youth, such as the inability to assume a gender identity other than that of their physical appearance or realizing that their sexual orientation is not heterosexual. Also mention that the problems are different for males and females.
 7. If possible, give each participant a copy of Material 10: **Sexual and Reproductive Rights Charter**, and emphasize that these rights are part of the set of human rights.

SESSION 7 MATERIALS

Activity	Educational Material
23. Adolescence – yesterday and today	Material 9: Questions about adolescence
24. Presentation	PPT® 6: Sexual development in adolescence
25. Prioritizing the problems of adolescence today	Material 10: Adolescents’ sexual and reproductive rights charter

MATERIAL 9. QUESTIONS ABOUT ADOLESCENCE

Females	Males
(Female) adolescents from “my era”:	(Male) adolescents from “my era”:
Our relationships with family:	Our relationships with family:
Our sex lives:	Our sex lives:
Our relationships with members of the opposite sex:	Our relationships with members of the opposite sex:
Our attitudes toward LGBTI persons	Our attitudes toward LGBTI persons
What we liked:	What we liked:
The health topics that worried us most:	The health topics that worried us most:
Their general concerns are:	Their general concerns are:
(Female) adolescents today:	(Male) adolescents today:
Their relationships with family:	Their relationships with family:
Their sex lives:	Their sex lives:
Their relationships with members of the opposite sex:	Their relationships with members of the opposite sex:
Their attitudes toward LGBTI persons	Their attitudes toward LGBTI persons
What they like:	What they like:
The health topics that worried us most:	The health topics that worried us most:
Their general concerns are:	Their general concerns are:

PPT® 6: Sexual development in adolescence

<p>Sexual Development in Adolescence</p> <ul style="list-style-type: none"> Session 7 Activity 24 PPT 6 	<p>Puberty and adolescence</p> <ul style="list-style-type: none"> Puberty <ul style="list-style-type: none"> Secondary sex characteristics Physical maturation Adolescence <ul style="list-style-type: none"> Psychosocial process Moral and social development Clinic and neurotic symptoms Interpersonal and relationship skills 	<p>Definitions or criteria</p> <ul style="list-style-type: none"> Chronological Biological Psychological Sociocultural
<p>Chronological criteria</p> <ul style="list-style-type: none"> Early adolescence: ages 10-16 Delayed adolescence: ages 17-19 Youth: ages 20-25 	<ul style="list-style-type: none"> In early adolescence: QUESTIONS ABOUT IDENTITY In delayed adolescence: ABILITY TO ESTABLISH INTIMATE RELATIONSHIPS 	<p>Achievements of the adolescent phase</p> <ul style="list-style-type: none"> Establishment of the capacity for abstract thinking Establishment of identity: Individuals know who they are Autonomy and economic and emotional independence from the family Establishment of a personal value system Ability to maintain lasting relationships and to combine sexual love with tenderness and affection, among others.
<p>Young people are sexually active, and at a young age</p> <ul style="list-style-type: none"> Approximately 50% of adolescents under the age of 17 in the Region are sexually active. Between 33% and 71% of women in the Region had sexual relations before the age of 20. The average age for first intercourse is approximately ages 15-18 for young people in male Latin American and Caribbean countries; for males, the average age is approximately 14-15 years old. Young people in certain Caribbean countries begin sexual relations at ages as young as 10 and 12 years old. 	<p>Young people are sexually active, and at a young age (cont'd)</p> <ul style="list-style-type: none"> A significant number of female adolescents are aware of cohabitating between 25% (Peru), 31% (El Salvador) and 34% (Trinidad and Tobago) of adolescents are married at the age of 18. Most sexual relations among young women occur while they are married. 	<p>Knowledge levels are high, but there are still gaps</p> <ul style="list-style-type: none"> In general, knowledge levels about contraception and awareness of the risk of HIV are high, but adolescents know less about other STIs and the ways in which HIV is transmitted. One-fourth to one-half of adolescents between the ages of 15 and 19 in Guatemala, Peru, Haiti and Brazil do not know that a person with AIDS may appear to be healthy.

MATERIAL 10.⁶ CHARTER – ADOLESCENTS’ SEXUAL AND REPRODUCTIVE RIGHTS

1. *The right to freely decide about my body and my sexuality.* The decisions you make about your body and your sex life must be respected, without anyone pressuring or conditioning you or imposing their own values.
2. *The right to practice and fully enjoy my sex life.* No one can pressure you, discriminate against you, lead you to feeling remorse or punish you for carrying out or not carrying out activities related to the enjoyment of your body and your sex life.
3. *The right to publicly express my affections.* You can express your ideas and affections without anyone discriminating against you, limiting, questioning, blackmailing, shaming, threatening or verbally or physically attacking you.
4. *The right to decide with whom to share my life and my sexuality.* You are free to decide with whom to share your life, your sexuality, your emotions and your affections. No one can force you to get married or share your life and your sexuality with someone you do not desire*.
5. *The right to respect of my intimacy and privacy.* You have the right to have your private spaces respected and to confidentiality in all aspects of your life, including sex life. No one can disclose information on the sexual aspects of your life, without your consent.
6. *The right to live free of sexual violence.* Any form of violence against you affects the full enjoyment of your sexuality. No one can sexually pester, harass, abuse or exploit you.
7. *The right to reproductive freedom.* You have the right to decide whether or not to have children, how many, when and with whom you decide*.
8. *The right to equal opportunity and equality.* Although women and men are different, they are equal before the law.
9. *The right to live free of all discrimination.* You cannot be discriminated against due to age, gender, sex, preference, health condition, religion, ethnic origin, way of dressing, physical appearance or any other personal condition.
10. *The right to complete, scientific and secular information on sexuality.* You must receive information that is true, not manipulated or biased. The Government must provide secular and scientific information.
11. *The right to sexual education.* The education you receive must be free of prejudice, promote free and informed decision-making, a culture of respect for human dignity, equal opportunity and equality.
12. *The right to sexual healthcare and reproductive healthcare services.* Public healthcare service personnel cannot deny you information or care under any circumstances and they must not be subject to any prejudice*.
13. *The right to participate in public policies on sexuality.* You may participate in the development, implementation and evaluation of programs on sexuality, sexual health and reproductive health.”

*If you are under legal age, consult the Civil Code of your state.

⁶Sexual and reproductive rights charter for adolescents and youth, supported by the: Comisión Nacional de Derechos Humanos [National Human Rights Commission], Comisión de Derechos Humanos del Distrito Federal [Mexico City Human Rights Commission], Elige Red de Jóvenes por los Derechos Sexuales y Reproductivos [Choose Youth Network for Sexual and Reproductive Rights], Red Democracia y Sexualidad [Democracy and Sexuality Network] (Demysel), Balance, Equidad de Género [Gender Equality], Mexfam, Sipam, Sisex, Católicas por el Derecho a Decidir [Catholic Women for the Right to Decide], Ave de México and 109 other organizations. At: <http://www.cndh.org.mx/node/594>.

RESOURCES

Advocates for Youth. I Think I Might Be Transgender, Now What Do I Do? At:

http://www.advocatesforyouth.org/storage/advfy/documents/Spanish/spanish_trans_web.pdf

Advocates for Youth. Resources for parents of LGBT youth. At: <http://www.bidstrup.com/spardata.htm>

<http://www.advocatesforyouth.org/topics-issues/glbqt?task=view>

Advocates for Youth. Other publications. At:

<http://www.advocatesforyouth.org/library/919?task=view>

<http://www.advocatesforyouth.org/publications/424?task=view>

<http://www.advocatesforyouth.org/component/customproperties/tag?tagId=45>

IPPF, GTZ. (2011). Young People Implementing a Sexual and Reproductive Health and Rights Approach. Resource Pack.

WHO (2011). The Sexual and Reproductive Health of Younger Adolescents. Research Issues in Developing Countries. Background paper for a consultation. Geneva. At:

http://whqlibdoc.who.int/publications/2011/9789241501552_eng.pdf

SESSION 8

This session examines some situations that arise in the daily practice of healthcare services because, due to a heterocentric culture, the healthcare needs of adults of various sexual orientations are often overlooked and ignored. Although providing inclusive healthcare service requires various changes to be made, going over patient questioning and treatment is a good start.

Session 8 Healthcare professionals and sexuality in the lifecycle. Adulthood		Time: 1.5 hours
Objectives		
<ol style="list-style-type: none"> 1. Reflect on the need to accept diversity in adults as a fundamental aspect for those working in healthcare, from a perspective of gender and human rights. 2. Reflect on the importance of initial contact and approach, suggesting aspects that must be taken into account. 3. Raise awareness about some prejudices that exist among healthcare workers regarding sexual orientation and identity that lead to an inadequate approach to the consultation and/or to rejecting the opportunities for solving problems affecting adults' health. 4. Question prejudices regarding sexual diversity that allow healthcare practices in violation of people's dignity to be changed and go on to eliminate differences so that no one requires "special treatment." 		
Steps	Activities	Minutes
Observing the circumstances	26. Thinking outside the box	20
Reinforcing concepts	27. Presentation	30
It's clear to me that...	28. We are already doing this, but we need to be doing that	40

What do you need to have in advance?	<p>Material 11: Personal data form</p> <p>Video: <i>What is the Difference?</i> Available at: http://youtu.be/doyf6m79ZIs</p> <p>Note: although the name is similar to the name in session 4, it is not the same. You must identify the video segments that are going to be analyzed (Facundo and Ana María) starting at 10 minutes and 25 seconds.</p>
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	PPT® 7: First meeting and initial clinical evaluation
Step 1	Observing the circumstances
Activity 26	Thinking outside the box
Educational material	Material 11: General data form Video: <i>What is the Difference?</i>
Equipment	Flipcharts Color markers Computer Projector Internet connection

PROCEDURE

1. Distribute a copy of the **general data form** (Material 11) to each participant.
2. After three minutes, ask them to give you back the forms and check to see if there were any difficulties.
3. If the group members say that their names are not included, tell them that these are the most common names according to the country's statistics records; if they say that none of these nationalities are theirs, tell them that most of the world's population has one of these nationalities and that they are the broadest categories; if anyone says that his/her occupation also does not appear, reiterate that census records indicate that these groups represent the majority of the population.
4. Ask the group:
 - a. What difficulty do you see?
 - b. How do you feel when "we don't fit" or they want to pigeonhole us into the most common box? Mention that one of the characteristics of adulthood is being clear and certain about identity (national, professional, sexual).
 - c. What needs to be done?
 - d. If this happens with a name, nationality and occupation, what happens to the box indicating sex?
 - e. Does everyone fit into one of the two categories of male or female?
 - f. Based on everything you have seen up to now, what changes would you make to clinical data forms or in the way patients are addressed?
 - g. Do you foresee any resistance? From whom?
5. Briefly summarize and ask the group to keep this experience in mind when carrying out the analysis based on the next video.
6. Invite the group to watch the second part of the video *What is the Difference?* After reviewing the cases of Facundo and Ana María, ask the following questions about healthcare personnel's actions in the different sections:
 - a. Would you reconsider the way healthcare personnel carried out the interventions and/or asked questions? What did they cause? Why?
 - b. About what aspects do you think healthcare personnel need to be careful? Why?
 - c. Does it happen often?
 - d. How did this make the patient feel?

7. At the end of the video, start a discussion to compare the different ways of carrying out the interview with a patient and the consequences of doing so in one way or another.
8. Go over the group's conclusions and validate any statements that may arise about the importance of having clear guidelines that must be followed depending on different needs, in addition to an environment of trust in doctor-patient interaction.
9. Reinforce the idea that the first interview represents a defining moment not only to be able to appropriately meet a specific need, but also for the patients to develop trust and remain in the healthcare system.
10. Tie this in to the following activity.

Step 2	Reinforcing concepts
Activity 27	Presentation
Educational material	PPT® 7: First meeting and initial clinical evaluation
Equipment	Computer Projector Screen

PROCEDURE

1. Ask the group to think about the need for healthcare services to include the LGBTI population and to set aside simplistic views and labels that prevent true openness to sexual diversity.
2. Refer to situations, sometimes part of routine services, that have detrimental effects on the patients.
3. Follow the contents of PPT® 7: **First meeting and initial clinical evaluation**, and pause so the group can take part by either asking questions or providing examples.
4. Before closing, ask the group to provide their comments and ask them to continue with the following activity so they can focus in on some pending issues on this topic.

Step 3	It's clear to me that...
Activity 28	We are already doing this, but we need to be doing that
Equipment	Flipcharts Color markers

PROCEDURE

1. Form two subgroups and give each one a flipchart sheet. One of the subgroups for **what we are already doing**, and the second for **what we need to be doing** in healthcare services so that sexually diverse patients can approach us with trust and assurance and receive the care they require.
2. Provide some examples of actions that are already being carried out: a clinical history is taken, a physical examination is carried out; also, give other examples of activities that need to be done. For example, how to train the team members, go over language, etc.
3. Ask the group to jointly identify actions to remedy, over the short term, some of the pending issues that were mentioned.
4. Together with the group, focus in on the main conclusions of the session.

5. Before closing, indicate that the healthcare needs of LGBT groups are no different from those of the rest of the population although, of course, they do have specific needs. On the other hand, emphasize that the assumption of universal heterosexuality, or an identity that is consistent with data such as a name, aside from being offensive, causes distortions in the clinical approach in many cases.

SESSION 8 MATERIALS

Activity	Material
26. Thinking outside the box	Material I I: Personal data form Video: <i>What is the Difference?</i>
27. Presentation	PPT ® 7: First meeting and initial clinical evaluation
28. We are already doing this, but we need to be doing that	

MATERIAL I I. PERSONAL DATA FORM

Dear Participant:

In order to keep a record of those attending this workshop, we ask that you please provide us with some general information by checking off the applicable boxes below:

Name

- Juan/a
- Mario/a
- Carla/os
- Luis/a
- Fernando/a

Nationality

- Chinese
- Hindu
- American
- Russian

Trade or profession

- Law
- Business Administration
- Accounting
- Engineering
- Education

Sex

- Male
- Female

Thank you in advance for your responses!

PPT® 7: First meeting and initial clinical evaluation

First meeting and initial clinical evaluation

- PPT® 7
- Session 8
- Activity 27

"Talking about labeling"

- + Goffman (1961) developed one of the principal social theories on the relationship between stigma and health.
- + He defined stigma as "the identification that a social group creates of a person (or group of people) based on some physical, behavioral, or social trait perceived as being divergent from group norms."
- + This identification lays the groundwork for subsequent disavowal of membership from a group.

Link and Phelan (2001) carried out a study on stigma as a social process

Labeling
People identify and describe differences.

Negative stereotypes
Based on beliefs of the dominant culture, they are passed to recipients, stereotypes of social media, character traits.

Separation
Different categories are created to separate people who are labeled.

Stigmatization
People who are labeled experience a loss of value status, leading to actions of discrimination.

Conclusion of Link and Phelan's study

As a condition for the process of stigmatization, the stigmatizing group has to be in a position of greater power than the stigmatized group. The stigma as a devaluing element is therefore strictly related to concepts such as stereotype, prejudice and discrimination, based on socially consensual criteria of normality.

So...

- + The taxonomy is different, depending on what we are referring to: epidemiology, biology, etc.
- + These terms we have learned are a "guide" to understanding each other and speaking a common language.
- + There is no need to label. What is important is to clearly understand the questions we will be asking each individual in order to make a comprehensive evaluation and have a proper diagnosis and treatment.

All of these elements must be taken into account in the initial approach and the first consultation



Fundamental principles of care

- + Respect the gender identity preferred by the patient and use the nouns, pronouns and terminology the person prefers.
- + Do not treat trans people as if they are just a body.
- + The body of a trans person may have elements, traits or characteristics that do not fit their person's gender identity.
- + The professional must respect the patient's gender identity, regardless of physical appearance.

RESOURCES

Institute of Medicine. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People. Building a Foundation for Better Understanding*. Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. Washington (D.C.): National Academies Press (US).
At: <http://www.ncbi.nlm.nih.gov/books/NBK64806/>

SESSION 9

This session goes over the approach to diagnosing and treating trans persons. A proposal that defines guidelines to follow in order to guarantee them safe and efficient quality healthcare is examined. For any citizen, dignified and professional care is a right; however, the lack of directives and inappropriate approaches have, in many cases, resulted in seeking alternative solutions of dubious quality, with well-known health risks. These circumstances are especially prevalent in certain groups, as is the case for trans persons.

Session 9		Time:
Healthcare professionals and sexual healthcare. Special needs of key populations		3 hours
Objectives		
<ol style="list-style-type: none"> 1. Acquire basic knowledge about the healthcare needs of trans persons. 2. Identify and analyze factors associated with services and trans persons' perceptions of these services that limit the possibilities for comprehensive care of these groups. 3. Review strategies for comprehensive treatment of trans persons and come up with recommendations for the respective services. 		
Steps	Activities	Minutes
Observing the circumstances	29. Brainstorming	30
Reinforcing concepts	30. Open discussion	110
It's clear to me that...	31. The news	40
What do you need to have in advance?	PPT® 8: Healthcare professionals and sexual healthcare. Special needs of key populations. Material 12: Algorithms (one copy of each) Data about the trans population's health, corresponding to the country in which the workshop is taking place.	
To learn more	Characterization of the most common health problems in trans persons. Problems related to service providers. Problems related to how trans persons perceive services and how they are conducted.	
Step 1	Observing the circumstances	
Activity 29	Brainstorming	
Equipment	Flipcharts Color markers	

PROCEDURE

1. Begin the activity by mentioning that care for previously seen health problems is often hindered by how trans persons perceive healthcare services as well as by actual deficiencies within the services themselves.
2. Organize a brainstorming session and ask the participants to identify family, cultural, medical, sexual and economic factors that can be generalized in the context in which trans persons live in their community, and which result in less access to healthcare services and preventive care for these persons.
3. Emphasize the need to put the promotion and offering of healthcare services into context and stress the following aspects:
 - Health problems that affect trans persons are similar to those that affect the rest of the population, but some conditions are more widespread within these groups because they are facing situations that increase their vulnerability or the risk of exposure to pathogens.
 - In addition to health problems that disproportionately affect groups of trans persons, such as HIV, syphilis, gonorrhoea, hepatitis and genital herpes, to name a few examples, there are demands for gender affirmation or construction that require attention from the healthcare sector.

Step 2	Reinforcing concepts
Activity 30	Open discussion
Educational resources	PPT® 8: Comprehensive care, prevention and support for trans populations Material 12: Eight algorithms (four copies of each)
Equipment	Computer Projector Screen

PROCEDURE

1. Tell the group that next, they are going to focus on comprehensive care, prevention and support for trans populations.
2. Explain that the tools that are going to be presented are taken from a study carried out by the PAHO, which consulted with broad sectors of Latin American countries. This work is: *Blueprint for the Provision of Comprehensive Care for Trans Persons and their Communities in Latin America and the Caribbean*.
3. Using PPT® 8, talk about some tools available for the comprehensive management of some of the issues that were analyzed in this session.
4. Ask the participants to gather into the four subgroups in which they worked previously.
5. Present the **eight algorithms** (Material 12) with the text facing down and ask representatives from each group to randomly choose two.
6. For each of the algorithms, ask the group to come up with ONE recommendation on how to use this material for the team as service providers and ONE recommendation for healthcare services, and to write them down on a flipchart sheet.
7. Ask each subgroup to present their conclusions in a plenary session (five minutes per group).

8. Be receptive to comments from participants and encourage them to express their concerns, questions and comments.
9. Close the activity by asking them to read the complete PAHO document mentioned above.

Step 3	It's clear to me that...
Activity 31	The news
Equipment	Flipchart Color markers

PROCEDURE

1. Ask the participants to summarize the topic that was just covered and to identify actions that they commit to implementing over the short term.
2. Organize four subgroups and ask them to prepare a report in *news* format about activities for offering comprehensive care to the trans population.
3. Each subgroup can specify whether their news is for the press, radio or television.
4. Organize the news presentations and wait until the end for comments.
5. On the flipchart, write down the aspects mentioned by most of the participants.

SESSION 9 MATERIALS

Activity	Material
29. Brainstorming	
30. Open discussion	PPT® 8: Healthcare professionals and sexual healthcare. Special needs of key populations Material 12: Eight algorithms (four copies of each)
31. The news	

PPT® 8: Healthcare professionals and sexual healthcare. Special needs of key populations

HEALTHCARE PROFESSIONALS AND SEXUAL HEALTHCARE, SPECIAL NEEDS OF KEY POPULATIONS

- PPT® 8
- Session 9
- Activity 30

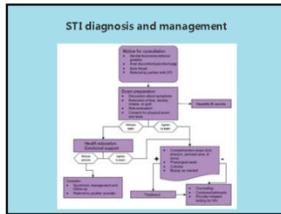
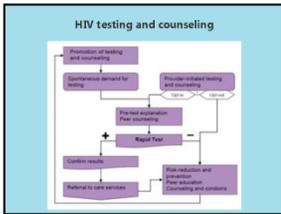


Knowledge and other data on HIV (Include data on your country here.)

For example, in El Salvador:

- 80% know where to go to receive HIV-specialized healthcare
- 99% of participants correctly answered most of the questions on HIV knowledge

Data by A. and Bergman, H. (2012) Diagnosis of Health Needs and Services Available for the Trans Population in El Salvador



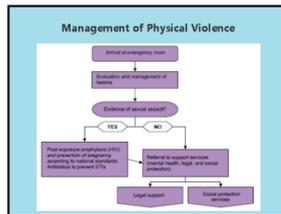
Problems reported due to being Trans (Include data on your country here.)

For example, in El Salvador

- 40% of participants report arguments or disagreements with their parents, siblings, other family members, teachers or bosses, and classmates or coworkers
- Approximately 50% have had problems with the police

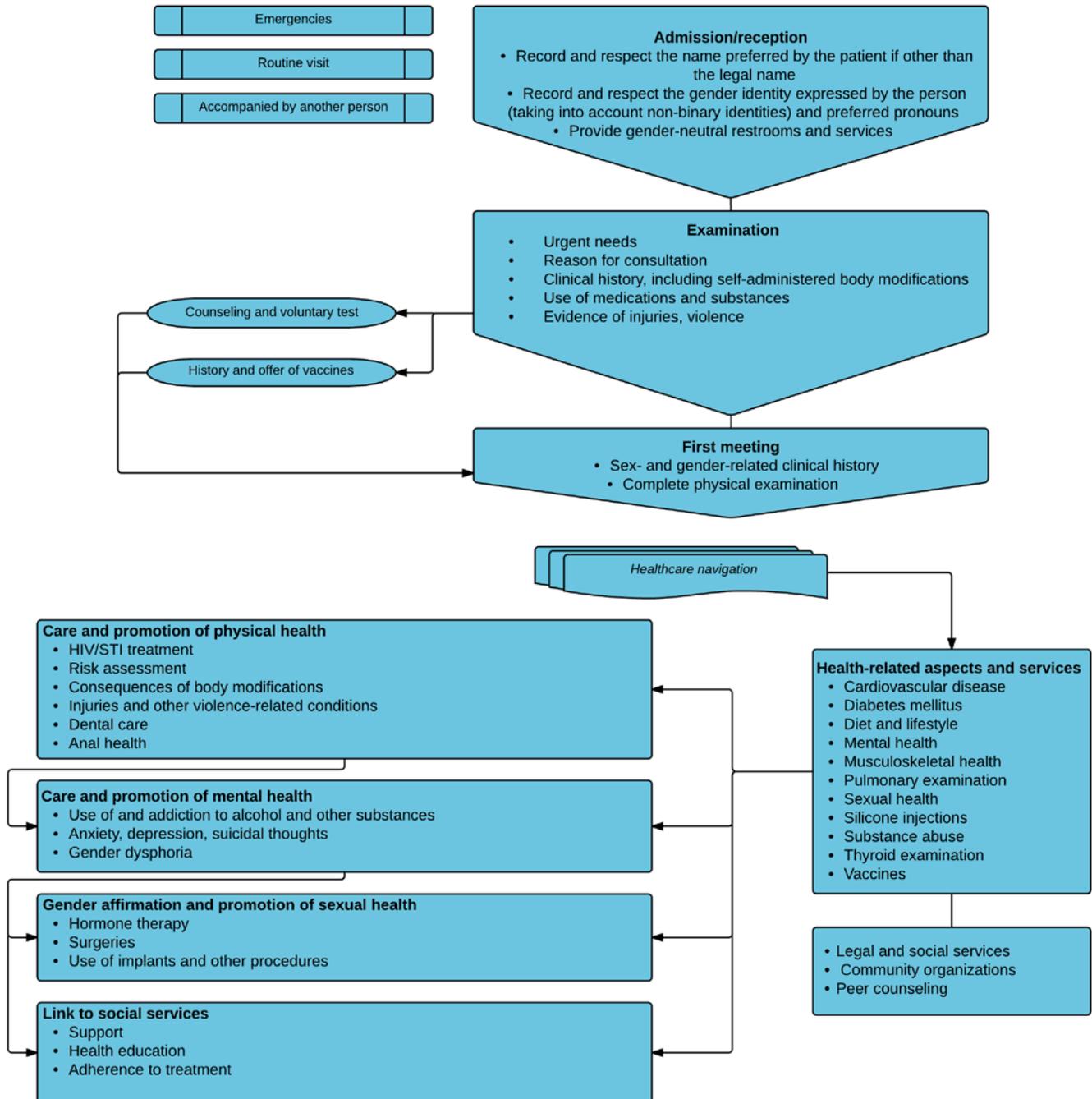


Include data on violence on Trans persons in your country

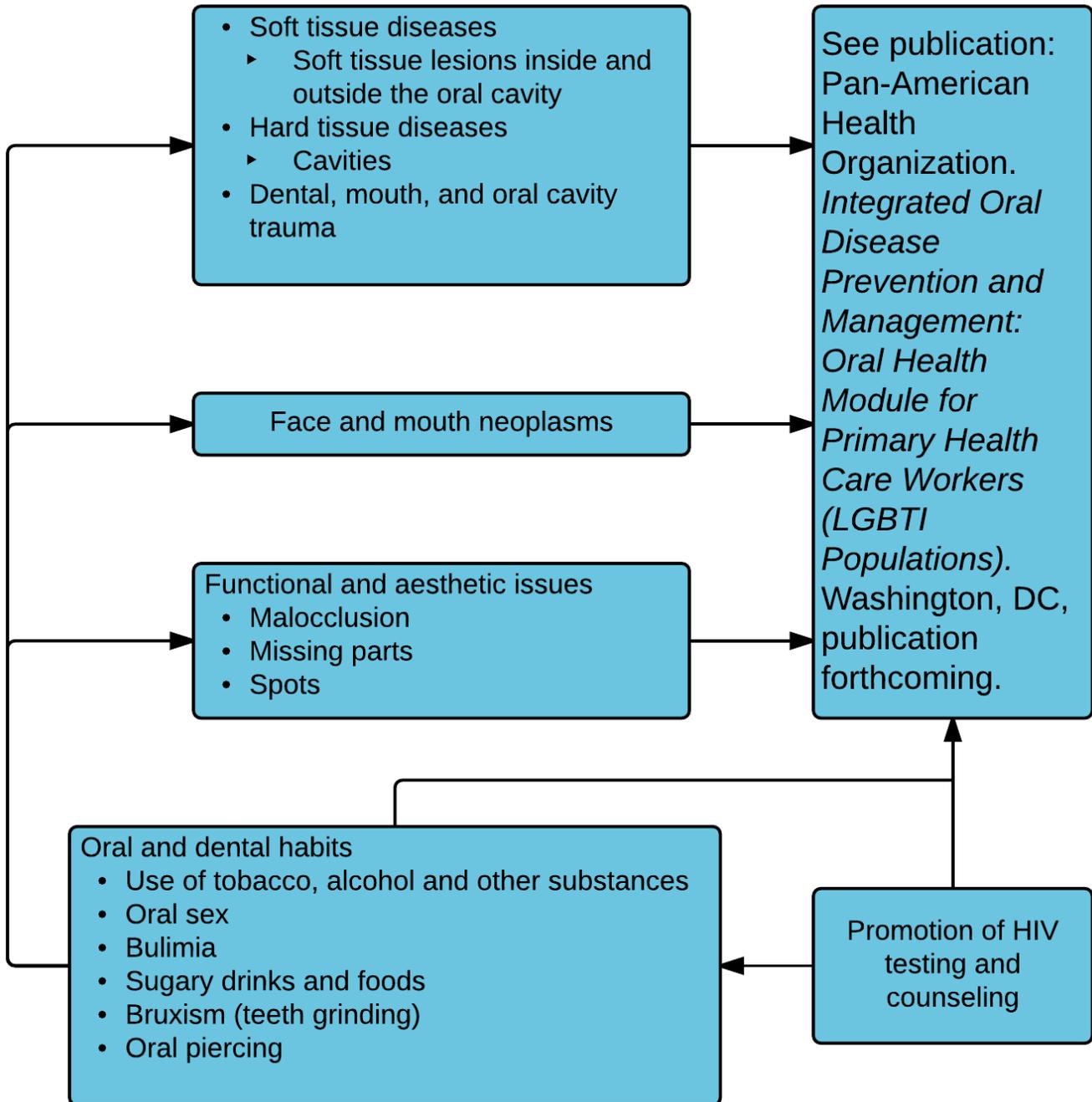


MATERIAL 12: EIGHT ALGORITHMS

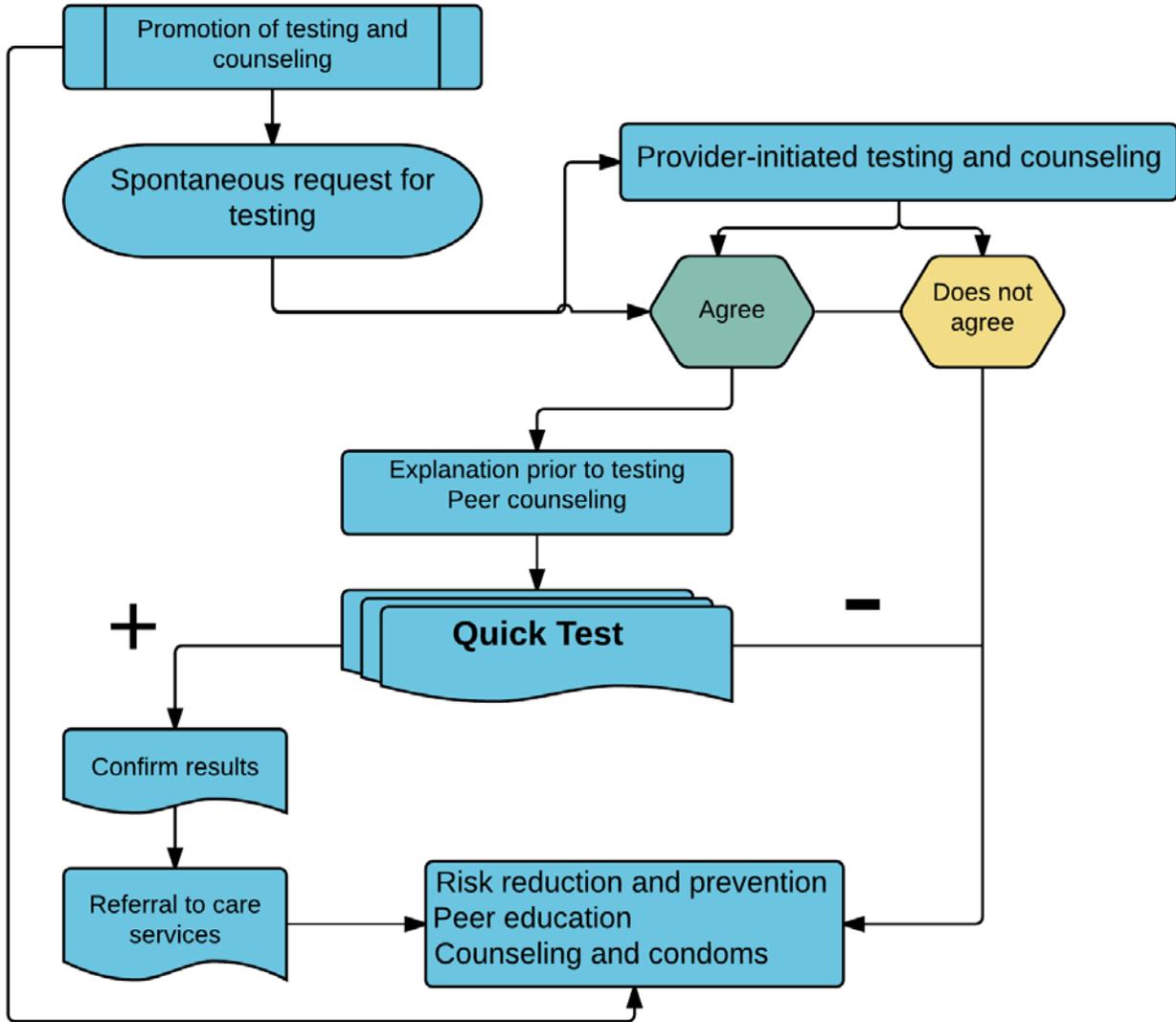
Reception, first meeting and initial clinical evaluation



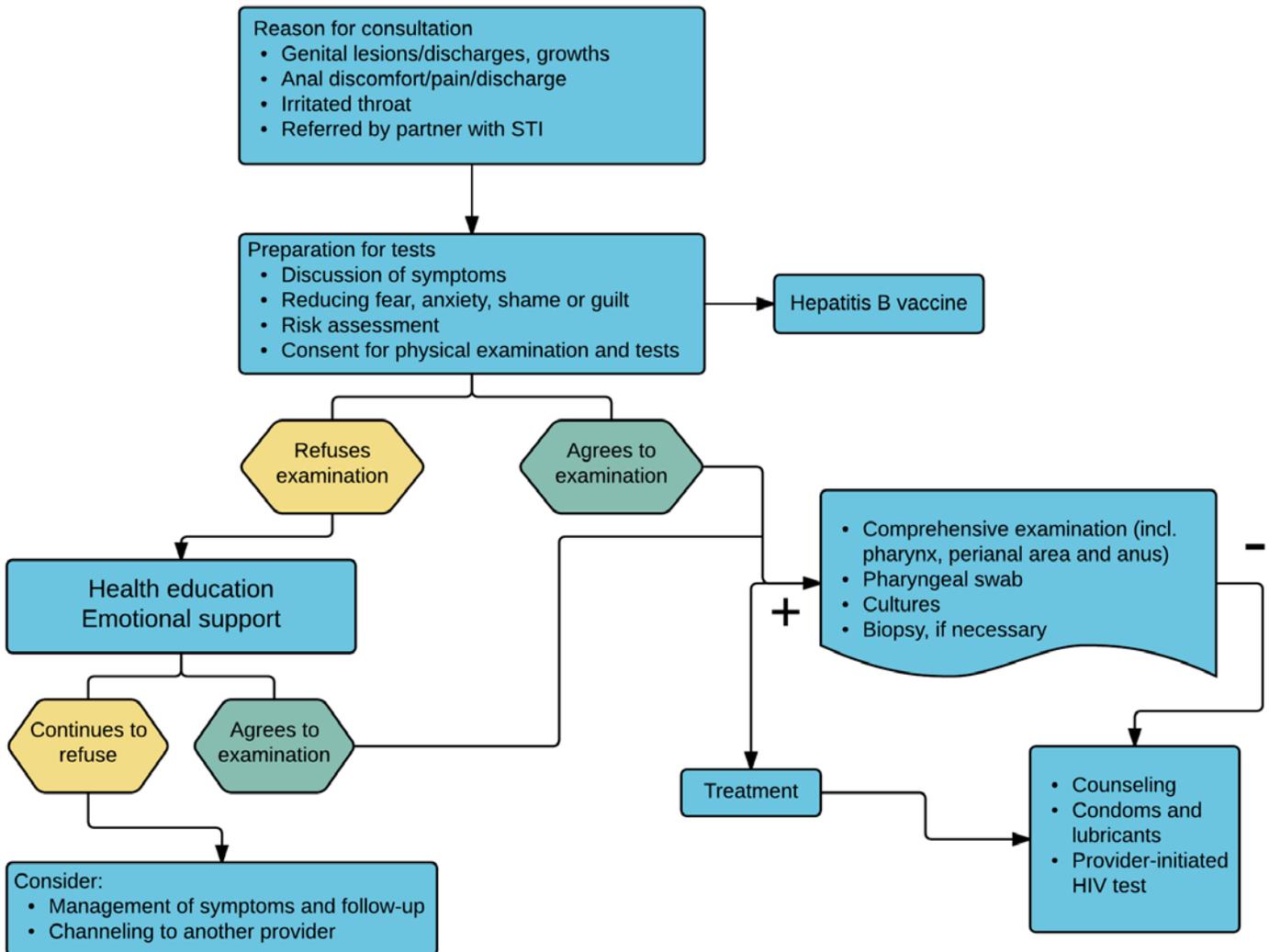
Oral Health Issues



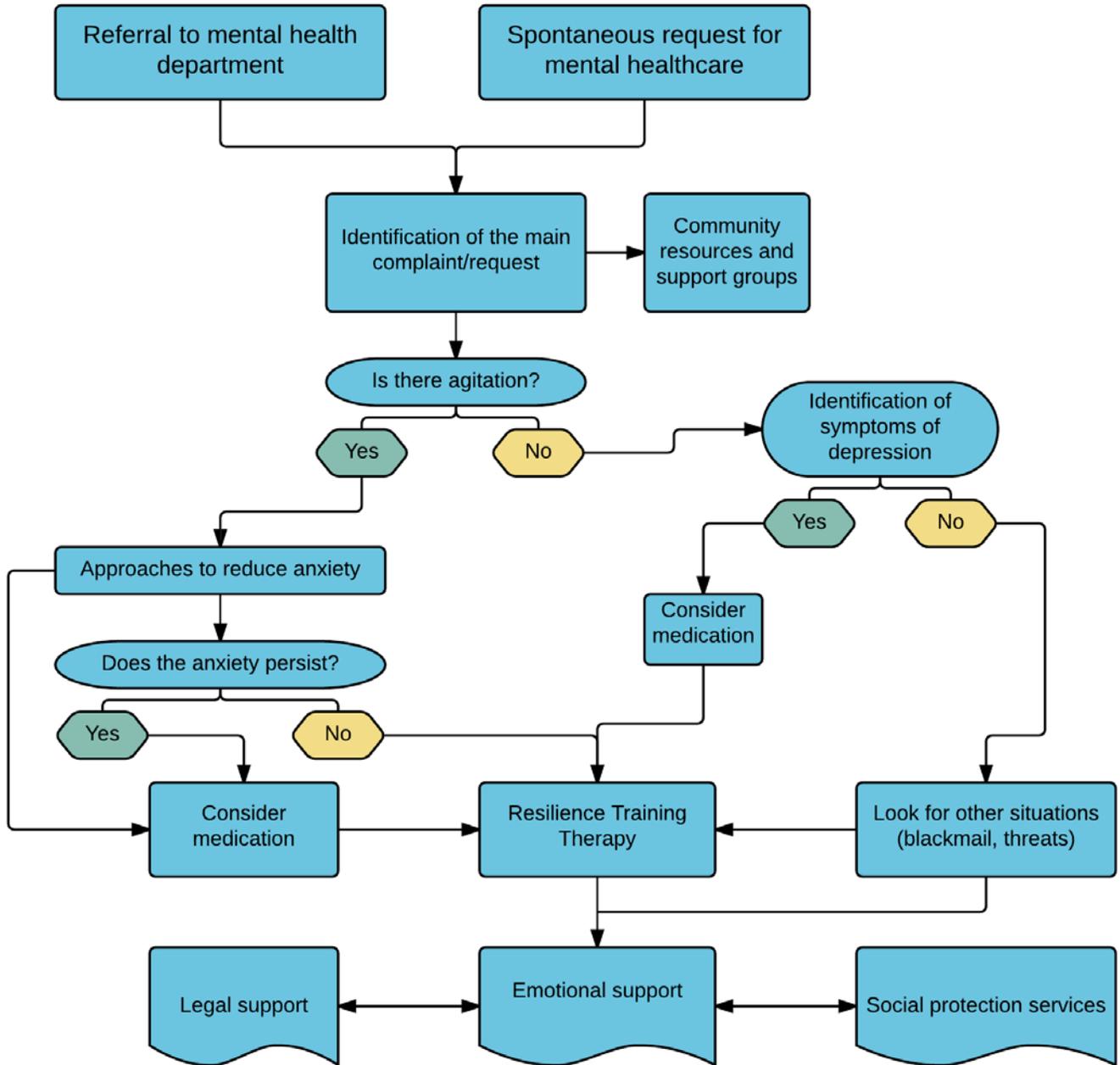
HIV Testing and Counseling



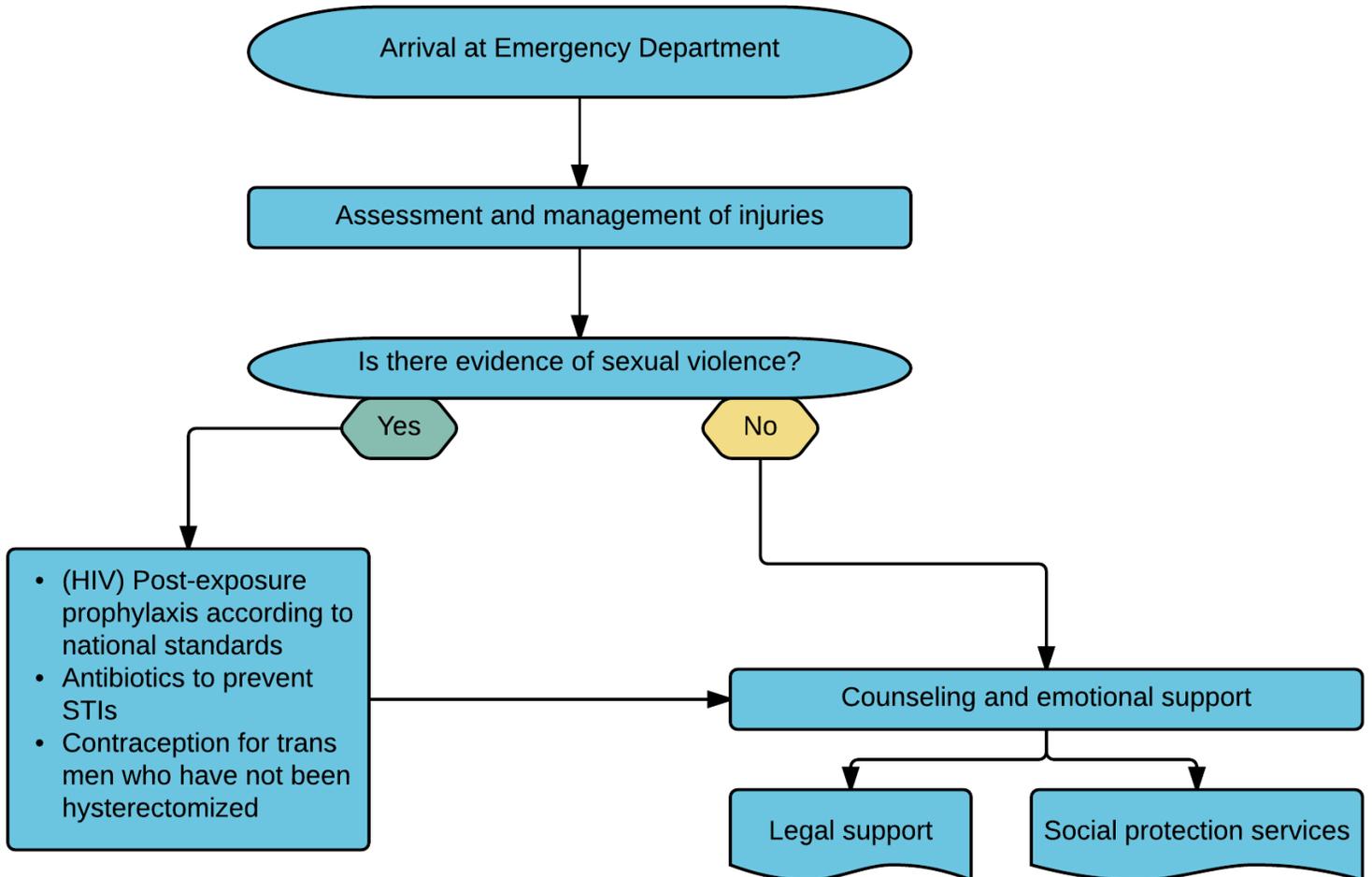
STI Diagnosis and Management



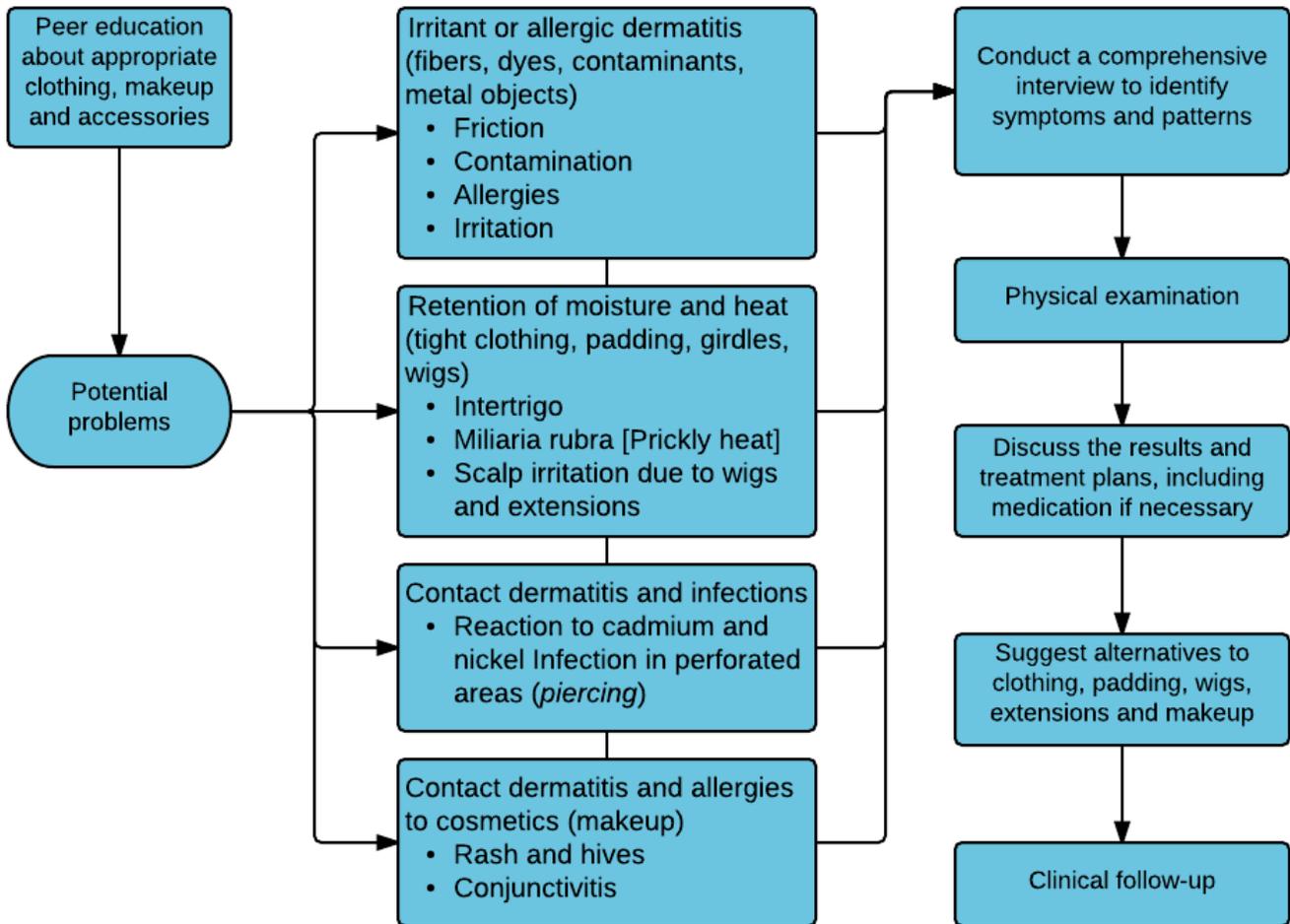
Clinical Management of Minority Stress



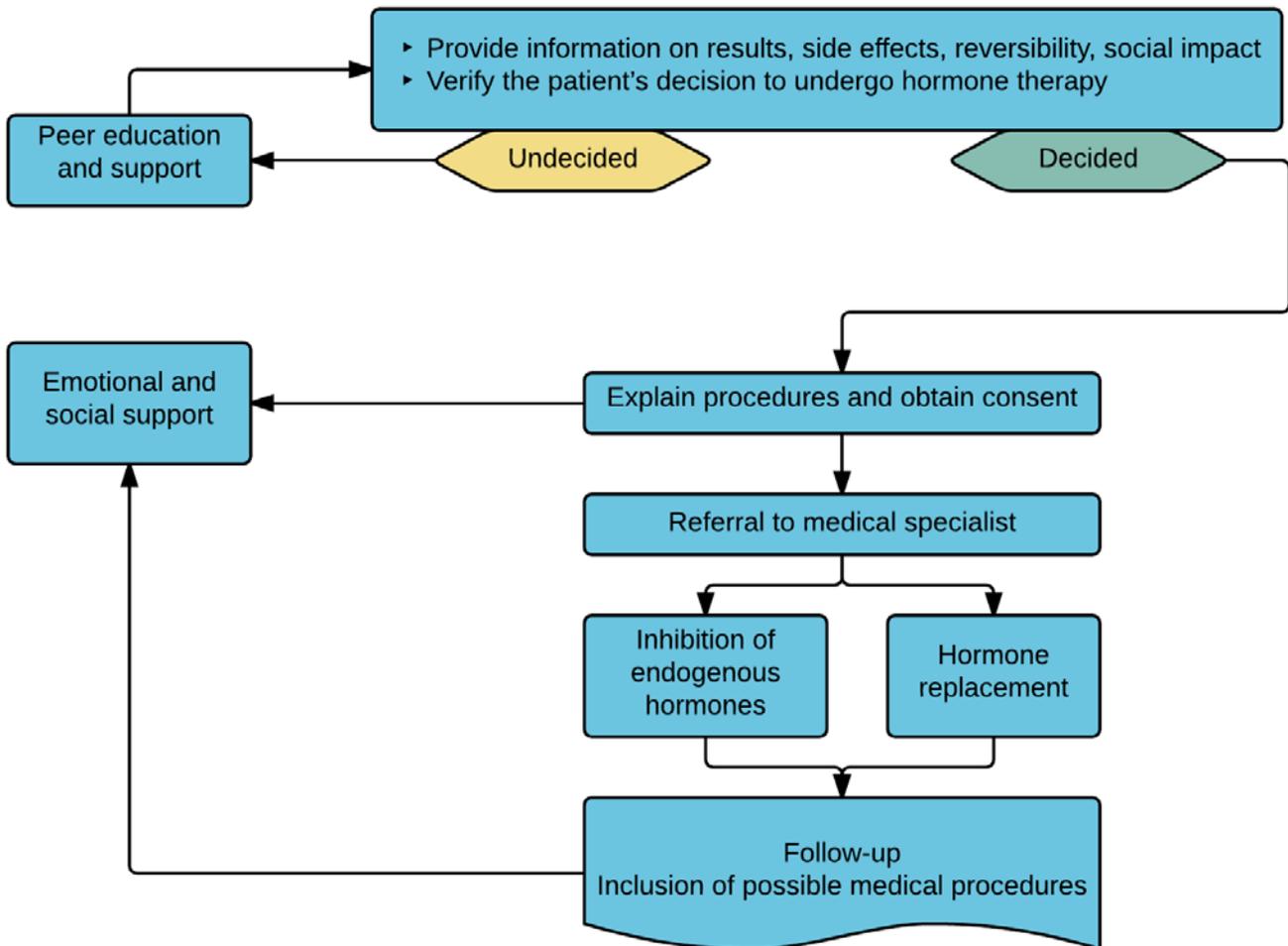
Management of Physical Violence



Care of Skin, Attire and Accessories



Administration of Hormones



RESOURCES

- Allison, R. (2012). *Ten Things Transgender Persons Should Discuss with Their Health Care Provider*. Gay and Lesbian Medical Association (GLMA). At: <http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageID=692>
- Coleman, E. et al. (2011). *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People*, Version 7. *International Journal of Transgenderism*, 13:165–232, 2011. World Professional Association for Transgender Health. At: <http://www.wpath.org/documents/IJT%20SOC,%20V7.pdf> (The Spanish version will be available soon.)
- Ministry of Health (2008). *Salud, VIH-sida, y sexualidad trans. [Health, HIV-AIDS and Trans Sexuality.] Atención de la salud de personas travestis y transexuales. [Healthcare for Transvestites and Transsexuals.] Estudio de seroprevalencia de VIH en personas trans. [Study on HIV Seroprevalence in Trans Persons.]* Buenos Aires. pp. 29-41.
- PAHO (2012). *Elementos para el desarrollo de la Atención Integral de personas trans y sus comunidades en Latinoamérica y el Caribe [Blueprint for the Provision of Comprehensive Care for Trans Persons and their Communities in Latin America and the Caribbean.] Final version in print.* Chapter 7. https://www.dropbox.com/s/prg7qeluo1fkz9s/DEFINITIVO%20FINAL%20FINAL%20Por_la_salud_de_las_personas_trans-version_digital%281%29.pdf
- Tallada, J (2013). *Diagnóstico de necesidades de salud y servicios disponibles para mujeres trans de El Salvador. [Diagnosis of Health Needs and Services Available for Trans Women in El Salvador.]* Available at: http://www.aidstarone.com/resources/reports/el-salvador_assessment_spanish

SESSION 10

The purpose of this session is to clarify the scope and limitations of actions by first-level healthcare personnel. It emphasizes the importance of this level as a gateway to the system and also covers the educational and preventive functions personnel can carry out as well as their role in the process of channeling to other more complex levels of the healthcare system and other community support resources.

Session 10		Time:
Professionals and specialized sexual health		1.5 hours
Objectives		
<ol style="list-style-type: none"> 1. Emphasize actions by primary care professionals to meet LGBTI health needs. 2. Analyze the scope and limitations of primary care as part of comprehensive care of LGBTI persons. 3. Go over the situations in which it is appropriate to make referrals and how they should be made. 4. Identify actions to be taken that allow the lessons learned in this workshop to be put into practice. 		
Steps	Activities	Minutes
Observing the circumstances	32. Collective construction – Inward and Outward	30
Reinforcing concepts	33. Interactive talk	30
It's clear to me that...	34. My task is	30

What do you need to have in advance?	PPT® 9: Role review Material 13: Ideas to organize and carry out a talk on sexuality and diversity awareness. (Copies for each participant or for each institution)
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To learn more	Guide to good practices for healthcare of trans persons within the framework of the national health system
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Step 1	Observing the circumstances
Activity 32	Collective construction – Inward and Outward
Equipment	Flipchart sheets Color markers Post-its Tape (masking)

PROCEDURE

1. Mention that comprehensive care of LGBTI persons' health needs require commitments and actions in which all sectors of society take part. In this context, the first level plays a key role, but it needs to be supplemented with actions within and outside the healthcare sector.
2. Organize a brainstorming session so that the participants, taking into consideration the possibilities at the first level of care, state in what ways they are limited and in what ways they are able to take action.
3. Have the largest possible flipchart sheet ready with an image of two concentric circles.
4. Hand out Post-its of two different colors and ask them to write legibly in one color (of your choice) which actions each participant is able to take within his/her healthcare unit, and in

another color, write the actions he/she is able to take outside the unit, i.e., toward his/her community, the authorities, etc.

5. Ask them to place the activities they can carry out within their units in the inner circle, and those that they are going to carry out “outside” in the outer circle.
6. Ask a participant to skip the duplicates and read the contributions from the group. Clear up any questions.
7. In closing, reiterate that the first level is a gateway for trans persons into the healthcare system and the strategic role of service providers to provide care and connect them to other services within and outside of the healthcare sector.

Step 2	Reinforcing concepts
Activity 33	Interactive talk
Educational resources	PPT® 9: Role review

PROCEDURE

1. Make a short presentation using PPT® 9: **Role review**, which allows the group to reflect on the function of providers at the first level of care.
2. Emphasize the significance and scope of their involvement.
3. Encourage participation, the exchange of comments and the use of examples.

Step 3	It’s clear to me that...
Activity 34	My task is...
Educational resources	Material 13: Guide for awareness actions

PROCEDURE

1. Explain to the group the need for the workshop, which is coming to an end, to be continued through the actions of all the participants in their fields of work.
2. State that there are numerous tasks to be carried out, all of a diverse nature, but that the first step is always to create a context of awareness regarding pending needs.
3. Explain to the group that one way to apply the lessons learned in this workshop is to organize sessions for raising awareness in their institutions and communities. However, to do so, they will need the support of authorities and key groups, and they must be convincing.
4. Indicate that as part of the training process, they are being asked to give at least one awareness talk to their colleagues or to community groups.
5. Hand out a copy of the **guide for awareness actions** (Material 13) to each participant or to each institution represented in the group so they can review it. Indicate that the topic and exercise being presented are only examples, but that they can choose other topics and ways to approach them.

SESSION 10 MATERIALS

Activity	Material
32. Collective construction – Inward and Outward	
33. Interactive talk	PPT® 9: Role review
34. My task is	Material 13: Guide for awareness actions

PPT® 9: Role review

Role review

- PPT® 9
- Session 10,
- Activity 23

Trans persons

- Have a variety of healthcare needs, just like all individuals they represent all ethnicities, ages, social classes and genders. Some equity access being, Trans others are more needed and aware of they can, mentioning this during the medical consultation.
- They make up a population whose needs are not met.
- Just like other groups, many trans persons live in poverty and do not have access to free, quality healthcare.
- They avoid healthcare services due to transphobia, discrimination, lack of qualified personnel, discomfort and other experiences.

- Trans persons have specific healthcare needs and concerns. These include higher rates of depression, suicide, substance abuse, smoking, STIs and others.
- Most of these health problems are related to the stress caused by stigma and discrimination.
- They need providers who know their specific healthcare needs and know the appropriate way to make referrals and give advice.

Why become involved?

- Care for trans persons must strive to create conditions to improve their quality of life.
- Being trans is not what leads someone to a medical consultation; it is the relationship with the set of social norms that make the daily lives of trans persons difficult.
- Moving from the paradigm of illness to that of rights, professionals who are involved in the process must fulfill an important duty of accompaniment.

Acting proactively involves:

1. Promoting and respecting individuals' autonomy instead of telling them what is right for them or what they should do.
2. Keeping in mind the multiple existing paths and the influence of cultural origin on social context.
3. Being open to the meanings of experiences and being able to establish whether the request to begin a process (endocrine, surgical, etc.) actually corresponds with the individual's request and not to a need in the medical system.

4. Preventing the request for healthcare from being yet another experience of discrimination and victimization.
5. Questioning the social constructs under which the trans person's identity is considered a mistake of nature that the medical system will strive to correct because it believes it has the answer.
6. Opening access to visions and life experiences in which trans identities are options that are worthy of being lived.
7. Bonding with local community networks; being aware of spaces and groups outside of the medical system allows the trans reality to be separated from a medicalizing vision and allows the autonomy of trans persons to be strengthened.

Roles

- With patients

- Help people to become aware that the issue is not their gender identity (regardless of its understandings and peculiarities), but the social violence (transphobia) that is exhibited toward those who do not conform to social norms.
- Provide elements for Trans persons who are requesting procedures so that they can develop real expectations about what they are seeking.
- Ensure that the person knows about the various medical treatments.

- Recognize that identity crises can be found within the context of the surrounding environment.
- Inform the person of the various community resources and facilitate inclusion in social networks.
- Provide therapeutic support at the person's request.
- Be available for subsequent questions.

MATERIAL 13. IDEAS FOR ORGANIZING AND GIVING A TALK ON SEXUALITY AND DIVERSITY AWARENESS

One of the main objectives of the “Broadening Our Understanding of Diversity” Workshop is to offer participants the opportunity to organize a talk with their colleagues at their work facility and, potentially, with interested members of the community.

This talk uses an interactive methodology that starts with the participants’ experiences, opinions and perceptions, and then presents information that serves to raise awareness of healthcare teams and members of the community about the population’s right to comprehensive healthcare, including sexually diverse populations.

To carry out this talk, some steps must be taken in advance, such as planning the activity:

- Establish an alliance with institutional authorities in order to outline the objectives of the talk.
- Together with the authorities, go over the appropriateness of serving the comprehensive health needs of the LGBT population.
- Comment on the needs and obstacles that exist at the institution for the care of LGBT persons.
- Organize the logistics of the event: place, time, announcements, etc.

Duration: An awareness talk requires at least 60 minutes to be carried out, but it could be extended if the participants’ and facilitator’s time allows.

Number of participants: In order to have good communication and for participants to be able to take part easily, it is recommended that the number of people not exceed 30.

Sequence of the talk

Step 1: Presentation of the activity. (If there is time, introduction of the participants).

Step 2: Exercise

- a) Place two signs at the edges of a wall, one with the word AGREE and the other with the word DISAGREE.
- b) Tell the participants that you are going to read some statements and that they must go stand by the sign they consider appropriate or stay in the middle if they are undecided.
- c) Read each of the statements, and when the participants have gone to stand by the applicable sign(s), alternatively ask two or three people (depending on the time available) to explain the reasoning behind their choice. The important thing is that they listen to each other and that they do not get into dead-end controversies or discussions. After listening to the reasoning, ask if anyone would like to change places.
 - LGBT persons are sick and must seek healthcare services to be cured.
 - In general, healthcare personnel believe that LGBT persons are dangerous, and their habits and behaviors inspire mistrust in them.
 - In general, healthcare personnel feel uncomfortable with non-heterosexual patients and do not know what to say to them, how to ask them questions, or how to approach matters of a sexual nature.
 - In my department, all personnel know how to act with LGBT persons.

- What we need most is respect.
- d) End the exercise by pointing out that opinions on the matter may differ, but that healthcare of the general population and diverse populations must be based on rights. This is especially important for sexual health, which, according to the WHO, is:

“a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”

Step 3: Give the suggested presentation, taking into account the aspects discussed in the Workshop in which you participated. Ask for comments, clear up any confusion and answer questions.

Step 4: End the talk by asking: How does this presentation change the ideas you have regarding comprehensive healthcare services for the sexually diverse population and, in particular, the trans population? Summarize the conclusions and thank the group members for their participation.

FINAL SESSION

Workshop evaluation and closing		Time: 1.5 hours
Objectives <ol style="list-style-type: none"> 1. Have information about the effectiveness of the workshop. 2. Gather ideas and suggestions to improve future training sessions. 3. Formally thank everyone who was involved in the training session by wishing them the best and concluding the activity. 		
Activity		Material
35. Overall evaluation		Material 14: Overall evaluation of the workshop
36. Post-workshop tests		Material 1: Riddle Scale Material 2: Lists for matching terms and definitions. Material 3: Case
37. Future planning		Material 15: Follow-up form
38. Closing		

What do you need to have in advance?	Copies of Material 14 for each participant. Copies of materials 1, 2 and 3.
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PROCEDURE

1. Ask the participants to individually answer the **overall workshop evaluation** questionnaire (Material 14) as well as materials 1, 2 and 3, which they completed in the initial session: **Riddle Scale, lists for matching terms and definitions**, and the **case**.
2. Verify that each participant uses the same identification he/she used in the pre-workshop tests.
3. Tell them that their responses will help incorporate changes to improve future workshops.
4. Collect the forms.
5. Pass around a copy of Material 15: **Follow-up form**, so that everyone can write down his/her contact information and invite the participants to stay in touch after the activity to offer each other mutual support as they apply their new knowledge and skills. Be sure to send each participant a copy of this form with everyone's e-mail addresses as soon as possible.
6. Set aside some time for the group to talk about the conclusions they gathered from the workshop.
7. Proceed with the **closing** of the workshop and thank everyone for his/her participation.
8. If the authorities have so agreed, proceed with the handing out of certificates of attendance.

MATERIAL 14. OVERALL WORKSHOP EVALUATION

Instructions

We are interested in having your opinions and comments on the training sessions in order to improve them. Please answer all sections of this evaluation, using the backs of the sheets if necessary, to add to or expand on your comments. We appreciate your cooperation.

Overall Evaluation

1. Please check off the option that best reflects your overall evaluation of this training session:

- Very good
- Good
- Fair
- Poor
- Bad

2. Achievement of objectives. Check off the appropriate box for each objective.

OBJECTIVES	Fully	Mostly	Somewhat	Hardly	Not at all
First-level healthcare personnel should:					
1) Approach and treat sexual health in all its diversity in an informed manner, free from prejudice and within a framework of respect for human rights.					
2) Gain a broad and scientific vision of some of the fundamental aspects of sexual health.					
3) Acquire tools so that they can provide better treatment for their patients in areas involving sexual health.					
4) Be aware of the health problems that affect the LGBTI community and obtain resources to serve them in a positive and respectful way.					
5) Provide their services considering the sexual health needs of the sexually diverse populations that they treat and protect the sexual rights of these groups.					
6) Acquire the ability to replicate some of the Manual's elements, acting as facilitators in activities and workshops within their professional field.					

Other aspects of the training session

For each of the following questions, check off the answer that best represents your opinion. Please add any comments you may have.

1. To what extent did the topics discussed in the workshop meet your expectations?

- Fully
- Mostly
- Somewhat
- Hardly
- Not at all

For the next two questions, please check your agenda for the names of the workshop sessions.

2. Out of all the sessions, which were the two that were MOST useful to you and why?

a. _____

b. _____

3. Out of all the sessions, which were the two that were LEAST useful to you and why?

a. _____

b. _____

4. To what extent did the training methods contribute to achieving the objectives of the workshop?

- Fully
- Mostly
- Somewhat
- Hardly
- Not at all

5. Please check off the items that you think could have improved the workshop.

- Use of more realistic examples and applications
- More time to familiarize oneself with the theory and concepts
- More time to put skills and techniques into practice
- More effective group integration
- More effective training activities
- Focusing on a more limited and specific topic
- Covering a topic more broadly
- Other

Comments:

VII. APPENDIX: TO LEARN MORE

SESSION I. INTERPRETATION OF RIDDLE SCALE RESPONSES

The responses range from repulsion to nurturance.

Repulsion	Pity	Tolerance	Acceptance	Support	Admiration	Appreciation	Nurturance
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In accordance with the scale developed by psychologist Dorothy Riddle, these are your perceptions, opinions and feelings in relation to LGBTI persons.

		Responses
Repulsion	Homosexuality and transsexuality are seen as “crimes against nature.” People who are lesbian, gay, bisexual, and/or transgender are seen as sick, crazy, immoral, sinful, wicked, etc. Anything is justified to change them: prison, hospitalization, negative behavior therapy, electroshock therapy, etc.	1-2
Pity	Heterosexuality is regarded as more mature and absolutely preferable. Any possibility of “becoming heterosexual” should be encouraged; people who seem to be born <i>that way</i> should be pitied.	3-4
Tolerance	Homosexuality is just a phase of adolescent development that many people go through, and most people grow out of. LGBT persons are less mature than heterosexuals and should be treated with the indulgence one uses with a child.	5-6
Acceptance	Implies there is still something that has to be accepted. It is characterized by such statements as “You’re not lesbian; to me, you’re a person,” or “What you do in bed is your own business,” or “That’s fine with me, as long as you don’t flaunt it!”	7-8
Support	Works to safeguard the rights of lesbians, gays, bisexuals and trans persons. People at this level are aware of the homophobic and transphobic climate, and the unfairness.	9-10
Admiration	Acknowledges that being LGBT in our society takes strength. People at this level are willing to truly examine their own homophobia, attitudes, values and behaviors.	11-12
Appreciation	Values the diversity of people and sees LGBT persons as a valid part of that diversity. These people are willing to combat homophobia in themselves and others.	13-14
Nurturance	Assumes that LGB are indispensable in our society. They view them with genuine affection and delight, and are willing to be allies and advocates.	15-16

SESSION 2. OVERVIEW OF SEXUALITY⁷

SEXUALITY: A DEFINITION

We consider sexuality to be a subjective experience and a social manifestation, within a concrete sociocultural context, of the sexual being. It is an integral part of human life and the core of its development. It is structured through human beings' reproductive potential, emotional relationships and erotic ability, always within the framework of gender relationships.

The various components of sexuality are intertwined to form a complex system of meanings. One definition of sexuality, which is very effective in capturing its complexity, was created as a result of a consultation by the WHO, which stated that:

“...a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.”⁸

THE SOCIAL CONTEXT

From the abovementioned concept, it is clear that sexuality is influenced by socially constructed factors, such as our knowledge, attitudes, meanings and practices. The role that social forces and power struggles play as determining factors of sexual health in communities and societies is well known. There are likewise other factors of equal importance that influence it, such as poverty, migration and globalization. On the other hand, it is impossible to understand sexuality without knowing how it is shaped by groups such as family, churches, and educational and healthcare systems, among others.

Weeks⁹, a prominent historian of sexuality, points out that social class is one of the main organizational backbones of sexuality. This factor is extremely important for Latin American countries that have high percentages of people living in extreme poverty.

Poverty is linked to sexuality in different ways; for example, there are many people who find themselves in situations involving exploitative sexual practices solely in an attempt to resolve their financial situations. This is the case for many of the sex-trade workers in our countries.

Another example consists of so-called street children, who may be especially predisposed to risky sexual behaviors. A study carried out by non-governmental organizations in the region¹⁰ shows that HIV transmission in this group occurs primarily through sexual contact and not through the exchange of contaminated syringes. Most of these children and youth have been sexually active since they were young, have been the victims of sexual abuse or have had sexual relations with adults or among themselves as a means of economic survival.

⁷Adapted from: Corona, E. and Ortiz, G. (2004). Hablemos de Salud Sexual. [Let's Talk about Sexual Health.] Mexico.

⁸ Working definition of the International Consulting Group of the World Health Organization.

At: http://www.who.int/reproductive-health/gender/sexual_health.html#4

⁹ Weeks, J. Sexuality. Tavistock Publications, London and New York. 1986.

¹⁰ Birch, A.L., Report on the work of Casa Alianza's Luna project. Prepared for The United Nations Committee on the Rights of the Children, September 1998.

The role of family is emphasized by the International Conference on Population and Development (ICPD) Programme of Action¹¹, which reiterates in its paragraph 5.1 that family is the basic unit of society. Families, regardless of their composition and structure, are the broadest sphere in which our relationships are the longest over time, more intense and emotionally profound. The family is the place where gender begins to be created, identities are formed and patterns of behavior are observed and replicated. It is also the sphere in which social norms are transmitted and where social control of sexuality begins.

Families are experiencing great changes throughout the world, and Latin America is no exception. Demographic and socioeconomic change, urbanization and migration have generated considerable changes in family composition and structure. Nuclear families are replacing the number of multigenerational and extended families. The number of households headed by women is also increasing.

The family can also be a breeding ground for violence. The results of 50 open-population surveys in different parts of the world show that between 10% and 60% of the women interviewed reported that they had been victims of physical assault by their intimate partners. These physical assaults included all types of sexual abuse as well as rape. Sexual violence within marriage can have a wide range of consequences, from low self-esteem and depression to fatal consequences such as maternal mortality, homicide and suicide.¹²

Religious institutions also play a fundamental role in defining how sexuality is lived in a specific society. Major religions, as systems that contribute to regulating sexuality, influence the sexual conduct of individuals to a greater or lesser degree through their teachings, beliefs and regulations.

This happens even in secularized societies through cultural structures. In Latin America, ever since the era of the Spanish Conquest, the Catholic Church has acted as one of the most important forces in shaping sexuality as a form of social control.

Even today, the beliefs of this Church in reference to certain issues such as sexual diversity, autoeroticism, contraception and condom use have intervened in the definition of public policies on sexual and reproductive health in some Latin American countries.

However, despite the great influence of religion on many societies and the fact that there are many people who hold deep religious beliefs, resistance and alternative practices are often developed. One clear example is the extensive use of contraception in most Latin American countries, which, in censuses, proclaim to be practicing Catholics. In fact, as Amunchástegui¹³ notes, morals and practices seem to belong to two different universes that can “peacefully co-exist.”

Other institutions, such as healthcare and educational systems, also play an important role in shaping sexuality.

We will distinguish among four basic potentialities of sexuality:

¹¹ ICPD Programme of Action

¹² Heise, Lori; Ellsberg, Mary and Goetemoller, Megan; Ending Violence Against Women. Population Reports. Series L, no. 11, Population Information Program. The Johns Hopkins University. School of Public Health, 1999.

¹³ Amunchástegui, A. *Virginidad e iniciación sexual en México. [Virginity and Sexual Initiation in Mexico.] Experiencias y significados. [Experiences and Meanings.]* The Population Council, Mexico/Edamex, 2000.

REPRODUCTIVITY

Our sexuality is intimately associated with our reproductive nature. The first component of our sexuality is reproductivity. We prefer to think of reproductivity and not reproduction, because what exists in human beings is the potentiality. This may not always materialize in the form of having sons or daughters, either due to illness, personal decision or because it is not consistent with the lifestyle that is led, but we all have the potentiality. Reproductivity is not limited to the biological fact of being able to impregnate or to become pregnant; in fact, it is a much more complex and sophisticated human dimension.

Reproductivity is not limited to the biological events of conception, pregnancy and giving birth, since it also has psychological and social manifestations of great significance.

GENDER

Starting from the body differences that make us men or women, personal experiences and interaction with others are shaping a certain concept of self and of the world that are usually differentiated depending on the sex to which one belongs. This set of ideas gives rise to gender, the second of the potentialities we are going to cover. Conventionally, *sex* refers to the biological characteristics that make up the differences between the masculine and the feminine, and *gender* refers to the differences and categories resulting from the mental edifices that, in turn, are above all the product of social construction processes.

Social construction assigns specific responsibilities and roles to men and women in a given society. These roles are influenced by perceptions and expectations emanating from cultural, political, environmental, economic, social and religious factors, as well as customs, law, class, ethnicity and individual and/or institutional prejudices. Gender is learned and changes over time.

Humans are a sexed species, a quality that leads to something much more complex than an evolutionary advantage. From the first months of life, according to leading sexologists Money and Eckhardt, a very complex psychological dimension called gender or generic identity is acquired. Gender identity is a frame of reference of ideas and concepts that we all have regarding who we are (as men or women), who others are and who we must (or should) be depending on our sex: male or female. These concepts are the product of the shared ideas societies have historically developed.

The intensity of feelings about our sexuality is almost always associated with another one of its components. We mention isolated words such as: passion, desire, love, lover, surrender, possession, commitment, rupture, impotence, frigidity, fidelity, infidelity, satisfaction, pleasure, pain. All are sexual words or rather, words with a sexual connotation, that speak to us of the other two components of our sexuality: eroticism and affection.

EROTICISM

We understand eroticism as the human dimension that results from the potentiality of experiencing sexual pleasure. Namely: it is the human ability to experience the subjective responses that are evoked by physical phenomena perceived as sexual desire, sexual arousal and orgasm, and which, in general, are identified with sexual pleasure.

All human beings are born with that potentiality; however, not everyone develops it, experiences it and enjoys it.

Although the potentiality exists, we are exposed to experiences in our growth that regulate its appearance, its development, its expression and also its dysfunction; i.e., the appearance of eroticism in a manner that we or the social group to which we belong do not desire.

Sexual pleasure is a unique life experience. Although it is true that a pleasurable erotic experience is mostly associated with the desire for another person, this is not always the case, especially during the stages of our lives in which we discover eroticism. To experience it, we need our bodies to be healthy; i.e., that there be no interferences of a biological nature on the physiological mechanisms of eroticism.

Erotic pleasure starts to become a reality when our bodies experience neurobiochemical, vascular, blood and muscular changes, which in turn lead to our acceptance of experiences that are stimulating to us. All cultures grant importance to erotic life. Whenever a human group is formed, among the first things that are regulated, standardized, prescribed and/or prohibited are erotic experiences.

As noted above, given the importance that human groups grant to erotic experience, it takes on many nuances and can be expressed in numerous ways. It is interesting to wonder what its purpose is; the most satisfactory response comes from researchers of biology and the evolution of species, who affirm that it is a very sophisticated and developed way of increasing the chances of evolutionary success.

THE EMOTIONAL BOND

We still have to consider the fourth basic component of our sexuality: affection. The first bond with any other person that we have as human beings is physical. It is called the umbilical cord. We all have it for roughly eight months of intrauterine life and it connects us to the woman who carries us in her womb. This bond (which certainly involves a more complex meaning than a mere cord) is abruptly broken when a new human being is born. This new human being is born in such a condition that it needs the care of other human beings for a long time, or it dies. Between the two people involved, usually the mother and the baby, another bond very quickly develops; namely, another union, now not only physical, made up of tissues and cells, but made up of emotional responses conveyed by the presence of that other human being. What each of the two individuals involved feels in regard to the presence or absence of that other human being – not just of any human being, but of that one in particular – is the fabric of which the emotional bond is woven.

Affection and bonds, including the set of feelings called love, certainly and in some way interact with the other potentialities to construct sexuality.

TERMINOLOGY AND DEFINITIONS¹⁴

The conceptual framework of the terminology presented below was guided by the pragmatic goal of developing recommendations for policies and preventing misunderstandings that could hinder their successful implementation. Under no circumstances is its purpose to diminish the authenticity of the experiences and identities that may extend beyond the limits of the terms and concepts used. If these terms and concepts fail to fully reflect the experiences and identities of the persons whose needs the document seeks to address, we hope that they will be interpreted in a flexible manner.

For the purpose of this document, and as agreed by the participants at the various consultations held in Washington, D.C., San Salvador, Mexico City and Santiago, Chile, the term “trans” will be used as an umbrella term to refer to **persons whose gender identity and/or gender expression does not correspond with the social norms and expectations traditionally associated with their sex assigned at birth**. As such, the term “trans” may be compared to the term “cis” or “cisgender,” which is sometimes also used to refer to persons whose gender identity and/or gender expression corresponds with his/her sex assigned at birth.

It is important to emphasize that many of the gender-related concepts used in Western cultures are based on a binary interpretation that proposes sexual polarities: man-woman, masculine-feminine, male-female. However, current literature explores gender – and sex – as a conceptual continuum. In this respect, Weeks (2011) concludes that “what recent theorization of both gender and sexuality have demonstrated is that the edifice of gender can no longer plausibly be seen as an emanation of Nature, but is built on the ever-shifting needs, desires and social practices of millions of people.”

The following concepts were derived from internationally accepted working documents.

SEX

Biological characteristics (genetic, endocrinal, and anatomical) used to categorize humans as members of either a male or female population. While these sets of biological characteristics are not mutually exclusive (they naturally occur in various degrees or combinations), in practice, they are used to differentiate humans as supposedly opposite extremes within a polarized binary system.

Typically, a distinction is made between primary sexual characteristics (i.e. an individual’s reproductive organs) and secondary sex characteristics (i.e. other, non-genital physical traits that differentiate males from females).

SEXUALITY

“Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values,

¹⁴Taken from PAHO. (2012) Elementos para el desarrollo de la Atención Integral de personas trans y sus comunidades en Latinoamérica y el Caribe. [Blueprint for the Provision of Comprehensive Care for Trans Persons and their Communities in Latin America and the Caribbean.]

<https://www.dropbox.com/s/prg7qeluo1fkz9s/DEFINITIVO%20FINAL%20FINAL%20Por%20la%20salud%20de%20las%20personas%20trans-version%20digital%281%29.pdf>

behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.” (WHO, 2002)

SEX ASSIGNED AT BIRTH (OR NATAL SEX)

“Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex (Grumbach, Hughes, & Conte, 2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender-nonconforming individuals, gender identity or expression differ from their sex assigned at birth.” (Coleman et al., 2011, p. 97)

INTERSEX TRAITS OR CONDITIONS

In certain contexts, they are also called “DSD. Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the “disorder” label and instead view these conditions as a matter of diversity (Diamond, 2009), preferring the terms intersex and intersexuality” (Coleman et al., 2011, p. 95)

GENDER IDENTITIES

A person’s sense of being a man, a woman, or some alternative gender or combination of genders. A person’s gender identity may or may not correspond with natal sex.

GENDER EXPRESSION(S)

An individual’s way of communicating gender identity through physical appearance (including clothing, hair styles, and the use of cosmetics), mannerisms, ways of speaking, and behavioral patterns.

GENDER ROLE

The ensemble of social and behavioral norms and expectations associated with different categories of sex and gender identity in a given culture and historical period. A person’s behavior may differ from the gender role or gender identity traditionally associated with sex assigned at birth, and may transcend the system of culturally established gender roles altogether.

SEXUAL IDENTITY

Sexual identity includes how the individual identifies as male, female, masculine, feminine, or some combination; and the individual’s sexual orientation. It is the internal framework constructed over time that allows an individual to organize a sexual self-concept based on his or her sex, gender and sexual orientation, and to perform socially in alignment with his or her perceived sexual capabilities. (PAHO; WAS, 2002)

Sexual identity includes physical characteristics, gender identity, gender expression and sexual orientation. This encompasses a constellation of possibilities, including homosexual trans woman; heterosexual cis (i.e., non-trans) male; heterosexual trans man, and others.

SEXUAL ORIENTATION

Sexual orientation is understood to refer to each person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender (e.g. heterosexual) or the same gender (e.g. homosexual) or more than one gender (e.g. bisexual) (*The Global Fund, 2009, p. 29*) or regardless of gender (pansexual). Sexual orientation represents a personal characteristic that is independent of gender expression and identity. Therefore, an individual's gender expression or identity does not allow inferences to be made regarding his/her sexual orientation.

GENDER NON-CONFORMITY

The extent to which a person's gender self-concept and expression differs from the social norms and expectations traditionally associated with her or his sex assigned at birth or gender identity.

TRANSITION

“Transition is the period of time when individuals change from the gender role associated with their sex assigned at birth to a different one. For many people, this involves learning how to live socially as a person of that gender. For others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body (and modification of sex characteristics) through hormones or other medical procedures. The nature and duration of transition is variable and individualized.”

(Coleman et al., 2011, p. 97)

As noted above, the term “trans” covers a range of conceptions of identity and gender expressions. The following non-exhaustive list reflects this diversity by explaining the most common terms used to describe trans identities. There are significant differences about the acceptability and exact definition of these terms across regional and cultural contexts, as well as at the individual level. This means that there may be alternatives for each of the definitions that follow. Also, the meaning of these terms may not be mutually exclusive.

It is important to keep in mind that a person's physical sex, gender identity, gender expression, and sexual orientation constitute four distinct individual characteristics. They are conceptually independent of each other and can occur in any combination. There is a widespread cultural assumption of the coincidence of male sex, male gender identity, masculine gender expression, and sexual attraction to women; and the coincidence of female sex, female gender identity, female gender expression, and sexual attraction to men. However, contrary to this assumption, a person's position in one of the characteristics mentioned may be accompanied by any position in the other characteristics. For example, regardless of sex assigned at birth, a person may identify as a woman while adopting “masculine” forms of gender expression, or as a man while adopting “feminine” forms of gender expression. In addition, nonconforming gender identity or

gender expression is not intrinsically linked to a specific sexual orientation. Regardless of his/her gender identity and expression, and whether or not it corresponds with social norms and expectations associated with sex assigned at birth, a person may be attracted to individuals of a different gender, the same gender, more than one gender, or regardless of gender.

At the same time, across cultures, the predominant models of self-conception and social interaction accommodate individual gender identity, gender expression, and sexual orientation in different ways and to varying degrees. In Latin America and the Caribbean (LAC), to a certain extent, gender identity and sexual orientation appear to be more closely intertwined than in North America and Europe. Qualitative research in Brazil (Kulick, 1998) and Mexico (Prieur, 1998) revealed that the nuances of sex with men were a major theme in the lives and discourse of travestis (trans women). Sexual behavior, rather than genital anatomy, signified gender: for a man to be considered capable of affirming a travesti's femininity, the male partner's sexual behavior would have to be limited to assuming the insertive role in anal intercourse. This is what travestis typically require of their primary and casual non-paying male partners, in contrast to exchange partners (i.e., partners who offer money or other goods in exchange for sex), with whom they are more versatile (according to Kulick, 1998, 27% of the time). Primary male partners may be referred to as *cacheros* (Schifter, 1999), *maridos* (or *bofes*, *homens*, *machos*) (Kulick, 1998), *mayates* (beetles) (Prieur, 1998) or *chacales* (jackals). Casual non-paying partners may be referred to as *vicios* (a vice) (Kulick, 1998) or *cachuchazo* (a free indulgence). Exchange partners may be referred to as *mariconas* (those who enjoy being anally penetrated) (Kulick, 1998). The close link between gender identity and sexuality (top/bottom, referred to in Spanish as *activo/pasivo*) can be contrasted with alternative models of relationships between gay men who are more similar in gender identity and expression.

The term "trans" and the linked concepts defined above should be distinguished from the concept of *intersexuality*, which refers to variations in physical sex characteristics that occur independently of a person's gender identity. More specifically, the term "intersex" is used to refer to persons whose congenital sex characteristics are ambiguous, according to the characteristics on which male or female sex is commonly assigned. In the medical literature, the term "DSD" is used to refer to the different (chromosomal, gonadal, or anatomical) forms that such a condition may take. However, critics of the term "disorder" stress that intersex conditions are natural variations and advocate for more descriptive concepts such as "difference," "divergence," or "variation of sex development."

Although differences in sexual development do not equate to a person being trans, persons with differences in sexual development (intersex or DSD), such as trans persons, may experience high levels of anguish in relation to their physical characteristics. This discomfort, however, may differ significantly from the anguish experienced by trans persons in its phenomenological presentation, epidemiology, life experiences, and etiology (Meyer-Bahlburg, 2009). In some cases, the anguish is directly associated with the person's sexual characteristics at birth. In other cases, people experience anguish and suffering as a result of the sex assignment surgery, often performed without the person's consent soon after birth, creating a physical appearance with which the person does not identify. The distinct situation of persons with differences in sex development is reflected in the Diagnostic and Statistical Manual of Mental Disorders (DSM) category of "gender dysphoria" that provides a specific subcategory for gender dysphoria in persons with DSD.

Those healthcare professionals treating persons who exhibit DSD as well as gender dysphoria must be aware that the medical context in which these persons were raised is usually very different from those of persons without DSD. The gender-relevant medical histories of people who have a DSD are often complex and may include a number of uncommon inborn characteristics of a genetic, endocrine and somatic nature. There may also have been hormonal, surgical, and other medical treatments. For this reason, many additional issues must be considered in the psychosocial and medical care of these persons, regardless of the presence of gender dysphoria. The discussion of these topics exceeds the limits of this document. The interested reader is referred to existing publications (for example, *Cohen-Kettenis & Pfäfflin, 2003; Meyer-Bahlburg, 2002, 2008*). Some people and their family members find it useful to consult or work with community support groups. There is very ample medical literature on the medical management of persons with DSD. Most of this literature was written by high-level specialists in pediatric endocrinology and urology, with the cooperation of professionals specializing in mental health, especially in the field of gender. Recent international consensus conferences have focused on evidence-based care guidelines (including gender concerns and genital surgery) for DSD in general (*Hughes et al., 2006*) and specifically for congenital adrenal hyperplasia (*Joint LWPES/ESPE CAH Working Group et al., 2002; Speiser et al., 2010*). Others have examined the research needs for DSD in general (*Meyer-Bahlburg & Blizzard, 2004*) and for selected syndromes such as 46, XXY (*Simpson et al., 2003*).

SESSION 3. CARE QUALITY CONCEPTS:¹⁵ EXAMPLES FROM PERU

The concept of care quality varies depending on the healthcare providers and patients involved. Some of the former, specifically physicians who provide Periodic Medical Care, in accordance with their professional training, have a more medicalized view of health, which is expressed in the idea of care quality, which is centered on the ability to be effective, i.e., examining patients, providing an accurate diagnosis and appropriate treatment, and giving out free medications that the service includes, so that the patient feels that he/she is being cared for adequately.

What does quality include? Full service, care, physical examination, sample taking, i.e., do everything at the same time, so the patient leaves, agreeing that: "I have received care, I have received my treatment, I don't have anything, or I have something and they are giving me free treatment." Right? Treatment for everything is free, except for some viral illnesses, the treatment is now up to them.

(Physician, Jaime, age 79, Lima)

The idea of quality is slightly broader among mental health professionals or those more directly linked to educational and peer education aspects, who seem to be able to place more value on other aspects of patients' well-being, such as how good treatment results in greater satisfaction with care, in addition to offering the information they require, as well as appropriate treatment.

It would first involve good treatment, quality of information, being able to clear up all the patient's concerns, and above all, in this type of population with which we are working, that he/she be treated and see that he/she is actually receiving a treatment, that a difficulty is being resolved, i.e., not only the consultation, but carrying out a complete follow-up on him/her.

(Psychologist, Carmela, age 27, Lima).

For the Iquitos and Arequipa regions, it was found that for obstetricians, who are the healthcare personnel who have the greatest amount of contact with the TLG population, and who, in general, are younger, proper treatment and non-discrimination are the most important aspects in offering quality care to the TLG population. However, they report that there are other factors that diminish the quality they provide, mainly the short amount of time they have to dedicate to each patient, due to the scarcity of personnel in the department.

On their part, the TLG patients interviewed also value the effectiveness of the care they receive in order to resolve their health problems, but they definitely place proper treatment, quality and non-discrimination in first place; they demand to be treated fairly, respectfully and for their particular needs as TLG persons to be taken into account. Most of them also indicated that they prefer to receive care at health facilities where they are guaranteed these aspects, rather than at establishments that have all necessary equipment, infrastructure and medications, yet cannot guarantee proper treatment and non-discrimination. Only three people who did not have good experiences with the management of medical tests indicated that they would opt for

¹⁵ PROMSEX. (2011). *La igualdad en la lista de espera. [Equality on the Waiting List.] Necesidades, barreras y demandas en salud sexual, reproductiva y mental en población trans, lesbiana y gay. [Sexual, reproductive and mental health needs, barriers and demands in the trans, lesbian and gay populations.]* Chapter 2. Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos PROMSEX. [Center for Promotion and Defense of Sexual and Reproductive Rights – PROMSEX.] Lima, Peru.

establishments with better infrastructure and equipment rather than those where proper treatment is a priority.

In this sense, the Centros Especializados de Referencias de Infecciones de Transmisión Sexual y VIH/sida [Sexually Transmitted Diseases and HIV Healthcare and Referral Centers] (CERITS)¹⁶ are seen as services with comparative advantages compared to other Ministry of Health and Seguro Social de Salud [Peruvian Social Security Health Insurance] (ESSALUD) (*Seguro Social de Salud* [Peruvian Social Security Health Insurance]) social security healthcare services. Patients prefer to go to them because they think that, in general, the service is not discriminatory or stigmatizing in relation to their sexual orientations and/or gender identities, the social class to which they belong or their job occupations. They emphasize that the personnel that care for them is used to working with the TLG population.

However, most also have a critical view of the service provided, mainly related to the delay in treatment due to lack of personnel and the deficient infrastructure of the health facilities, as well as the lack of mental health personnel, which provide care not only through pre- and post-test counseling, but also the variety of affective and emotional problems they may be experiencing.

This critical evaluation of care quality offered by the Government health facilities is greater among peer educators. In the cases of Lima and Iquitos, they do not question proper treatment and non-discrimination in the care provided by healthcare personnel. However, in Lima, the scarcity of human resources is emphasized, while in Iquitos, it is mainly the little prospect of improving the infrastructure. For Arequipa, peer promoters have greater criticism of the service provided by healthcare personnel. They emphasize that, although there is no open discrimination or obvious mistreatment, there is a certain coldness in the care, a lack of commitment and little knowledge of sexual health problems. This critical attitude can also be explained in part by a recent deterioration in relations between peer educators and professional personnel. On the other hand, the providers who specialize in caring for the TLG population who were interviewed emphasized that the current healthcare system still has basic problems, such as providers' prejudices, in providing quality care that is free of stigma and sensitive to the specific needs of the TLG community, taking into account the time and technical precautions each patient requires.

The reality is also that healthcare professionals have prejudices and these prejudices limit the type of adequate care that should be given. In addition, there should also be a certain infrastructure. For a lesbian woman who wants to receive care and is apprehensive about a gynecological checkup, it should be known that it takes time and requires certain precautions; the same applies to others of the sexually diverse population, certain mechanisms fine-tuned for this population, with professionals who are aware, cautious and use certain techniques to be able to approach this population.

(Physician, Ernesto, age 52, specialist in TLG issues).

In short, it can be said that despite regional nuances, the conceptions of care quality among the various individuals who participated in the study do not necessarily contradict each other; rather, they are becoming more and more similar as contact between professional personnel

¹⁶ Centros Especializados de Referencias de Infecciones de Transmisión Sexual y VIH/sida [Sexually Transmitted Diseases and HIV Healthcare and Referral Centers]

and TLG patients increases. The main principle is kind, non-discriminatory treatment, one that creates bonds of trust over time and ensures the confidentiality of each person's care.

Regarding the effectiveness of the care, TLG patients emphasize the need to have personnel with sufficient training and awareness, who have experience treating vulnerable populations and can carry out the necessary examinations, providing the proper medication in addition to clear and relevant counseling. They also mention the wait time at the establishment and that they be ensured privacy during care.

Concepts of health rights

Although, as noted above, a large part of the TLG population has a conception of care quality centered on proper treatment and non-discrimination, as well as fast service, assertiveness and effectiveness in diagnoses and treatments, one of the significant findings of the study carried out in the three regions refers to the little prospect of the TLG population to demand their health rights. On the one hand, the same healthcare providers refer very few cases of formal complaints; verbal complaints have been made only on some occasions. Furthermore, peer promoters from all the regions indicated that often, patients they refer express their discontent and annoyance to them about different aspects of the care, but they generally refuse to state them in front of the same healthcare personnel who treated them.

Never, ever have they directly made complaints, they have almost never approached me to say something to me, like one of them saying: "Doctor, you know what?" for a situation or a problem.

(Physician, Alberto, age 69, Arequipa).

Many activists from the TLG community that were interviewed emphasized the little prospect for TLG persons to express disagreement and demand better care, in part because healthcare personnel represent a social hierarchy to patients.

They do not see healthcare service as a right; rather, they see it as a favor and healthcare personnel also have some hierarchical attitudes toward the population and I think, for example, that if the doctor does not properly treat them or does not give them the right medications, they don't have much of a chance to file any complaints.

(Gay, Ángel, age 42, Lima).

The possibility of exercising, demanding and overseeing health rights seems to be much lower in the TLG community that is not part of activist organizations, especially for trans persons who carry out sex-trade work in the Arequipa region, where the healthcare personnel's work is viewed as special help, so they have no right to complain or to ask for changes in care.

I don't think I would be capable of that (complaining), these people are supporting me, for example, with condoms, and I think that is a lot and I think they are doing a lot to support me and I wouldn't have the right to complain. (...) I would be okay (with a male doctor), but I would feel slightly uncomfortable, that is, I wouldn't have much trust.

"Would you ask the young lady to give you a checkup?" No because, I don't know, I don't think I have the right, I feel that they are supporting me, I assume they're supporting me, and I can't tell them, you know what, I want this, I want this, they are supporting me.

(Trans, Valeria, age 20, Arequipa).

They often think that they're going to the establishment and the healthcare professionals and the service itself are doing them a favor in treating them, due to the fact that it is free, they believe that this doesn't give them more right to complain. If they go and leave there, they tell them "wait" or "come back" or they suddenly abuse them verbally or with a look or a gesture, they just have to tolerate it, because they unfortunately believe that they are doing them a favor in treating them, that they don't have the right to complain. That happens in most cases, but there have been some cases about which I've been told and they've said to me: "Know what? This happened and I don't want to go back."

(Pep gay, Samuel, age 37, Arequipa).

The exercise of healthcare rights by lesbian women through formal reports or complaints about a quality service in accordance with their needs is also scarce, mainly due to the fear of being made visible as lesbians within the local context, to which their family and social networks belong, in those cases in which they go to government healthcare facilities.

One of the great difficulties we women have is that we don't have any cases of such a visible report, so as to say: "Look, how could that exist?" We don't have it precisely because there is still so much fear WITHIN lesbians, a fear of visibility. I'll give you an example, if I live in the zone and my healthcare area is three blocks away, do you think I'm going to go there? They're going to know me and everyone's going to find out, something that wouldn't be bad at all, but for that girl, we don't know what difficulty she has, if she hasn't told her parents she's a lesbian, she's not going to go there, she'll go somewhere else.

(Lesbian, Claudia, age 55, Lima).

In the three regions, it was found that in healthcare services that did not specialize in caring for TLG persons, there was greater discrimination towards them, stigmatizing them as having HIV and exhibiting fear in treating them, especially if surgeries were needed. Yet although the protocol for surgeries includes, among routine tests, the diagnostic HIV test, the population interviewed perceives this requirement as a procedure that is only applied to TLG persons, which indicates that the information being provided to them is insufficient or is approached as a requirement directed only at this population, when in reality, it applies to everyone. Regardless, this negative perception of the HIV test requirement prior to performing surgery contributes to increasing the stigma.

If a trans needs surgery, they definitely will not treat her or touch her, regardless of whether she is in a serious condition and they have to treat her, they don't even touch her, until they have done the HIV screening test or the rapid test, even if the person is dying, they don't touch her because they're afraid. Obviously, there is still the stigma that if they're going to touch her, they're going to get infected, so they tell them: "First you have to take the HIV test," they demand.

(Pep gay, Samuel, age 42, Arequipa).

I went to the emergency room so they could give me the shot and a female doctor or resident said to me: "Are you going to get a shot?" "Yes." "Which doctor did you come from?" "From Doctor Juan." Obviously they know that he works there; she looked at me and regardless of how courteous and talkative she had been, she moved about one meter away and left.

(Gay, Fausto, age 22, Arequipa).

It is important to emphasize that, in the case of both the trans persons and the lesbians who were interviewed, the perception of glimpses of discrimination, either through silence or a surprised look from a healthcare provider or from other people awaiting care, at any type of medical service, makes them feel uncomfortable and limits the prospect of seeking care.

Peer educators and TLG activists often take on the role of defending the rights of persons with illnesses or conditions against this outward discrimination by hospital personnel, and for that reason, they accompany them to receive emergency treatment or to undergo operations.

I've brought in several friends, they were going to be operated on, but they force them to take a mandatory HIV test, and that's terrible and I managed to not let that happen.

(Gay, León, age 42, Arequipa).

SESSION 4. TEN RIGHTS OF LGBT PATIENTS¹⁷

1. **Right to scientific knowledge about and approach to the healthcare needs and issues of lesbians, gays, transsexuals and bisexuals.**

We demand that all fields of science, and specifically the health sciences, properly research, learn about and explain the health needs and issues of the LGBT population, from a comprehensive viewpoint that includes its biopsychosocial aspects.

It is likewise important for such knowledge to be transferred and have an impact on the LGBT population so that we learn about the problems that most affect us or that could affect us, as well as what we can do to prevent them and seek solutions for them.

2. **Right to the promotion and protection of the LGBT population's health.**

We demand that all individual and social factors that make us more susceptible to our main health problems, and especially the influence of homophobia, lesbophobia, biphobia and transphobia, be examined and addressed so that they may be minimized.

Likewise, factors that protect health, or resilience factors, which act as adaptive coping mechanisms in the context of the stress-generating environments we usually inhabit as LGBT persons and which protect or improve our health throughout our lives, must be researched and promoted.

It is thus necessary to create policies and actions from a perspective of promoting health that makes it easier for us to adopt healthy lifestyles and allows all of us to want to, know about, and be able to stay as healthy as possible.

3. **Right to receive health information based on scientific evidence.**

The medical and health information that we receive as LGBT patients must be based on scientific evidence, and must always be provided in a language we can understand based on our abilities.

It is professionally and ethically unacceptable that still today, we are informed and advised by healthcare professionals on the basis of stereotypes, prejudices, and outdated or refuted theories, instead of following strictly scientific, professional criteria in the interest of our health.

4. **Right to receive quality healthcare.**

We demand quality healthcare, and therefore, it is vital that public authorities and administrations provide appropriate training for both primary and specialized healthcare professionals, enabling them to understand the realities of homosexuality, bisexuality and transsexuality, as well as our health needs and problems, so that they can effectively prevent, detect, diagnose and treat them and provide guidance and recommendations on good practice regarding care of our health and our individuals.

5. **Right to receive healthcare adapted to our needs.**

We demand healthcare that is adapted to the different needs of lesbian and bisexual women, gay and bisexual men, transsexual women and transsexual men, which also takes into account the cultural differences found in multiethnic and multicultural societies such as ours, as well as those that occur among ourselves.

Appropriate care for our needs is likewise necessary in relation to the lifecycle, with special consideration for adolescent and elderly LGBT individuals.

¹⁷Taken from: FELGTB – Federación Estatal de Lesbianas, Gays, Transexuales y Bisexuales de Madrid. [National Federation of Lesbians, Gays, Transsexuals and Bisexuals of Madrid.] Available at: www.felgtb.org

6. **Right to receive the same basic healthcare nationwide.**

LGBT individuals must be guaranteed that they will receive the same basic healthcare, regardless of the autonomous community in which we reside.

We likewise request the creation and disclosure of standardized protocols for the examination, diagnosis, treatment, and care of our healthcare needs, so that a change of residence from one autonomous community to another will not entail inequalities in the approach to our health.
7. **Right of LGBT patients to be involved and actively participate in matters pertaining to their health.**

We demand our right as patients to actively participate in resolving our health problems and needs, based on the principle of respect for the roles of the patient and the healthcare professional, but also based on the ability of informed and educated patients to share responsibility and manage our health together.
8. **Right of LGBT persons to be treated equally, respectfully and with dignity.**

In order to address our health problems and needs, it is important for the healthcare system, healthcare services, and medical and healthcare personnel to make it easier for LGBT patients to openly discuss our health problems and concerns, without fearing that we will be faced with their prejudices against our sexual orientations or gender identities. An open, trusting relationship between LGBT patients and the medical and healthcare personnel who treat us must be made possible. Therefore, it is essential that healthcare professionals always treat sexually diverse populations with equality, respect, and dignity, and extend this treatment to our partners and families.
9. **Right to privacy and confidentiality.**

Even though this right is recognized for all people in numerous laws and directives, at times, it is not enforced. For lesbians, gays, transsexuals and bisexuals, it is even more necessary to preserve this right, due to the prejudices and stigmatization that persist toward our group. Special prudence and discretion are likewise necessary for individuals in our group who are living with HIV and are consequently twice as vulnerable to social stigma.

Therefore, we demand that healthcare professionals be especially involved in, and committed to, ensuring that knowledge of their patients' sexual orientations, gender identities and their health problems is always handled in a strictly professional manner, thus preventing outside third parties from acquiring this knowledge.
10. **Right of LGBT organizations to be recognized as valid agents and representatives in healthcare policies.**

As organizations made up of LGBT persons defending our dignity, rights, health and lives, LGBT associations can and must be recognized as valid agents and representatives in healthcare policies by various administrations within the scope of their jurisdictions. They should be recognized, in the institutional setting of both political and economic dialog, as the promoters of health that they are.

SESSION 5. CHAPTER 2¹⁸

“Discrimination exists when we deny other individuals or groups of people the equal treatment that they may want.”¹⁹

As it is a more commonly used term, we will generally use the word homophobia, with the proviso that, although they share many things in common, there are differences in how homophobia is exhibited, depending on whether it concerns homosexuals in general, gays, lesbians, bisexuals, or transgender persons. That is why it should be made clear from the start that homophobia and transvestophobia, although almost equivalent in some aspects, are not the same. However, the first term is usually used to include forms of intolerance towards all sexualities that differ from the heterosexual standard.

Homophobia does not affect all homosexuals in the same way. It causes those who are truly men who have sex with men, those who have not accepted their homosexuality, those who are tightly locked up in the closet, those who are “married,” those who are hidden, those who just dabble in it every so often and others, to stay that way. It also makes it more difficult to work with them while conducting research samples. But more importantly, the use of the term MSM in relation to homophobia makes homophobia seem harmless, when in fact it is targeted at specific persons with specific choices and not at an epidemiological-type practice. Homosexual, lesbian, and trans identities are strongly linked to homophobia: the former are targeted by the latter.

The original idea of the concept of homophobia referred to a fear of homosexuality, homosexuals or anyone perceived to be so, which causes an irrational behavior of flight from or aggression towards homosexuals or anything related to them.

It is very difficult to define something as complex as homophobia, and that initial idea, although it comes close, considers homophobia to be an individual issue where someone, A, is afraid of another person, B, because he/she perceives that person to be homosexual. Thus, partly due to convention and largely due to simplicity and convenience, the word homophobia tends to be used to encompass all sexualities, yet in spite of sharing many common elements, each form generates different responses. For example, talking about homophobia when referring to the trans population is a way of exhibiting it, since it once again overlooks gender choices by not acknowledging them, not to mention the fact that transphobia and even more so, transvestophobia, are usually much more widespread than homophobia.

If homophobia is a fear of homosexuality and/or its manifestations, transphobia is a fear of persons whose gender identity does not match their biological sex, and can be applied to any transgender person (transvestites, transsexuals, intersexuals, etc.) In addition to transphobia and, more specifically, transvestophobia, transvestites also feel the effects of homophobia when the gender identity they have assumed is automatically associated with homosexuality; in the same movement, homophobic thought is reinforced when homosexuality is assigned the meaning of a feminization.

¹⁸Taken from: Duranti, R. (2011). Diversidad sexual: *Conceptos para pensar y trabajar en salud*. [Sexual Diversity: Concepts to Think About and Work on Health.] Buenos Aires. At:

http://www.cnm.gov.ar/generarigualdad/attachments/article/546/Diversidad_sexual_conceptos_para_pensar_y_trabajar_en_salud.pdf

¹⁹ The main types and causes of discrimination, United Nations, 1949, XIV, 3, p. 2.

It is assumed that a woman with “masculine” characteristics or a man with “feminine” characteristics, according to the cultural parameters that exist everywhere, must necessarily be homosexuals. As a result, attacks and insults directed at homosexual men usually make use of gender – not sexual – expressions, leading to a slippery slope from one’s choice of sexual object to one’s gender identity, as if being homosexual implied becoming trans.

In the same sense, being a transvestite does not mean that the person is gay or homosexual; to think so brings us back to the biological binary sex system, denying the path toward the chosen gender. There is overlap, however, because many gender identity games and variations are usually seen in the gay environment. Likewise, homophobia and transphobia are very common among MSM: a person who has been the victim of discrimination learns how to discriminate against others in the same way.

It is important to remember that homophobia and transphobia are not the same: while the former is based on the choice of object, the latter is based on the choice of gender and its resulting identities.

As can be seen, the main mechanism of homophobia and transphobia is the use of stereotypes, especially those that are gender-related: that one’s gender can or should be male and that it can or should be female.

The issues related to generalized inclusion within terms that are too limited can be seen, for example, in the clarification made by the PAHO in the introduction to its document against homophobia: “At this time, the Pan American Health Organization (PAHO) uses the expression “men who have sex with men” within the framework of epidemiological vigilance and preventive strategies, and refers to ‘homosexual men,’ ‘gays’ and ‘transgenders’ within the framework of communication.”

A basic principle of prevention is communication; prevention is, for the most part, communication. Is it possible to separate prevention (where the epidemiological concept of MSM would be used) from communication (where specific identity types such as gay or homosexual man and transgenders would be used) and to implicitly recognize that we are talking about the same thing?

We know that there is a large gap between epidemiological vigilance (based on a reduction to numbers) and prevention strategies, which, although they may make use of the data provided by epidemiological vigilance, concern the attitudes of the persons involved in the data, both toward themselves and toward others: types of relationships, managing public and private spaces, the quality of emotional bonds, belonging to networks, strategies for coping, etc.

If the expression “men who have sex with men” leaves out forms of communication as prevention strategies, then the differentiation made by the PAHO in terms of managing identities is not understood. On the other hand, including transvestites in the MSM issue, where they are mentioned as trans (a term that would in turn include transsexuals and intersex), is pure transvestophobia, with hints of transphobia, denying transvestites’ difficult struggle for their own identity and spaces as well as the transsexual and intersex agendas. So, MSM ceases to be a “useful” concept for epidemiology, instead becoming a veiled expression of ignorance where the use of the homosexual stereotype as a demasculinized man – of which the transvestite would be its greatest manifestation – is clearly visible.

PAHO's definition of MSM is not distinguished only by sex (men), meaning that transvestites, whose mark of identity is not sex, but specifically their choice of gender, are made invisible in an aggregate that does not apply to them. On the other hand, another question arises due to the differentiation made in the vague clarification between "homosexual men" and "gays." Does that mean that gays are not men? Are there no gays among homosexual men? Many trans persons define themselves as men and many lesbians define themselves as gays: the definition falls into the trap it claims to want to avoid, that homosexuality is an all-inclusive term that does not make any differentiations.

These oversights specifically fit into a broader vision of both social and institutional homophobia, as this homophobia is exhibited through what is intended to be a tool, which is then taken and repeated by everyone who is dependent on that institution, through subsidies, for example, or who accept these definitions without questioning them, solely due to the prestige of the organization that is stating them.

Due to the prevalence of homophobia and transphobia, both MSM and transvestites are populations that are not vulnerable, as they have already been violated. The effects of homotransphobia are real, not potential.

We stated that homophobia is more complex and broader than the simple atypical concept that a person may have regarding another person or a group that is seen as different, in that it is a set of ideas that transcends individual thinking to be etched on the fabric of society, from which it will later come back to label the individual and go back yet again.

"Homophobia" is defined as the negative feelings, attitudes, and behaviors directed against homosexual persons (Weinberg, 1972). This is the most traditional definition.

We could expand upon it by adding that it also includes heterosexual persons perceived to be homosexuals and, by extension, every practice or behavior that differs from the behaviors associated with the gender assigned to people on the basis of their biology. According to Daniel Borrillo (Borrillo, 2001), homophobia is a problem that goes beyond each person's individual nature and is, on the one hand, an epistemological problem since the issue is no longer thinking about homosexuality itself, but instead focuses on the hostility it produces and, on the other hand, it is also a political problem since the issue of homophobia must be seen as a disorder of society rather than an individual problem.

We can think of homophobia as a system by which a society, through various mechanisms, rejects those forms of sexuality that are not accepted by the traditionally consensual norms in that society. As we saw in another section, these norms are learned from birth, when newborns are included in the prevailing cultural system of separation into sexes (male-female), which is reinforced throughout life by all the conventions that classify situations, behaviors and objects as masculine or feminine. However, we must not forget the individual aspect, homosexuals, because as we will see, it is at this level where this cultural process is internalized. This can be observed in the different levels where homophobia is exhibited.

- I. **Social or interpersonal homophobia (also called cultural homophobia).** This is the homophobia that circulates among persons based on beliefs, transforming potential prejudices about homosexuality into actions. This enactment can be interpreted according to Allport's Scale of Prejudice (Allport, G. 1971):

- antilocution
- avoidance
- discrimination
- subtle aggression
- physical attack
- extermination

This type of homophobia directly affects interpersonal relationships: as nicknames that seek to label others as different, reaching the level of direct slander.

As jokes, one of the most customary and accepted forms, which are usually based on stereotypes and degradation. Many jokes are based on linking homosexuality to effeminacy. Expressing unreal practices, generally frowned upon by society, which are presumed to pertain to the other person as different. When same-sex marriage was being debated in Argentina, one woman stated on a television program, with opposition that was more token than heartfelt: “The purpose of gays is to infect us with AIDS.” The belief in a presumed homosexual hypersexuality with the resulting presumption of promiscuity.

This occurs in everyday conversations, in routine exchanges among people in which others are denigrated or their worth is diminished due to their sexual choices (of object, of gender, etc.) or due to certain practices that are perceived to be linked to those choices. For example, when a man carries out tasks that are considered to be feminine.

Through isolation – at work, at school, and even within the family of the person presumed to be different. One patient, upon disclosing his homosexuality to his family, was forced to live in a separate section of the house and was expressly forbidden to walk through certain sections or come to family events or be seen in the presence of visitors.

Through intimidation, which may take the form of threats to a person’s future or job future and even physical threats. Intimidation may result from the homophobic discussion that reigns in a workplace, causing individuals to fear for their job stability or for the impossibility of advancement if their homosexuality were to be revealed.

There are also potential forms of discrimination, in which the discrimination is not actually put into practice because the threat of a loss of rights is enough. During divorce proceedings, it is not uncommon for the homosexual spouse to be threatened with not being able to see the children.

Finally, through direct verbal aggression, which can result in minor to serious physical aggression, including death.

It can also take on seemingly positive forms, such as when a person who has revealed his/her sexual orientation is put in a specific place or receives special benefits. One patient says that at one of their sessions, his coming out at work was well received by his colleagues, who then started to ask for details about his personal life, including his sexual performance, insisting that he put his private life on display, all in a context of joyful “acceptance” that it generated. Social and institutional homophobia are very closely related. Both can be thought of as the norms or codes of conduct that, without being expressly written or stated, are expressed in a social context to legitimize it.

As we have seen, there are many examples: being denied spaces to congregate, being prevented from access to positions of power, issues in access to healthcare services, restricted representation. But there are also more subtle, academically tinged forms of this type of discourse, such as medical and psychoanalytic discourse.

Not mentioning the homosexuality of important or historical figures (by default, they are always heterosexual; we cannot even find a random MSM), but doing so when it relates to criminal or scandalous news. When a crime is committed by a homosexual, or when a homosexual is the victim of a crime, his/her sexual orientation is immediately emphasized. On the other hand, no one says that a heterosexual was attacked or that the assailants were heterosexuals.

What causes the most damage, however, is the fear that differences will become too conspicuous, which pressures individuals of sexual minorities to go unnoticed and presumably be “integrated.”

The creation and support of stereotypes operate as a means of controlling and avoiding social understanding. Stereotypes can range from presumably insatiable sexual appetites to physical appearance, to the constant search for biological, social, or psychiatric causes.

Through many places, society (meaning everyone) constantly fosters differences between and with sexual minorities, not only within those minorities, but also in a presumed heterosexuality normality from which no one can escape. The image that is created is negative and stereotypical and communications media further distort this image by associating homosexuality or transvestitism with crime, drugs, and a presumed promiscuity that is, in reality, shared by everyone.

2. **Institutional homophobia.** In this type of homophobia, the institutions and social organizations are the ones that discriminate.

This type of homophobia is expressed in all laws, rules and regulations that establish any kind of difference between persons based on their sexual preferences, and is exhibited through obstacles and/or prohibitions whenever someone perceived as being outside the sexual norm interacts with any kind of institution, whether educational, health, governmental, private, etc.

At the beginning of the HIV epidemic, when a person came to donate blood and identified herself as homosexual, she was rejected in accordance with National Ministry of Health directives. Meanwhile, the same person, identifying herself as a heterosexual, would not have had any problems donating blood.

We can find examples in sports (the questioning of gay athletes on soccer teams, the exclusion of trans tennis players), in television programs where stereotypes are customary, in movies (an example is the movie “The Celluloid Closet,” which narrates how the U.S. movie industry hid, stereotyped or mocked homosexuality), in the opinions of commentators, yet also in the educational system, public and private healthcare systems, and in the workplace.

The speeches made in opposition to approving the marriage act for sexual minorities during the debate in the Chamber of Deputies and later, in the Senate of the Argentine Congress, are another excellent example.

If we believe that discrimination exists whenever individuals or groups of people are denied equality in treatment or in their rights, then institutional homophobia is its most suitable expression.

3. **Personal or internalized homophobia.** This type of homophobia is based on the personal set of values, beliefs, judgments, mandates, attitudes, etc. that the individual assimilates from the time of birth, when the individual is assigned a sex and is raised/educated according to that assignment.

We can find examples in the sex education transmitted by family, educators, the social milieu, peer groups, and any other significant figures, as well as by the discussions that make heterosexuality the only option, and all the demands of heterosexuality, which, when they cannot be fulfilled, will reinforce the individual's sense of being abnormal or inadequate.

A person, any person, is born and grows up in a society that only accepts one form of sexuality: heterosexuality. But even within heterosexuality itself, no variations are accepted; heterosexuality is the standard, it has its rules, which also affect heterosexuals themselves. Any non-heterosexual person will live each day of his/her life submerged in a social network that considers not being heterosexual a disability, something unnatural (a deviation) and, along those lines, as something immoral.

Each person whose sexuality differs from the heterosexual norm usually expresses a certain degree of discontent, unhappiness, little or no satisfaction with his/her different 24 sexuality (previously known as ego-dystonic homosexuality and/or gender dysphoria, diagnoses that have now been removed from the DSM-IV-TR), since the process of socialization and subjectivation entails the incorporation (internalization) of the social prejudice about these different sexualities. A prejudice that includes not only homosexuality, but any variation of the established and accepted ways of being a man in a given society.

Let us remember that the assigned sex assumes social forms on how to be a man or a woman, and automatically assumes that children will be heterosexual. These images of being a man or woman (where it is implicit that biological sex and gender will fit like a glove), added to the presumption of heterosexuality, create an outline for how the children will be raised.

In this child-rearing process (in which school and its associated narratives will later intervene), children are steeped in all the prejudices about a non-heterosexual sexuality, starting from the following sequence:

- Heterosexuality is normal and, therefore, natural
- All deviations from heterosexuality are abnormal
- All abnormalities are perversions (of nature)

“Negative feelings about one’s sexual orientation may be overgeneralized to encompass the entire self. Effects of this may range from a mild tendency toward self-doubt in the face of prejudice to overt self-hatred and self-destructive behavior.”

(John Gonsiorek) (Gonsiorek JC, 1991).

Thus, the most effective and paralyzing homophobia is that which everyone whose sexuality differs from the norm bears throughout his/her life, the effects of which can be devastating. Homophobia does not have to manifest itself in an actual outward act; internalization of homophobia means that it is acting on its own.

All homosexuals or trans persons grow up in a homophobic society, and since in most cases, their sexual identities do not become apparent until adolescence, they learn the stereotypes

against those with different sexualities at a very early age. This is regardless of the age at which the homosexual or transvestite becomes aware of his/her nature. That is why we talk about internalized homophobia: the homophobia/transphobia that eats away inside individuals, whether they are homosexual, transsexual or heterosexual.

Homosexuals find it difficult to accept that homophobia – and all of the contempt and aggression it implies – is part of their personalities and involves an emotional framework.

Even in the most liberal fields of psychotherapy, searching for a solution to the effects of this label, homosexuals and trans persons must confront the ideology, supported by the theories to which therapists adhere, that their sexual preference is pathological, that it is transitory, that its origin must be investigated, etc., even though the studies that have attempted to find a difference between the mental health of homosexuals and heterosexuals have failed. And there are few therapists (even among homosexual therapists) who search for the source of many of these patients' symptoms, in the burden of homophobia and in social intolerance, without going to the other extreme of denying the latter, as if belonging to a minority had no consequences whatsoever.

No sexual orientation/preference is free of disorders and although doubts may exist about the quality of life that a certain choice of object or gender may give each individual, the analysis of internalized homophobia in homosexual or transvestite patients should be a priority, since the psychological damage that it causes is not usually recognized.

The principal effect is silence and invisibility, along with the resulting personal degradation this causes. Homophobia acts as a constricting force that prevents moving freely, to a greater or lesser degree, in any social, work or bonding space.

Invisibility, a presumed guarantee of integration to some, leads to an enormous loss of energy and to suffering from imbalances in all areas of human activity.

Furthermore, homophobia is pathogenic because it is mostly composed of repressed material – internalized in childhood and through negative, reinforced experiences – that will be exhibited in the form of symptoms or paradoxical behaviors. The role of the “always-available super relative,” who is capable of putting his/her personal life on the back burner for others, compensates for the guilt of being different, and is the best demonstration of one's own weaknesses before others. When a gay person mocks “fags” or queens, he/she is projecting aggression onto others in the form of jokes, which, in reality, they themselves receive from the culture they inhabit. When a “fag” acts aggressively, assuming that everyone wants to be a woman, mocking everything that does not fit into the set of stereotypes (a way of identifying with the aggressor), he is only reenacting everything that attacks him in his daily life. When a transvestite reacts paranoically to presumed aggressions from others, she is only defending herself against an aggression that she foresees and fears because she is carrying it with her. Feeling constantly persecuted is one way of accepting repression by recognizing, somehow, that one is unacceptable and prosecutable. Homophobia also appears in that fantasy, shared by many gays, of preferring “real men,” heterosexuals, a quest that reinforces the stereotype that homosexuals would be somewhat similar to a failed woman or a fake man. And at the same time, this quest is a paradox, since if a heterosexual can be seduced, in the terms of this fantasy, this heterosexuality should be asking questions. What would a real man be? Or, in the words of Coccinelle, a transsexual, “You've got to have balls to cut them off.” Preferring men who

cannot be seduced puts internal homophobia into play through the pursuit of nonexistent idealized figures of masculinity, converting them into an impossibility, which only reinforces their own presumed inadequacy. Every faggot is a potential homophobe.

Two of the methods the subconscious mind most frequently uses to exhibit internalized homophobia are displacements and projections; antagonism or direct hate and rejection of others recognized as peers: “I want a real man” (gays are not men), “I am not gay” (being homosexual sounds better, it is more distant, protects against the stereotype), distrust of moderately stable relationships others establish and their tendency to sabotage or scorn them, inflexibility in accepting alternative styles of partners (in the same way that society does not accept non-heterosexual relationships), division into clans (gays, transvestites, lesbians, etc.) who are deemed irreconcilable, the denial of differences (bisexuals do not exist or they are just gays in transit). These are only some examples of the appropriation of social disdain toward homosexuality.

Prejudice appears at the most unexpected moments, in the most affectionate relationships, in the tightest bonds.

Denial is another of the most common degradation mechanisms. Thus, MSMs (all along the spectrum) who deny repression or say they are happy and do not suffer from any problems due to their homosexuality – somewhat difficult in a homophobic and intolerant society – or who believe that if they behave like “integrated” persons, they will not have problems, are simply denying the reality of the situation, at least to some extent.

According to Margolies (Margolies *et al.*, 1987), internalized homophobia can be exhibited in eight ways: i. Fear of being discovered, and thus trying to pass as a heterosexual. ii. Feeling uncomfortable with people who openly exhibit a different sexuality. iii. Rejection and denigration of heterosexuality, expressing reverse discrimination. iv. Feeling superior to heterosexuals, overvaluing one’s own different sexuality. v. Believing that having a different sexuality is no different from being heterosexual. vi. Maintaining that children can only grow up in homes with one father and one mother. vii. Feeling attracted to unreachable objects, which results in reinforcing the idea of inadequacy and incompetence. viii. Establishing short-term relationships.

As we can see, homophobia is not socially harmless; it has consequences that affect everyone (although not all equally), regardless of sexual preferences or gender identities.

According to Blumenfeld (Blumenfeld WJ, 1992), among the effects of homophobia, we find that:

1. Homophobia is one cause of premature sexual relations, which increase the number of teenage pregnancies and the incidence of STIs, including HIV. Young people of all sexual preferences feel compelled to demonstrate that they are heterosexually active in order to prove their normality to themselves and those around them. This pressure is stronger on men than on women.
2. Homophobia combined with sex phobia (fear and repulsion of sex) prevents any discussion about the lifestyle and sexuality of sexual minorities as part of sex education, thus concealing vital information about sexuality from students.
3. Homophobia can be used as a weapon to stigmatize, silence and occasionally target people who are perceived or defined by others as homosexuals, even if they are not.

4. Homophobia rarely acts alone; it is usually deployed along with racist, classist, sexist elements as well as a strong sex phobia, etc. The combination of all of these elements can prevent a unified and effective personal, social and governmental response to AIDS.
5. Homophobia locks people into rigid gender roles that inhibit creativity and self-expression and prevents close and/or intimate bonds from being formed with members of the same sex/gender. These sex/gender roles primarily affect men, as they set very strict limits on what appropriate behavior among “real” men should be. One example is the increased emotional distance between a father and his son, since affection cannot be openly displayed.
6. The development of negative self-esteem can lead to acting out stereotyped roles as a defense mechanism. These roles may be the fake use of a heterosexual identity with the adoption of rigid masculine stereotypes, or the person may be pigeonholed into the expected stereotype of a homosexual. For children, this can lead to confusion and to a weakening of their identity, which, over time, will reinforce low self-esteem. It can also cause excessive self-criticism or a negative, critical view of others who are similar (internalized homophobia directed at peers or presumed peers).

All of this hinders the possibility of developing bonds with the people seen as possible peers, resulting in isolation and greater emotional vulnerability when engaging in sexual relations.

The use of heterosexual stereotypes and a hypercritical attitude toward oneself, along with low self-esteem, leads to careless behaviors: addictions or compulsive behaviors (gambling, work, sex) and less attention to personal care (nutrition, rest, leisure, medical appointments), or, on the contrary, obsessive self-care behaviors.

Leadership positions are avoided, so as not to stand out due to the fear of being exposed, which increases the feeling of inadequacy. A personal vision develops with few expectations of oneself or of others (seen as peers).

This internalization of homophobia also leads people to overcompensate in terms of behavior, which can range from placing excessive importance on others’ influence on oneself, to acting out that homophobia against one’s own peers, either verbally or physically, when identifying with the aggressors and projecting one’s failure to accept one’s own homosexuality onto others.

Great discomfort may be felt around homosexuals who have accepted their homosexuality (also due to identification with the aggressor), partly due to the fear of being associated with them (the effect of others’ homosexuality). Or, on the other hand, there may also be an over-adaptation to homosexuality, generating rejection and denigration of heterosexuality, which will strengthen one’s own homophobia by generating the feeling of a ghetto, favoring isolation (reactive training).

Bonds tend to be rather unstable: a stable, long-term couple works as a social catalyst of visibility, producing a commitment not only to each other, but to their own sexuality. The possibility of unwanted exposure with the inherent coming-out means that many prefer to form only transitory bonds, which allow them to better control their image in front of others.

Internalized homophobia can lead to suicide when the individual is unable to tolerate feeling different from the presumably normal rest, the possibility of losses, or real or imagined isolation. This can be due to an issue of personal degradation, not being able to confront one’s family or friends, grief due to losses, or to harassment.

Persons with sexualities other than the heterosexual norm may come to fully or partially accept their sexuality, but they will always be affected by the process of dealing with homophobia, both social and internalized (we think that both have a dialectical relationship; one cannot exist without the other). That is to say, these people had to and have to deconstruct and reconstruct both social homophobia and internalized homophobia. This construction/deconstruction process is now known as “coming out” (of the closet).

No one can come to terms with being different from one day to the next. Acceptance of that difference evolves, with an undefined ending that will have a lot to do with the environment where that individual develops and the type of social networks to which they belong (family, school, friends, work, social milieu, etc.). For homosexual and trans persons, this process is known as “coming out of the closet,” an expression that refers to the process through which a person with a different sexuality accepts it, forging an identity that includes this difference, before themselves and others. It is both a personal and social process, and also includes a political aspect, since people generally come out in homophobic societies.

SESSION 6. DEVELOPMENT OF SEXUALITY IN INFANCY AND CHILDHOOD²⁰

Recognition of child sexuality is a relatively recent achievement in our culture. According to Weeks (2012), it is “a necessary first step in recognizing the developing subjectivity of the young person, not as a prematurely and artificially sexualized proto-adult, but as a person in his or her own right, with a developing sense of sexual self and growing Agency.”

GENDER IN INFANCY AND CHILDHOOD

John Money and Anke Ehrhardt (1972) have made notable contributions to the study of identity development and gender roles. In their classic model, it is observed that genital differentiation and hence, the assigned sex, impact on two different levels: on the one hand, social interaction (called “others’ behavior”), and on the other, the internal mental configuration (body image). These two elements act in synergy to form the basis of gender identity.

After birth, stimuli from the surrounding environment notably begin to influence the construction of gender. The choice of colors is traditional in our cultures, as is the use of different pronouns, specific declensions, or even idiomatic forms of language to refer to and about the newborn. These are of greater importance, since they will contribute to the formation of the language-thinking binary. The boy or girl will also be given a name, since a person who does not have a name does not exist. And it is an almost universal practice to use gender-specific names for males and females (Corona, 1994).

According to Money (1972), the “core gender identity” forms around eighteen months of age, based on superficial, conventional aspects such as clothing. That is to say, young children can express being “boys” or “girls.” Around age four, a concept of gender permanence is achieved. This means that it would be very difficult for a child to be confused about being or being perceived as a boy or a girl after the age of four.

Boys or girls do not always live with both parents, since there are many types of families. However, in all families or in the surrounding environments, there are usually masculine and feminine models that the boys and girls can observe and imitate. Therefore, this sense of belonging will be expressed more clearly; children will look to carry out activities, use toys and express themselves in ways that are in alignment with what society expects, mainly due to the parents’ influence. This type of gender expression is called “gender role.” But the process has not been fully completed, even when the boy and girl have identified with a gender role. There are other very important elements that relate to the value that culture places on the roles, and which influence a preference of sexual role, i.e., the perception of which role is the most valued by the culture.

The boy’s and girl’s perception of which role the culture values more – usually the male one – is learned. The more rigid the culture is in terms of categorizing what is feminine and what is masculine, the earlier it is acquired. This is exemplified by preferences for toys and games.

²⁰ Adapted from: “Hablemos de Salud Sexual.” *Manual para profesionales de atención primaria de la salud.* [Let’s Talk About Sexual Health. Manual for primary healthcare professionals.] Corona Vargas, E., Ortiz Mtz, G. Editors. AMES (Asociación Mexicana de Educación Sexual [Mexican Sex Education Association]), AMSSAC (Asociación Mexicana para la Salud Sexual, A.C. [Mexican Association for Sexual Health]), Ministry of Health of the Government of the Federal District. Ortiz, G. Chapter 2. Sexuality and Human Development. Mexico City, 2003.

Around the age of three, boys and girls already show a marked inclination toward certain categories of toys and activities, but later, there is an interesting change: males continue to show a preference for their own role and activities, whereas females demonstrate a greater variety in their preferences for toys and activities. In studies carried out in various cultures (Goldman and Goldman, 1982) in boys and girls, when asked, "If you could have chosen, what would you have liked to be: male or female?" the majority chose, as was expected, their own sex. However, a percentage of the females in each age bracket chose the opposite sex, something that practically did not occur among the males. This represents the greater appreciation attributed by almost every culture to the masculine role.

The process of adopting a gender or sex role lasts from the preschool stages until puberty, when it changes its form and the models to be followed. The core gender identity, belonging to a gender, gender roles, identification with and adoption of a gender role, are lessons that are gradually incorporated to construct the meanings of being a boy or a girl. This meaning is also incorporated into the body one has.

EROTICISM IN INFANCY AND CHILDHOOD

"The child appears ready for erotic life (...) Even in earliest infancy, stimulation of different areas of the epidermis (erogenous zones), the action of certain biological instincts and the excitement accompanying many emotional states engender a certain degree of undeniably sexual pleasure (...) this is known as autoeroticism"

(Freud).

The human sexual response (desire, arousal, orgasm) "refers to a series of physiological processes whose main objective is to respond to certain stimuli with the potential to trigger an orgasm" (Rubio and Revuelta, 1994). Autoeroticism is usually considered to be a positive element of erotic development, which helps to consolidate body image, increase understanding of body sensations, and increase the feeling of being loved and appreciated in a given body. However, in our culture, it is a seldom tolerated manifestation of sexuality, and is usually associated with ideas of evil, filth and sin, which have negative effects on erotic development. We also frequently find the opposite behaviors, such as allowing children to touch themselves at home without any limits in this regard. Ideally, children should be told that they can learn about their bodies and touch them to feel good, but that this is a private and intimate act that we do alone, in a safe place, away from the view of others, such as a private room, when there is one.

In general, children clearly identify their sexual orientations around the age of seven or in the following years. Debra Haffner (1999) defines orientation toward the same sex (homosexual), toward the opposite sex (heterosexual), or toward both sexes (bisexual). It is important to note that there are children who, from early childhood, do not feel that their sexual identities match the sexes they have been assigned.

EMOTIONAL BONDS IN INFANCY AND CHILDHOOD

The stimuli and affection that babies receive will be a guideline in building their ability to bond. They learn that they are loved, that they exist as individuals, and that they are beings that others want to get close to and love. Children can make their first true friends around the age of five (Papalia, 1992), and can show symptoms akin to those we experience as adults in love; they may want to bring flowers to their “boyfriend” or “girlfriend,” and serve and care for them, and they can experience truly painful grief when they lose significant bonds, from pets to family members. One of the manifestations of children’s ability to form relationships is reflected in the way they play.

REPRODUCTIVITY IN INFANCY AND CHILDHOOD

An inevitable childhood question is precisely the one related to how we come into the world. According to Méndez (1994), this question has different implications at each age. For example, before age six, generally, when a child asks how he/she was born, he/she is not referring to concerns about sexual relations, which may indeed occur later. In general, there is a sequence in children’s curiosity about reproduction. First, they ask where they were before they were born, then how they came out of their mothers’ bodies, and not until age seven or eight do they question the father’s role. At that age, when they receive explanations about adult eroticism, they may be surprised to learn that their parents had sexual relations in order to have them. Learning that their parents have this level of interaction may not come as a very welcome surprise. Let us recall that we cannot make generalizations regarding development. Therefore, some children may display more curiosity, specifically about sex life, before or after age seven and want more complex explanations.

Around age seven, children can accept explanations such as the one about the father’s cell and the mother, although they are not concerned about how the cell reaches the mother’s womb. After age eight, almost all children clearly understand more complex explanations.

Children’s potential for mothering and fathering is also revealed in their ability to care for, help, protect, and attract the attention of others, especially pets, toys and children younger than they are. In these games, they usually clearly repeat the patterns of how they perceive their parents.

They will soon have their first menstruation or first ejaculation, giving them the ability to reproduce. Children are interested, curious and concerned about these issues, and therefore, they must be given adequate preparation at the appropriate time.

REFERENCES

- Corona, E. (1994). *Identidades de género: en busca de una teoría. [Gender Identities: In Search of a Theory.]* In: Antología de la sexualidad humana. [Anthology of Human Sexuality.] Volume I.- Mexico: Grupo editorial Miguel Ángel Porrúa, CONAPO (Consejo Nacional de Población [National Population Council])
- Haffner, D. (1999). *From Diapers to Dating. A parent's guide to raising sexually healthy children.-* EUA: Newmarket press.
- Méndez, L. (1994). *La sexualidad en la infancia. [Sexuality in Childhood.]* In: Antología de la sexualidad humana. Volume II.- Mexico: Grupo editorial Miguel Ángel Porrúa, CONAPO.
- Rubio, E. & Revuelta, S., (1994). *Fisiología del erotismo humano. [Physiology of Human Eroticism.]* In: Antología de la sexualidad humana. Volume I.- Mexico: Grupo editorial Miguel Ángel Porrúa, CONAPO.
- Weeks J. (2011) *The language of sexuality.* Routledge. London

SESSION 7. LA CONSTRUCCIÓN DE LA SEXUALIDAD EN LA ADOLESCENCIA [CONSTRUCTION OF SEXUALITY IN ADOLESCENCE].

Esther Corona

GENERAL ASPECTS OF ADOLESCENCE

Almost all secondary school students are already adolescents, with adolescence being understood by the WHO and the PAHO as the stage of life between the ages of 10 and 19. Youth is also defined as the interval between the ages of 15 and 24, and the term young people is used to include both groups (WHO, 1995).

Physically, adolescence begins with puberty, around age 12 or 13, and ends in adulthood, at age 19 or 20. These periods take place differently in different environments. Obviously, adolescents who live in cities do not have the same experiences as those who live in rural regions. Furthermore, opportunities vary radically depending on social class, geographic location and gender, among other factors. The impact of globalization, which has been felt around the world due to communications media and new technologies, has particularly affected adolescents and young people, must also be taken into account.

Adolescence researchers intellectually consider adolescence to be the period in which individuals consolidate their capacity for formal thought, which tends to be deductive, rational and systematic. Emotionally, it is the stage in which individuals can learn to control and direct their sexual urges, establish their own sexual roles and develop mature relationships. The second decade of their lives includes emotional independence from their parents and the establishment of a clear hierarchy of values. There are several trends that divide adolescence into phases or stages. In this study, we will divide it into two stages: early adolescence, the period between ages 10 and 14, and late adolescence, from the ages of 15 to 19, as the second stage. Of course, these stages do not have specific limits; they overlap each other and are not necessarily tied to chronological ages. In addition, as we have said, they are determined, defined and limited by the sociocultural contexts where they occur.

Adolescence is not just a transitional stage. It must be deemed a specific evolutionary stage in the growth and development of human beings, with its own value. The passage from adolescence to adulthood is not clearly defined, but gradually takes shape in diverse aspects. Adolescence can be said to have ended when the following parameters have been fulfilled:

- Establishment of the capacity for abstract thought.
- Establishment of identity. Individuals know who they are.
- Autonomy and financial and emotional independence from the family.
- Establishment of a personal value system.
- Ability to maintain lasting relationships and to combine sexual love with tenderness and affection, among others.

It is undeniable that these developmental achievements appear at different ages and do not always coexist.

EARLY ADOLESCENCE

Puberty: Physical changes

Puberty marks the end of childhood and the beginning of adolescence. However, puberty and adolescence are not synonymous. While puberty is a biological event, adolescence is essentially a psychosocial phenomenon.

Puberty occurs due to a series of messages sent from the hypothalamus to the pituitary gland, the “director and coordinator” of all of the endocrine glands, through hormones. These changes, which will become primary and secondary sexual characteristics, originate at birth and usually appear in a certain order in boys and girls. Usually, girls begin the processes of change between ages 8 and 16 and take an average of four years to reach maturity. In boys, the process begins between ages 10 and 16 and requires up to seven years more to be completed.

Pubescent individuals experience worry about the development of their bodies and their new appearance. They compare themselves with deep feelings of frustration and discontent against their peers in whom the process is slower or too fast. In this context, it is important for healthcare professionals to assure them that sooner or later, their development will be complete and that they are healthy overall, and help them appreciate their bodies and perceive the changes as a natural process.

For many pubescent individuals, the first menstruation or ejaculation is experienced with fear and shame because they do not know what is happening to them. For others, it can mark the entrance into adulthood with all of its responsibilities and concerns. The experience of the first ejaculation or menstruation can be a desired event, awaited and received in optimal conditions with respect and appreciation if the children receive appropriate sex education and the acceptance of their families and communities.

General psychological aspects

A core aspect of adolescents’ psychological development is the search for their identities. According to Erikson (in: Papalia *et al.*, 2003), the identity crisis versus role confusion begins in this stage. This means that adolescents seek to develop a coherent sense of self, and to participate in society in a useful, valuable way. However, these achievements are gradual and are not fully resolved from one moment to the next. Unfinished traits may even present themselves in adulthood.

In the first few years, this growth crisis heightens, and in order to resolve it, adolescents need their families, schools and society in general to provide them with opportunities to practice, learn, earn recognition and increase their self-esteem in order to make it possible for them to get to know themselves, including sexually, so that they can make planned decisions, evaluate the potential for progress and avoid stagnation in building their identities.

According to Piaget, in this phase, young people enter the highest level of cognitive development: the period of formal operations, in which individuals achieve the ability for abstract thought. This usually occurs after age twelve, and gives adolescents the opportunity to handle information differently. Now, not only do they process ideas and resolve conflicts based on the present time, but they can anticipate events and their consequences; based on what could be true, they imagine various possibilities, present their hypotheses and formulate new theories.

Identification and self-image

Adolescents identify themselves as members of a particular group and also express that group identity through their images. For example, through their clothing, the use of certain specific colors, through their music and language, their favorite artists and types of dances. Cultural stereotypes and specifically, social agreements regarding the roles assigned to adolescent males and females, influence how adolescents express which group they belong to and their social status to the world.

Communications media plays an increasingly significant role in their search for models with whom to identify. The ideal models of beauty promoted in this day and age are shown in the form of strict diets and an unhealthy control of one's weight and body size. Eating disorders are increasingly common in this age group, and endanger health.

Relationship with parents and family

In early adolescence, the family continues to be the most valuable social unit, even when adolescents' search for their own identities leads them to "separate" themselves from the family. Often, adolescents' interactions with their parents become ambivalent, impulsive, intense and aggressive, with constant, perplexing mood shifts and fluctuations between intense happiness and love or pessimism and rejection.

The cognitive changes that take place make it possible to educate adolescents about sexuality in new ways and increase the potential for dialog, reflection and analysis. More complex, multifaceted concepts can be included, and to some extent, by planning their sex lives, adolescents may anticipate the future.

What is the difference between families that are conflictive during adolescence and families that also have crises but resolve them more efficiently and with less friction and aggression? The answer to this question is certainly multifaceted. One significant variable that has been studied is the degree of closeness and emotional contact that adolescents have with their parents and the type of authority exercised in the family. In 1999, Blum (in: Schutt-Aine 2003) found that having significant relationships with parents and/or an adult as well as having an extended family are highly protective factors for youth. Autocratic and overprotective parents diminish their children's self-esteem, hindering their development and the acquisition of life skills.

When healthcare professionals are able to include parents, they help create powerful, logical and coherent guidance that will definitively have more weight in creating sexual health than communications media or any other information medium. Thus, adolescents are not solely responsible for their sexual health; rather, their surroundings also play a role, potentially offering them a high level of confidence and security and strengthening their "life skills." The WHO (1998) defines life skills as: "abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life."

Interpersonal relationships with friends and the group of peers

Outside of the family, the group of friends or peers provides insecure, fearful and solitary adolescents with a "group identity." This identity leads to a separation of the "adult world" from the "world of youth."

When they separate from their parents, young people seek other meaningful figures to fill their emotional void: other adults who are not their parents, as well as their classmates and friends. With these adults, who may be close, they establish intense emotional bonds with open communication of relative equality.

In a special way, friends fill the void and the loneliness that occurs when adolescents distance themselves from their families in search of their own identities. They have very important functions, of which parents are sometimes unaware. Although it is true that children have had friends since childhood, it is during adolescence that those friends play a fundamental role.

Groups can help a child bridge the emotional and even financial gaps experienced in childhood, and in turn, they also put pressure on adolescents. Adolescents' attitudes toward these influences may vary. From those who do not allow their peers to direct them or suggest a behavior, to others who adopt the behavior, to act just as their peers do. In many cases, female adolescents, and particularly those females who have poor social skills and self-confidence, are more susceptible to peer pressure than males are (Feldman and Elliot, 1990, in: Shutt-Aine, op. cit.).

Sometimes adolescents are pressured to do something that goes against their upbringing or good judgment, but their need for acceptance is so compelling that they will agree to situations, even when they may be harmful or self-destructive. Thus, adolescents are often influenced by peer pressure to start having sexual relations, refuse to use contraceptives or condoms, be open to coercive relationships, have several partners or engage in activities such as smoking or taking drugs, even when they do not feel ready to do so at their own initiative.

When parents criticize friends that the adolescent has chosen, he/she needs to defend them because deep down, the criticism is directed against the person who "didn't know how to choose his/her friends wisely," questioning his/her ability to do so. On the other hand, since friends are actually a mirror of adolescents themselves, those receiving the criticism understand it to mean "what you say about them, you are saying about me."

In early adolescence, adolescents repeatedly have crushes on people who are impossibly out of reach, such as actors, singers, or even adults they are close to, but with whom there is not even the slightest chance of being reciprocated, as in the case of a teacher or a friend's mother or father. The reason for this type of love is explained as the need to establish a bond of love with a real person, who already has a recognizable image, but at the same time, there is a fear of rejection or that they do not possess the attributes that the loved one would find attractive. As a result, this platonic relationship flourishes solely in a fantasy world.

Adolescent love is strongly influenced from childhood by stereotypes of the "ideal love" in which "everything is tolerated and forgiven" and in which "love changes everything," particularly in the case of females. Far from helping children develop effective relationship-building tools, these ideals foster violence, fear of losing the loved one, and denial or deferral of conflicts that must be resolved in any relationship.

Falling in love at this stage of life is an intense experience, and the emotional losses related to these experiences must be taken seriously.

Especially in adolescents with low self-esteem, on whom the impacts may be devastating if they are not helped to envision a positive outlook for the future.

Sexual behavior

The most common sexual practice in early adolescence is autoeroticism (masturbation). However, parents and adolescents themselves worry about the possible effects of autoeroticism. It is important for healthcare professionals to clear up these concerns.

Not only are there no studies that show autoeroticism to be physically or psychologically harmful, but it helps (Sanz, 1990) in the integration of an appropriate self-image, to appreciate and value the body and to learn about its sensations, aside from being a preparatory measure for an encounter with another.

Erotic games are usual at this age, in adolescents of the same sex as well as of different sexes, but this does not necessarily imply an expression of homosexuality. Among males, games and competitions related to penis size and ejaculation are common, and are sometimes accompanied by caressing.

On the other hand, adolescents who have intercourse for the first time during adolescence do so one or two years after the first menstrual period or ejaculation (Haffner, 1995). In LAC, the average age at first intercourse is generally in the second stage of adolescence, although the age at first intercourse appears to be dropping.

Cases in which women first engage in intercourse before the age of fifteen tend to often be related to sexual abuse and forced marriage. Although in countries such as Haiti, sexual initiation may commonly occur between the ages of 10 and 12 (Shutt-Aine, op. cit.).

By this age, males and females have clear ideas on whom they find sexually attractive and with whom they want to bond. However, homosexual minors who have been influenced by social pressure may not immediately express their orientation and may even have girlfriends or boyfriends of the opposite sex in order to be accepted and avoid conflicts that are the result of ignorance and social rejection. About one out of every ten people has a homosexual orientation and suffers significant damage to his/her self-esteem due to the absence of social support for his/her dignity and rights. Even more dramatic is the case of trans adolescents, who generally find it impossible to express their sexual identities and are often subjected to bullying by their classmates.

Early adolescents are highly vulnerable to sexual aggression. However, in this group of adolescents, false ideas, such as sexual abuse only happens to girls, or distorted information, such as thinking that sexual abuse only occurs when rape has taken place, or that it only happens to certain types of women, only increase the group's vulnerability to sexual aggression. López (1999) notes that sexual abuse most often occurs in individuals between the ages of 12 and 15 (in Spain).

Lastly, early adolescents frequently express their curiosity about sex by watching films and looking at magazines. In this sense, it is advisable to make it clear to them that erotic life is usually more affectionate, less intense and diversified than what can be seen in these products, and to provide age-appropriate information in sound materials that will provide the minors with a balance as they build their erotic and esthetic ideals.

What criteria can be used to decide when the practice of masturbation is excessive?

The limits for deeming autoeroticism excessive are the same as those for any other activity: when it interferes with or prevents performing daily activities such as eating, studying, interacting with friends or even sleeping.

Pregnancy is a topic of interest for adolescents, and teachers have a prodigious task to carry out in this sense. Errors in information on this topic put this age group at high risk of unplanned pregnancies.

Gender and early adolescence

Gender stereotypes have a significant influence on the construction of adolescent sexuality. In many Latin American countries, society's expectation that females will remain virgin and chaste until marriage still persists. The 2000 National Youth Survey, carried out in Mexico by the Instituto Mexicano de la Juventud [Mexican Youth Institute] (IMJ, 2001) and other organizations, showed the reason that 40% of females had still not had sexual relations was "to remain a virgin until marriage." This was true for only 5.8% of males in the same circumstances.

On its part, the UNFPA (1998) indicates that "in many regions of the world where a high social value is placed on virginity, girls are forced to marry when they are young, and are often given in marriage to older men." In turn, it notes how in LAC, twelve countries still have laws in force that allow a rapist to avoid imprisonment if he marries the woman he raped. Even in cases of gang rape, if one of the aggressors offers marriage (an offer that the woman will often accept, at her family's insistence), all of those guilty of the rape are exempted from punishment.

Expectations of virginity lead to violence and hinder comprehensive sex education by restricting information on contraceptives use, also leading to risky behaviors regarding HIV/AIDS, especially as the practice of unprotected anal intercourse has increased. In this regard, Patz, Mazín, and Zacarías (1999) point out that most women who have been infected with HIV have only had sexual relations with their husbands or stable partners. They therefore consider it important to respect women's right to knowledge, as knowledge is essential to make informed decisions and use the appropriate protective measures to prevent HIV infection. Likewise, they suggest that professionals who provide sex education should encourage females to ask their partners to accompany them to healthcare services in order to discuss sexual health topics. Almost every Latin American country has services sponsored by the Ministries of Health that are specifically targeted at adolescents.

The same gender stereotypes and inadequate awareness of them may lead parents, teachers, healthcare professionals and adults in general to treat male and female adolescents very differently. It is often thought that young women need to be "more careful" than men due to the "greater risks" that they face. In many cases, these young women thus find their freedom more restricted.

Alongside these adolescent females raised to be dependent and submissive, we find young men, also adolescents, encouraged and pressured by society's generalized male stereotype to have several sex partners and begin their sex lives at an early age. Among common aspects of male sexuality in Latin America are the following (Lundgren, 2000):

- Male sexuality can often be experienced as uncontrollable and aggressive. Since they perceive their behavior to be expected by society, aggressive men may not even realize that they are like that.
- Likewise, violence can be experienced as uncontrollable when it is part of the social contract. For example, a man may expect that a woman must "put up with everything" if he supports her financially.

- Traditionally, machismo is organized around a pre-existing social hierarchy that establishes passivity in women and activity in men. Men must always be sexually active and women passive, without expressing their desires.
- Male sexual desire is expected to be separated from affection and emotions. Men experience intense discomfort if they are unable to respond sexually despite their anxieties, disinterest or relationship conflicts.
- Men are expected to have sexual experience. A male's masculinity can be questioned if, by a certain age, he has not yet had sexual relations, while women are expected to remain chaste. Under the effect of this pressure, a small number of Mexican adolescents still begin their sex lives with sex workers.
- Men are expected to dominate women and they are ridiculed if they do not. Men being jealous and possessive and reacting to infidelity with violence is justified. Jealousy is often perceived to be part of the expressions of love.
- Men are expected to take risks. This can lead men to having unsafe or unprotected erotic lives.
- Machismo emphasizes the view of women as sex objects. In some cultures, it is still thought that women do not have the same sexual rights as men, while it can be considered legitimate for men to be unable to control themselves, viewing women as sex objects.

As can be noted, these social influences and expectations may generate violence between genders.

Other significant influences on adolescent male and female sexuality are the stereotypes that our cultures attribute to them at this age. The popular idea of adolescents as individuals seeking risky sexual situations, who only live in the present, added to the mistake some adults make in thinking of adolescents as naturally promiscuous and therefore, if they are given information about sexuality, they will become more sexually active, rather than helping to strengthen their decision-making ability and practicing a healthy sexuality in accordance with what they want as men or women, means that educational topics on protected and safe sex is avoided (Rivers and Aggleton, 1998).

LATE ADOLESCENCE AND YOUTH

General Aspects.

Late adolescence begins in females around age 14 or 15 and in males after ages 16 and 17. Although this phase includes a wide range of changes and achievements, it is in general characterized by adolescents' increased autonomy and independence, by less marked emotional changes, and by less ambivalence and selfishness. Adolescents set out their own norms and values more clearly and show greater control over their impulses. Their identities are defined more clearly.

In this phase, neurological and environmental factors give rise to cognitive maturity. When adolescents have established full capacity for abstract thinking, they begin

As a society, males and females build and reaffirm patterns of violence that are upheld and repeated, based on the abuse of power. Therefore, healthcare professionals must make the need clear for equality and respect between genders, between children and adults, between adolescents and the elderly, and in any other relationship variation regardless of age, religion, sex, financial status, or the activity carried out by adolescents.

to demonstrate reasoning and arguments as reflections of the achievements of this formal operations stage, as this capacity entails deductive hypothetical reasoning in which individuals can think in terms of possibilities and manage problems flexibly, as well as the ability to actually demonstrate their ideas regarding various aspects of life.

In many cases, individuals find their choice of profession cut off due to the reality of poverty and limitations, and for many adolescents, the hope of being a doctor, teacher, engineer or lawyer “when I grow up” is no more than a fantasy, even though they might possess the necessary mental ability and skills for it. Luckily, this overview is not the same for the entire population, so when there are even the smallest opportunities for education, healthcare professionals, teachers, family and society in general should increase their actions in order to motivate young people to continue their schooling.

In this phase, there is a notable change in relationships with their parents. Although criticism persists, it becomes more objective and realistic. Adolescents no longer try to oppose something just because their parents said so, but rather reflect on these comments. The dependence-independence conflict begins to resolve. Gradually, they make decisions and take responsibility for themselves.

As they learn social skills, they acquire security and confidence in themselves to interact with others. The precursor to romantic and then erotic love is the love they feel for one or several friends. This means that in establishing friendships, they learn to earn the esteem and affection of someone who is not a member of their own families, and to appreciate the other’s qualities and tolerate their faults. Those who have not learned to love their friends will find it difficult to love a companion or spouse. The difference between one kind of love and the other is that the latter includes sexual desire and erotic manifestation.

Some of the most notable aspects of the transformations in late youth are experienced in sexuality.

Gender identity is consolidated and sexual orientation is defined, although not necessarily expressed. In late adolescence, adolescents come to know the experience of sharing with someone else. Their fantasies come down to earth, they feel attraction to that special person throughout their bodies, and their sexuality is lived intensely at all times.

Now, they start to experience pleasure more comprehensively, and that pleasure takes on adult tones. They continue to frequently engage in autoeroticism, though not as assiduously as in early adolescence.

Ideally, they now do so without guilt, according to their sexual desires and curiosity; this autoeroticism involves fantasies, fosters acknowledgement of all parts of their bodies, and even increases the likelihood of identifying certain STIs.

Intense petting between partners also helps minors identify their physical and emotional responses with an “other” and prepares them for intercourse, which in many cases takes place. The average age of the start of sexual relations (for those adolescents who begin) is estimated to be around age 15 for males and 17 for females.

Love and the late adolescent's partner

At this point in life, love is no longer necessarily a “mirror”; i.e., individuals do not seek carbon copies of themselves, but rather seek their complement, embodied by another person, which in our societies will almost always be of the opposite gender. Nevertheless, increasingly more young people recognize their orientation toward someone of their own sex. Once they have incorporated their identities, individuals then find it possible to risk intimate relationships, i.e., relationships in which, having overcome their insecurity, they can present themselves just as they are, without masks. Late adolescents increasingly direct their love towards a close, attainable person.

For young couples, the impact of falling in love must be given special consideration when attempting to delay the start of early, unprotected sexual relations and to promote condom use, the individual's ability to negotiate certain sexual situations within the couple and the overall planning of their sex lives. Falling in love can lead adolescents (and even adults) to make decisions only with their hearts, to fail to see the short- and medium-term consequences of their actions, to “surrender everything for love,” and in the case of people with emotional deficiencies, to give whatever may be necessary in order not to lose the person they love unconditionally.

While “love” is a desirable element within the union of a couple, mature love entails a conscious decision on commitment, and involves real knowledge of the heterosexual or homosexual partner, negotiation of differences and the potential for compatibility in terms of their life expectations, which in turn are explicit, among others. Therefore, adolescents need spaces where they can talk about, plan and make decisions about their futures, as well as private spaces where they can truly get to know their partners.

Sexual attraction

By the end of adolescence, the individual's sexual orientation, whatever it may be, has been precisely defined, whether or not it is openly expressed.

Certainly, this is an issue that is not much explored by families, healthcare professionals and adolescents themselves. However, it is highly important. For example, the isolated and repressed experience of being a homosexual adolescent is unfair and harmful.

There are groups that help adolescents and their parents accept, clarify and respect sexual orientation in a healthy environment. The first groups in which all orientations (homosexual, heterosexual or bisexual) should be respected and supported are in the family and at school.

Gender and late adolescence

As noted, there are differences between males and females, and females are clearly seen to be at a disadvantage.

Sex education itself is different for males and females. There are still groups in which the social pressure associated with motherhood limits the possibilities for female independence, in particular for those females who do not share that ideal. In turn, males' options are directed towards the potential for being economically productive, aggressive, determined and responsible, since men face a demanding world. Therefore, if the economic situation allows it, the best social option for adult males would definitively be education, or otherwise, paid work.

Sexually, it is not the same thing for a male and a female to have had several sexual partners. For males, still being a virgin at the end of youth may lead to rejection and ridicule and therefore, they often first have sex with a sex worker to learn, while in many environments, for women, virginity increases their “value.” The stereotype establishes and demands that a woman’s primary obligation is to raise children and that a man’s is to provide for them, and both fail as “men” or “women” if they do not fulfill these expectations. Women must not express their sexual desires and men must satisfy them; women must get married if pregnant in order to preserve their dignity and men must do so in order to do their duty and take responsibility “like a man.”

Sexuality has a direct impact on individuals’ health and quality of life and affects educational, economic and sociocultural development of both males and females. And everyone, when pressured to act in unhealthy ways, because they belong to one sex or the other, limit or even lose their life opportunities. Males and females of all ages have sexual rights, want to better themselves, and want to have an adequate quality of life. Most want to have a family and children, and their hope is actually to be happy in this world, with love, communication and respect. Both males and females want to grow, and have the potential to do so. The healthcare sector can and should participate in this ideal, helping to form more equal, healthy and constructive societies.

SEXUAL AND REPRODUCTIVE RIGHTS OF ADOLESCENT AND YOUTH POPULATIONS.

The issue of adolescent and youth populations having sexual and reproductive rights may seem controversial. However, young people themselves have been demanding these rights, and internationally, the idea that adolescents and young people are capable of making decisions and that they have the right to enjoy the exercise and protection of sexual and reproductive rights *with the same legitimacy and to the same full extent* as adults has been reaffirmed (Andar, 2007).

REFERENCES

- Andar (*Alianza Nacional por el Derecho a Decidir* [National Alliance for the Right to Choose]) (2007). Los Derechos Los derechos sexuales y reproductivos de las personas adolescentes y jóvenes [Rights Sexual and Reproductive Rights of Adolescents and Youth]. At: http://www.andar.org.mx/docs_pdf/D.SEX.REP..ADOLEES.pdf
- Encyclopedia Britannica, Adolescence, Electronic version 2000.
- Family Health International (1997). Gender norms affect adolescents, Network, vol. 17, no. 3. United Nations Population Fund (1998). Violence against Girls and Women. A Public Health Priority: UNFPA.
- Haffner, D. (1999). From Diapers to Dating. A parent's guide to raising sexually healthy children.- EUA: Newmarket Press.
- Herbert, M. (1992). Entre la tolerancia y la disciplina [Between Tolerance and Discipline].- Spain: Paidós.
- Instituto Mexicano de la Juventud [Mexican Youth Institute], Ministry of Public Education (2001). National Youth Survey 2000.- Mexico: Centro de Investigación y Estudios sobre Juventud [Center for Research and Studies on Youth]-Ford Foundation-INEGI (*Instituto Nacional de Estadística y Geografía* [National Institute of Statistics and Geography]) March 2003.
- López, F. (1999). La inocencia rota. [Broken innocence.] Abuso sexuales a menores [Sexual abuse of minors].- Spain: Océano.
- Lungarden, R. (2000). Protocolos de investigación para el estudio de la salud sexual y reproductiva de los adolescentes varones y hombres jóvenes en América Latina.- OPS: [Research protocols to study the sexual and reproductive health of male adolescents and young adults in Latin America.- PAHO:] Division of health promotion and protection. Family health and population program: PAHO.
- PAHO (2000). Promoción de la Salud Sexual, Recomendaciones para la acción, Actas de una reunión de consulta.- Guatemala. [Promotion of Sexual Health, Recommendations for Action, Proceedings of a Consultative Meeting.- Guatemala.] PAHO, World Association of Sexology (WAS).
- Papalia, D., S. Wendkos and R. Duskin (2002). Psicología del desarrollo [Psychology of Development], 8th Ed.- Bogotá: McGraw Hill.
- Papalia, D., S. Wendkos and R. Duskin (2003). Desarrollo humano [Human Development].- Bogotá: McGraw Hill.
- Papalia, D. (1992). Desarrollo humano [Human Development].- Mexico: McGraw Hill.
- Patz, D., R. Mazín, and F. Zacarías. (1999). Women and HIV/AIDS. Prevention and care strategies: Pan American Health Organization.
- Rivers K. and P. Aggleton (1998). Adolescent sexuality. Gender and the HIV epidemic.- London: Institute of Education, University of London Press.
- Schutt-Aine, J. and M. Maddaleno (2003). Sexual Health and Development of Adolescents and Youth in the Americas: Program and Policy Implications: PAHO-Swedish International Development Cooperation Agency (SIDA) and NORAD, Washington.
- UNFPA (2003). Adolescent pregnancies/HIV/AIDS and other sexually transmitted diseases.

SESSION 9.

Description of the most frequent health problems in trans persons

Cardiac health	The effect of hormones on cardiac health is not sufficiently understood, but there are grounds for concern about estrogen and testosterone.
Mental health	Social isolation, physical violence, family rejection, fear and stigmatization contribute to symptoms of depression, anxiety, self-punishment, suicide and substance abuse.
Transition from male to female: trans women	Hormones (estrogen) Androgen blockers Breast enlargement (implants) Vaginoplasty and labiaplasty Orchiectomy Tracheal shave Facial bone reduction Rhinoplasty
Transition from female to male: trans men	Hormones (testosterone) Masculinization of chest Hysterectomy, salpingo-oophorectomy Phalloplasty Metoidioplasty Vaginectomy Scrotoplasty Urethroplasty Testicular prosthesis

Cross-gender hormone treatment
Cross-gender hormone treatment – Female-to-Male Trans Androgens – injectable: Testosterone (cypionate or enanthate) Androgens – other: Testosterone (AndroGel, Androderm, Testim, Striant, etc.)
Cross-gender hormone therapy – Male-to-Female Trans
<ul style="list-style-type: none"> – Injectable estrogens – Transdermal estrogens – Oral estrogens: Estradiol (Estrace). Spironolactone (anti-androgen) – 5-a – Reductase inhibitors: Finasteride (Proscar, Propecia), Dutasteride (Avodart), Flutamide (Eulexin)

Effects of estrogen and anti-androgen therapy. From male to trans woman

Desired effects of estrogen therapy	Adverse effects
<ul style="list-style-type: none"> • Breast development • Decrease in body hair • Reduce, stop or reverse androgenic hair loss • Softening of the skin • Effects of estrogen therapy • Redistribution of fat to a gynecoid pattern (smaller waist, wider hips) • Reduction of upper body muscle mass and decreased strength • Psychological feeling of well-being • No effect on beard hair • Genital changes (chemical castration): • Testicular atrophy • Decreased penis size • Decreased erection frequency and strength • Decreased semen volume and content • Decreased prostate size 	<ul style="list-style-type: none"> • Thromboembolism • Increased breast cancer risk • Hyperprolactinemia/pituitary adenoma • Hepatotoxicity • Cardiovascular risk • Infertility • Anxiety/depression • Gallstones • Hypertension •

Trans women	
Silicone	It is common to find trans women in low economic classes with advanced physical deterioration and necrosis associated with the use of poor-quality implants or injectable products used to mold or shape their figures, from mineral oil and paraffin to industrial silicone or retinol.
	Often, when women come to healthcare services, they are again victimized and blamed for the state of their health as a result of having used these practices, which endangered their health and which, in the opinion of some healthcare service providers and of the healthcare system itself, are simply “esthetic issues.” Silicone injections, particularly at so-called ‘silicone or pumping parties,’ can cause many problems and side effects:

	<ul style="list-style-type: none"> • Hepatitis B and C transmission • HIV transmission • Reactions that result in disfiguring scars • Contaminants that enter the bloodstream and cause death
Cancer	<p>The effects of hormones on the risk of cancers – of the breast, liver, uterus, prostate – are not well understood</p> <p>Cancer risk may increase due to:</p> <ul style="list-style-type: none"> • Less access to healthcare services • Avoiding healthcare services • Avoiding specific genital exams (pelvic, PAP smear, anal, prostate, testicular, breast/chest) • Perceived decreased risk (prostate cancer in Trans women, breast cancer in Trans men). If the individual keeps the organ – e.g., testicles, prostate, cervix – even though it may be atrophied, it can still be susceptible to developing cancer. • Upper surgery in Trans men may leave residual breast tissue in the chest and near the armpits. • The use of estrogen in Trans women may lead to an increased risk of breast cancer, which may be harder to detect due to silicone implants or injections.

Problems associated with healthcare service providers²¹	
Lack of sensitivity	Healthcare providers' lack of sensitivity on transgender-related issues.
Health system limitations	In some countries, in order for trans persons to make their transitions clinically, they must be diagnosed with a gender identity disorder, formally issued by a psychiatrist. In dealing with this obstacle, they come up against negative responses, delays, ridicule and mistreatment by healthcare personnel.
Gaps in public policy and regulations on trans issues	When there is no formal national policy for the care of trans persons, their health depends on the “random luck” of finding a healthcare service provider who understands their needs and problems fairly well.
Lack of information	Lack of information about the health needs of transsexuals and of formal training on transsexual health issues for medical and nursing personnel
Lack of care plans	Difficulty in understanding the special needs of trans persons at the first level, which leads to erroneous referrals to second- and third-level services.
Lack of specialists	The absence of a specialist in trans health to supervise the adaptation of services and healthcare plans for trans persons.

Problems associated with behavior and perception of the services by trans persons	
Fear of discrimination and abuse	They fear acts of discrimination and aggression by personnel due to a history of abuse and mistreatment in healthcare services.
Lack of healthcare coverage	Many trans persons do not have health insurance or jobs. Those who do have health insurance often find that this insurance does not cover their needs.

²¹ Same.

Fear of being exposed	Discomfort when facing a possible physical examination and about being publicly exposed in front of a team of healthcare professionals.
Fear of revealing their identity	Many trans persons refuse to reveal their identities or that they use hormones, which can lead to them not receiving appropriate care. Unfortunately, revealing their gender identity or the use of hormones can also lead to discrimination and inappropriate treatment.
Multiple discrimination	Trans persons face multiple discrimination when they also identify as homosexual, lesbian, gay or bisexual, or are members of an ethnic minority, or live with some type of physical limitation, or belong to a low economic class.
Limited psychosocial support services	Limited qualified psychosocial support services for trans persons, for their families and significant others.
Limited number and quality of specialists	Limited availability of qualified surgeons, post-operative care, endocrinologists and psychiatrists.
Exorbitant costs	For most trans persons, costs are beyond their reach.

COMPONENTS OF A PROTOCOL FOR OVERALL PREVENTION

1. Diet and lifestyle
2. Vaccines
3. Mental health
4. Substance use
5. Injections of soft tissue fillers
6. Sexual health
7. Diabetes mellitus
8. Cardiovascular disease
9. Pulmonary examination
10. Cancer
11. Musculoskeletal health
12. Thyroid exam

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