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Time for the two-spirits: Shaping the inclusive policy environment for hispanics and transgenders through global health diplomacy

Vijay Kumar Chattu¹, Mario O. Laplume², Soosanna Kumary³

¹Public Health, Faculty of Medical Sciences, University of The West Indies, Trinidad and Tobago, ²Consultant, New Life Medical Institute, Miami, Florida, USA, ³Public Health Researcher, Trinidad and Tobago

ABSTRACT

Minority populations in the world are permanently challenged with unequal living and working conditions in their daily lives that compromise their access to needed clinical and preventive services. When we discuss the health-care conditions for minorities, we must address the social determinants of access that are ultimately determined by the policies and politics of the governments. Renowned experts of quality in healthcare have been critical of the current design and implementation of randomized clinical trials, the gold standard of clinical research because they believe that they often, but not always, presume a linear, mechanistic system when in fact improvement in health care takes place within complex adaptive systems that evolve. The combined action of ignorance and prejudice can impair the efficient recruitment and retaining of “different people” like hispanics and transgender that have long suffered discrimination in their access to health-care services in spite that they are more prone to have chronic conditions. Even though the incidence of AIDS has decreased in the general population during the past two decades, it is continuing in the gay population due to educational issues, discrimination in health-care access and lack of proper public and private funding for the life-saving retroviral medication. The declaration of the “International Conference on Health Promotion” sponsored by PAHO in Colombia in 1992 have emphasized the aim of reducing differences in health status as well as ensuring equal opportunities and resources to enable all people to achieve their full health potential. Through the entreaties of the Global Health Diplomacy, the resiliently hardcore issues of discrimination and marginalization must be addressed by encouraging public policies that guarantee equity and ensure access for the most socially castigated groups.

Keywords: Equality, equity, global health diplomacy, hispanics, social determinants, transgender

“To deny people their human rights is to challenge their very humanity”

Nelson Mandela

Introduction

Minority populations in the world are permanently challenged with unequal living and working conditions in their daily lives that compromise their access to needed clinical and preventive services. Renowned experts of quality in healthcare have been

critical of the fair access to basic medical services for certain segments of the population, because they believe that they believe that the professional corps often, but not always, presume a linear, mechanistic system when in fact improvement in healthcare takes place within complex adaptive systems that evolve.^[1] They claim that care interventions must adapt to often difficult, different community contexts, which are at odds with the concept of improving health-care delivery as a fixed set of activities that do not take into account their complexity and their different responses to the continuity of care and monitoring techniques. Not only there is a need for evidence-based practice but also for

Address for correspondence: Dr. Vijay Kumar Chattu, Faculty of Medical Sciences, University of the West Indies, Trinidad and Tobago.
E-mail: vijay.chattu@sta.uwi.edu

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“practice-based evidence” that allows flexible learning techniques to obtain acceptable outcomes across all the segments of the population.

The combined action of ignorance and prejudice can impair the efficient recruitment^[2] and retention of “different people” such as hispanics and transgender that have long suffered discrimination in their access to health-care services in spite that they are more prone to have chronic conditions.^[3] The front desk staff is always the first responder to their particular needs, often expressed in nontraditional forms of expression, and should be carefully trained to avoid the most common pitfalls and misunderstandings. The professionals – nurses, technicians, physicians – in direct contact with these patients must anticipate the emergence of some controversial issues and negative feedback that can, and will, sabotage a continued participation.^[4] Through global health diplomacy (GHD), which aims to capture the real complexity of the multilevel and multiactor negotiation processes to shape and manage the public health-care policies, these issues of discrimination and marginalization can be addressed effectively.

The Hispanic Population

The term “Hispanic” in the USA usually refers to the immigrants from Central and South America and their descendants who continue to use Spanish as a first or second language. As the ethnic origins are varied,^[5] it identifies a socioeconomic population that has many different subgroups.^[6]

The major identifying features of this group are an attachment to family values and adherence to religious beliefs, with a majority of Catholics.^[7] Family and faith are the socially acceptable agglutinating factors that protect them from the uncertainty of settling in a different country, with unique laws and an odd language whose basic vocabulary many of them do not master.

Even though the lack of oral communication can limit the efficacy of the nurse or physician that encounter non-English speaking Hispanics in a medical interview, the most limiting factor is “the tone” of the conversation. If the interviewed sense that the professionals are using a condescending tone and make short shrift of their complaints, they wall off further contact. As there is usually someone, an aide or a patient’s relative, that can mediate in the conversation, the professional must not despair and show frustration.

The health-care practitioners must understand and respect the pivotal role of “the woman in the family” – be the mother, spouse or daughter – in the daily dynamics of a typical Hispanic family. Conventionally, the Hispanic woman has sustained the family nucleus when her companion was far away toiling in the fields, slogging in the factories, or emigrating to the North. She is often the ultimate arbiter of what gets done and what does not in her home.^[8]

The Transgender Population

We expressly use the term population because the transcommunity is particularly varied in its socioeconomic, cultural, and sexual features,^[9] which has been largely ignored and dismissed by the medical establishment. The ingrained prejudices against these “most different” people have largely kept them away from equitable, efficient care services,^[10] and out of the range of the population approaches that monitor and regulate the health-care arena. On top of the financial and structural barriers to access, the majority of health care providers lack the knowledge and expertise to treat this population.^[11]

The trans community includes the following major categories:

- People that put up with gender incongruence without transitioning
- Others transition without any gender-affirming healthcare
- Others do not have gender identity disorders or gender dysphoria, as they do not accept a simple binary system to identify their identities.^[12]

Sari Reisner says the “situated vulnerabilities”^[13] depriving transgender people of respect, opportunities, and dignity in the health-care system can precipitate or exacerbate depression, anxiety, and even suicidal behavior. Many of the transgender people suffer from a state of emotional frustration. The lack of updated and reliable data about a population that has largely stayed in the penumbra of the health-care delivery system has hampered the recognition of their unique needs to raise the quality of their care services.

The anxiety of gender incongruence often leads to inappropriate psychiatric diagnoses that are clinically irrelevant and potentially harmful for their care. The World Health Organization (WHO) is proposing to relocate the relevant diagnoses for children, adolescents and adults in a new chapter of “sexual health” in the international classification of diseases code-11.

Even though the incidence of AIDS has decreased in the general population during the past two decades, it is continuing in the gay population due to educational issues, discrimination in health-care access, and lack of proper public and private funding for the life-saving retroviral medication.^[14] There is no reliable data about the total number of HIV infections in the trans population but some studies suggest that it could be as high as 28%.^[15]

Equity and Equality

Equity in healthcare is an ideal status where the delivery of services is solely based on the needs of the patients and availability of resources, with disregard of socioeconomic status or ethnic/cultural/religious backgrounds. Equity is an ethical concept which means social justice and is based on principles of distributive justice.^[16-19] Unfortunately, our modern societies, with legal and administrative protection measures against disadvantaged people, still discriminate in the allocation

of clinical resources to minorities such as the hispanics and transgender people.

The WHO defines health as “the state of complete physical, mental, and social well-being and not merely an absence of a disease or infirmity.” Minority populations in the world are permanently challenged with unequal living and working conditions in their daily lives that compromise their access to needed clinical and preventive services. When we discuss the health-care conditions for minorities such as hispanics and transgender people, we must address the social determinants of access that are ultimately determined by the policies and politics of the governments.

As the equality in care access is determined by crisscrossing social, cultural, and economic factors in the real lives of the disadvantaged, the issue of human rights, as established by the WHO constitution,^[20] must be addressed. Rights to decent housing, good food, water, adequate toilet facilities, modern educational programs and facilities, safe transportation, well-paid jobs, employment for disadvantaged people, family-friendly entertainment, right to express the political opinions and to vote in fair elections, etc. This long list constitutes a reminder that these are basic rights of humans that need the concurrence of legal, political, cultural, and religious representatives.

Even though the term “equality” is used as a synonym to “equity,” there is a fundamental difference between them. Equity is a value-based concept while equality is not. Equality strives to achieve access to the same goods and services, regardless of the ability to pay or social differences. Equity is represented by “the means” while equality by “the outcomes.”

If we define Hispanics as an “ethnic” minority in the USA, we must consider the lesbian, gay, bisexual, and transgender (LGBT) population as an “ethical” one as there are individuals and institutions in health-care delivery that still actively and/or passively resist their acceptance as rightful members of our diverse communities. The national and international organizations of human rights must be involved in the defense of these disadvantaged to assure the equality of their care access. The medical organizations must stop boycotting the inclusion of trans people in a new category of medical classification and consider them as just “chronically sick people” that need psychiatric and not medical support.

Global Health Diplomacy

As the distances virtually shrink in our hyperconnected world, there is a convergence of multiple players and organizations that are concerned about the social, economic, and clinical implications of public health issues for the citizenry, which made them aggregate in GHD.

It’s a still to be defined-concept that describes an eclectic yet enthusiastic agglutination of defenders of Human Rights – with diverse legal, political, economic, cultural, and religious

backgrounds and interests – that address the widespread discrimination of minorities in the access of health-care services. GHD involves a number of disciplines ranging from public health, law, international affairs, management, and economics which aim to shape the policy environment for health through proper negotiations.^[21] It intersects the areas of health, foreign policy, and trade. “Health Diplomacy is the chosen method for interaction between stakeholders engaged in public health and politics for the purpose of representation, cooperation, resolving disputes, improving health systems, and securing the right to health for vulnerable populations”^[22] whereas another definition by Kickbusch *et al.*, describes it as “multilevel, multiactor negotiation process that shape and manage the global policy environment for health”.^[23]

This growing new paradigm has many successful outcomes including the recent WHO’s International Health Regulations (2015) and the framework convention on tobacco control, which are good examples of successful negotiations in global health issues under the leadership of a transnational organization. As the discrimination against minorities such as hispanics and transgender people is multifaceted – related to labor, health, housing, family, and educational policies – there should be an active attitude before rights are under threat.

In the particular case of the LGBT communities, there is a significant commitment of the United States Agency for International Development (USAID) to promote their right to live in dignity and without discrimination.

“USAID’s vision is the world in which the basic and universal human rights of LGBT persons are respected and they can live with dignity, free from discrimination, persecution, and violence.” Dr. Rajiv Shah, administrator.^[24]

In 2013, a large public-private partnership – including the USAID, bilateral organizations, NGOs, and business corporations – pledged economic and human resources to develop the capacity building, support the civic organizations, and strengthen the LGBT leadership in 15 different countries. According to USAID estimates, there are approximately 216 million LGBT people on the planet, and almost half of them live under criminalized status.

In 2013 the “Salzburg Global Seminar” highlighted the LGBT issues by designing multi-year programs focused on human rights to support them in our societies. In 2014, it brought, in collaboration with the German Federal office, activists from many countries to a Salzburg Global Seminar series.^[25]

The Two Spirit

Unlike the Europeans that invaded the North American continent, the Native peoples of what is now called the USA did not confound the “gender identity” with the “sexual orientation.” The presence of multiple-gender individuals was an accepted and

even revered fact in their communities. They were respected as visionaries, healers, medicine people, and caregivers.

In fact, Natives people divided sexual genders into four categories:^[26]

- a. Feminine woman
- b. Masculine woman
- c. Feminine man
- d. Masculine man.

Their prominent social profile entailed both privileges and responsibilities; the “two-spirit” were valued for their multifaceted perspectives in the tribe. Their rich tradition of civic tolerance to gender diversity was summarily dismissed and repressed by the simplistic hordes of European conquerors.

In the Republic of India, which has the only major civilization that has been transmitted almost intact from ancient times to ours, there is a tradition of respect for transgender women participating in an annual Hindu festival. In the southern region of Tamil Nadu, the festival of Mayana Kollai is held by the Kothis – transgender women that impersonate the major Hindu deities. Kothi performers converge for 10 days to freely worship and dance together. At present, transwomen preside fertility celebrations for infertile couples.^[27]

The Latino transgender women in the USA are straddling two cultural groups that are sometimes antagonistic in their perceptions of civic life, which makes them the target of social and economic discrimination. Their access to need health-care services is hampered by prejudice and ignorance from the health-care providers that stand guard at the system’s access points.

In times of social flux, the absence of hispanics and transgender in the upper cadres of health care is a major flaw that has to be addressed by those entrusted by the federal government to train the future professionals. The same generation of white men that trekked to a meadow in Bethel County for 3 days in August 1969t – their minds slowed by some kind of mushroom – is the one that, entrenched in institutions, is discriminating against them at present. They should hear again what the Dormouse said:

“Feed your head... Feed your head.”

Conclusion

The first “International Conference on Health promotion” in Ottawa in 1986 and the declaration of the “International Conference on Health Promotion” sponsored by PAHO and ministry of health in Colombia in 1992 have emphasized the aim of reducing differences in health status as well as ensuring equal opportunities and resources to enable all people to achieve their full health potential^[28] which, 30 years later, is still a pending assignment.

The United Nations General Assembly^[29] through its Political declaration in 2011 affirmed that its members “should create enabling legal, social, and policy frameworks in which national context to eliminate stigma, discrimination, and violence related to HIV... provide legal protections for people affected by HIV... and promote and protect all human rights and fundamental freedoms.” To attain the goal of equitable access to health-care services and rid the system of the unnecessary, unjust and certainly avoidable differences to exercise the right of well-being, we must first identify the individual factors at the local and national levels that encourage discrimination against the vulnerable groups. There is an urgent need for greater demand and greater support from communities and policymakers for rights-based, evidence-informed prevention strategies.^[30]

Through the entreaties of the GHD, the resiliently hardcore issues of discrimination and marginalization must be addressed by encouraging public policies that guarantee equity and ensure access for the most socially castigated groups such as hispanics and transgender people. The “Transforming our world: The 2030 agenda for sustainable development” is an ambitious global agenda that places the well-being and dignity of people at the center of the social and political agendas of the democratic countries.^[31]

Considering that the GHD aims to capture the real complexity of the multilevel and multi-actor negotiation processes that eventually shape and manage the public health-care policies, the trust and commitment on the part of stakeholders must be strengthened. Recognizing our stark reality is the first step but, in spite of the seemingly insurmountable odds, we must start to dream together of a better world. As Pedro García Cabrera, the poet from the Canary Islands^[32] said about Quixotesque hoping:

A la mar fui por naranjas
Que la mar no las tiene
Metí mis manos en el agua
Que la esperanza me mantiene.

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Conflicts of interest

There are no conflicts of interest.

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