to these notions of inclusive health systems and equity. The proposal was initially submitted for discussion in September, 2012, but was contested at a 6 h discussion of the Executive Board meeting's agenda in May, 2013. Since then, the agenda item was removed and has been repeatedly deferred while the Director-General undertakes informal consultations to reach a consensus.

As junior doctors, we are disappointed by global health leaders and the health community for the little progress on this issue. The comments by some Member States denying LGBT health disparities are not consistent with scientific evidence or WHO data.[4] By reinforcing ignorance and discriminatory practices, these statements could have real health consequences for LGBT individuals worldwide.

Challenges faced by LGBT individuals to access health services are a global concern; the governing body of WHO is entrusted to ensure equal access to health services by all groups of people without distinction.

WHO and its leaders are doing their global constituency a disservice by allowing discrimination to halt progress at their board meetings. The principles of equity and non-discrimination form the core of WHO's constitution. Therefore, how can WHO leadership celebrate the virtues of universal health coverage and simultaneously neglect to collectively address health-related LGBT disparities?

LGBT individuals are exposed to substantially more health-related risks—including HIV/AIDS and other communicable diseases, mental health disorders, violence against them, and suicide—than the general population.[5] To address these health challenges is at WHO's core functions and present priorities. The Pan American Health Organization (PAHO) has shown leadership on these issues with a unanimous resolution to address LGBT discrimination and health disparities in 2013.[6]

Action is needed globally. Following PAHO's lead, we urge WHO's Executive Board and Director-General to show leadership and not to shun their accountability towards health of the LGBT community.

We declare no competing interests.

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Population control policies in Iran

In their Correspondence (Nov 29, p 1926),[1] Mehdi Aloosh and Arash Aloosh shared their valid concerns about the drawbacks of the recent shift in population control policies in Iran, and they seemed to take a strong position on the wisdom of the new population-promoting policies. The population growth rate in Iran has decreased from 3·13% in 1966 to 1·29% in 2011.[2] Despite Iran's successful family planning and population control policies, serious concerns now exist that Iran has overshot the target, which has led to a total fertility rate of 1·92—less than the replacement fertility level.[2,3] Such a low population growth rate and demographic transition, and their potential socioeconomic consequences have driven the shift in policies.

Moreover, access to contraception and permanent sterilisation is not banned completely. Most contraceptive methods are still available in pharmacies, and condoms are sold in supermarkets. Access to all contraceptives remains free for vulnerable populations through service-providing centers (eg, drop-in centers). The main restriction and penalty is on surgical sterilisation, which is still accessible under some circumstances.

Lastly, the authors seem to overestimate the role of family planning policies in Iran's successful population control. The fertility rate in Iran began to decrease in 1985—4 years before the introduction of the family planning policies in 1989.[4] Furthermore, only 61% of the reduction in fertility rate was attributable to family planning; the rest was mainly caused by the increased age at marriage among Iranian women (mainly because of their pursuing higher education and changes in sociocultural norms) and desire not to have further children.[5] Overall, although we acknowledge these concerns, taking a cultural approach towards the implementation of these policies seems essential.

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