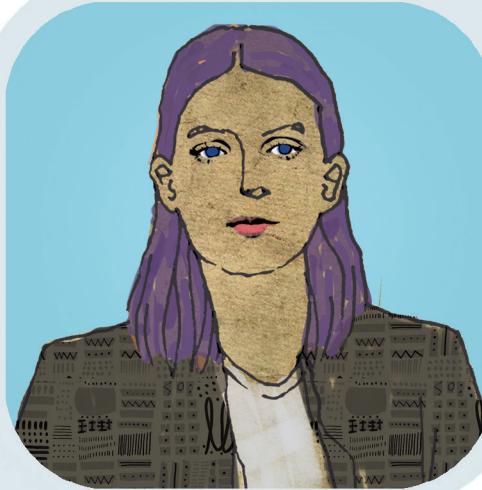


Global trans perspectives on health and wellbeing

TvT community report



Global trans perspectives on health and wellbeing: TtT community report

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Introduction

1 More about the terminology used on <https://transrespect.org/working-definitions/>

2 Global South and East is used here not as a mere geographical reference, but also to highlight historical and geopolitical power relations.

3 More about the TvT team on the website <https://transrespect.org/about/team/>

4 Berlant, Lauren and Michael Warner (1998). *Sex in Public. Critical Inquiry*, Vol. 24, No. 2, Intimacy.

Stigma and extreme violence against trans and gender-diverse people¹ are a global reality. In many countries in the Global South and East² political contexts and legal and social persecution often limit access to data. Lack of research and critical analysis add to erasure and marginalisation of trans and gender-diverse people. This report draws on activism and research of the TvT team regarding the health of trans and gender-diverse people in the Global South and East, viewing health as more than just the absence of illness.

The Transrespect versus Transphobia Worldwide (TvT) project was created in 2009 to provide a global overview of the human rights situation of trans and gender-diverse people and develop advocacy tools for trans rights activists. Our team consists of trans activists from around the world who coordinate and implement the research in their respective regions.³

“Heteronormativity [...] is produced in almost every aspect of the forms and arrangements of social life: nationality, the state, and the law; commerce, medicine and education, as well as in the conventions and affects of narrativity, romance, and other protected spaces of culture.”⁴ If we take cisnormativity or endonormativity as concepts that make use of these critical lenses on sexual orientation to regard gender identities and expressions and bodily diversities, we can analyse more complexly how the mechanisms that compound this system, made by and for cisgender and endosex people, disregard the existence of other bodies, gender identities and expressions, and permeate our lives in ways that are not always obvious.

Trans health or access to health for trans people in the Global South and East exist in a neo-colonialist framework, shaped by the legacy of colonisation and the structures it imposed: social, political, and economic violence, cultural changes, dictatorships, and warfare all impact the lives of LGBTI people and other pre-existent indigenous identities, such as *Muxhes* in Mexico, *Omeguid* in Panama, *Hijras* in India, *Fa’afafines* in the Pacific, and many others.

Globally, there are wide disparities in access to healthcare for trans people. In some parts of Europe and Latin America, trans-specific care is covered by national health insurance, while in parts of Asia and Africa, it is unavailable and, sometimes, illegal. Furthermore, pathologisation creates abusive practices that violate trans people’s right to dignity, bodily integrity, autonomy, and non-discrimination, fuelling stigma and violence.

This is a part of a cycle of oppression denying us basic rights: the legal framework enables and validates social persecution, giving power to medical oppression against trans people. Criminalisation, pathologisation, sterilisation, and absence of legal gender recognition reinforce the oppression produced by the healthcare system.

Though using evidence from our networks' accumulated knowledge and research, and online sources, our analysis is just the tip of the iceberg: we hope that communities, scholars, and social justice activists will use, complement, challenge, and build upon the information presented here.

Kyrgyz trans activists on a Trans Day of Visibility (TDoV) action to raise awareness among health providers.

Photo credits: Labrys Kyrgyzstan



I. Access to healthcare: total absence vs oppressive requirements

Globally, there is a lack of awareness and understanding of trans issues, resulting in limited policies and laws that protect trans people. As a direct outcome, there is a lack of trans-inclusive and trans-sensitive healthcare services, support in education and employment, and anti-discrimination measures.

Trans people's access to healthcare is further complicated by the fact that our experiences have been classified as a mental disorder, requiring a diagnosis to access healthcare in many countries. The World Health Organization (WHO) has proposed to move trans healthcare from the chapter on mental disorders to a chapter on "conditions related to sexual health".⁵ This has been welcomed by global trans communities, as well as trans-affirming clinicians and researchers.

Harmful sociocultural attitudes toward sexual and gender diversity are often internalised. In parallel, many health professionals continue to pathologise people who do not conform to the binary gender model, while isolation and social exclusion further limit access to care. Trans people can be afraid to seek care if they don't have a support network. Discrimination in healthcare, lack of knowledge about trans-specific needs, and no national and private health coverage for trans health, all make it difficult for us to access adequate healthcare services.

In most parts of Africa, there is no trans-specific healthcare. In North African or sub-Saharan countries, trans individuals face institutional discrimination and rejection in accessing basic health services. In South Africa and Botswana, medically supervised hormone therapy for trans people is available, but requires a psychiatric diagnosis. South Africa has only two facilities where transition-related surgeries can be done. In countries in East Africa, such as Rwanda, Uganda, South Sudan, Democratic Republic of Congo, and Tanzania, some parts of West Africa such as Liberia, and in South Central Africa such as Zambia, Malawi, Zimbabwe, Angola, and Namibia, hormone replacement therapy is not available, and there is no funding for gender-affirming surgeries. Trans-related health programs exist only in connection to HIV, AIDS, and STIs, and provision of condoms and lubricants for trans women or trans people assigned male at birth is under the MSM (Men who have Sex with Men) category. Many trans people from these parts of Africa seek medical care in private hospitals in neighbouring countries, such as Kenya in East Africa, where hormone therapy is available, without health insurance. Very few trans people in the region can afford this.

5 WHO (2018). ICD-11. <https://icd.who.int/browse11/l-m/en/#/entity/90875286>
<http://id.who.int/icd/>

In the Pacific, trans-specific healthcare is a foreign concept. Traditionally, this is attributed to the genuine and/or artificial Pacific society co-existence with trans communities as cultural identities known in the region, such as *vakasalewalewa*, *brasto*, *palopa*, *pina*, *fa'afafine*, *fa'atama*, *akavaine*, *tututane*, *fakafifine*, *leiti*, *binabinaine*. These different ethnicities and indigenous groups place their identities on a cultural scale and continuum that is defined by culture, division of labor, societal norms, myths and legends. Their coexistence is generally tolerated and/or adored on the basis of family lineage, genealogy, and inherited birth rights that make it extremely difficult to disconnect an individual, regardless of their gender identity or sexual orientation, from the basic unit of family, village, community, and island. This mindset has enhanced the peaceful coexistence of trans people in the Pacific, but it has also limited and isolated trans communities from key services such as healthcare.

Conservative social attitudes in South Asia towards sexual orientation and gender identities have a devastating impact on the lives and rights of trans people, and segregation and marginalisation in medical settings are common. In Peshawar, Pakistan, Alesha, a 23-year-old trans woman, was shot eight times in May 2016. Though immediately transported to a nearby hospital, she died due to being ignored by doctors and refused access to either the male or female wards.⁶ In East Asia, violence and discrimination in families, intimate relationships, and social spaces is often ignored.

While in China gender-affirming surgeries are available and regulated, there is an oppressive set of requirements: notarised parental agreement, divorce if married, and gender identity disorder diagnosis, which should also confirm that the applicant is heterosexual.⁷ Most parts of Southeast Asia do not have gender-affirming healthcare systems in place. When seeking access to these services, trans people have to travel to capitals or to neighbouring countries where trans-specific procedures are available. Often, these medical procedures are not covered by public or private health insurance, so trans communities have to shoulder the cost of their own medical transition.⁸ In most countries in the region, there are no regulations on the use of hormone therapy for trans people, who are forced to get hormones mostly from online illegal markets. With no established medical transition procedures, trans people in most of Southeast Asia start taking hormones without medical consultation.

In some countries in Central Asia and Eastern Europe (CAEE), for example, Estonia and Serbia, trans-specific healthcare is partially covered by insurance, but it is mostly privatised, creating a financial barrier for most trans people with such a need. The countries in CAEE still medicalise and pathologise trans people, while failing to provide access to quality trans-specific medical care.

- 6 TMM Update 2016
Available at: https://transrespect.org/wp-content/uploads/2016/11/TvT_TMM_TDoR2016_Namelist_EN.pdf
- 7 Bernotaite, Ausma, H.c Zhuo, and Lukas Berredo. 2017. *Voices from Trans Communities in China: Summary Report of Three Town Hall Consultations*. Beijing: Asia Catalyist.
- 8 Asia Pacific Transgender Network, United Nations Development Programme (2015). *Blueprint for the Provision of Comprehensive Care for Trans People and Trans Communities*. Health Policy Project.

An overwhelming majority of countries require a diagnosis of gender identity disorder for accessing trans-specific healthcare and changing documents. There is currently a lack of significant research on access to healthcare and level of health of trans people in the countries of the region. According to activists in the region, trans-specific care is either not available or not fully available in many CAEE countries, and only in capitals and major cities.

According to a TvT Expert Questionnaire, in many countries in Central Asia and Eastern Europe being trans is perceived as a disease. Unfortunately, not all countries have carried out studies able to assess the scale of violence and discrimination that trans people face in healthcare. But where such research or data exist the numbers are alarming. According to a study in Kazakhstan,⁹ of the 58 respondents, only three say that they have not experienced transphobia from doctors, and 12 people were denied medical care and/or were intentionally harmed by providers due to being trans. In Russia,¹⁰ 17% of the respondents indicated that they were denied medical care because their appearance and gender identity didn't match social expectations tied to their gender marker. 41% of respondents indicated that they were pressured to give up on getting medical care and treatment from doctors. While many CAEE countries have mechanisms against medical negligence and refusal of care in general, gender identity and expression rarely appear as protected grounds in this context. As a result, trans people do not receive proper medical services and engage in self-treatment, which negatively affects their health.

Physical, emotional, and psychological health are closely interlinked. High levels of verbal violence can lead to body damage, including death. The early use of self-administered hormones or silicone, as well as bad surgical practices, are common in Latin America. Added to this, there are numerous limitations in access to reproductive healthcare. The consumption of alcohol and drugs are mitigating devices of a hostile reality.

In Latin America, some healthcare protocols exist, e.g. in Argentina, Mexico, Colombia, and Chile, but not on national level and with major implementation issues. After demands of trans communities in the region, some States have developed a few trans-specific instruments. In 2016, the president of Mexico met with activists, which resulted in several initiatives, including the creation of a health protocol.¹¹ The aim was to “eradicate discrimination that blocks access to the dignified medical care for people from sexual diversity”. However, the protocol is presented at a time of change of

9 ALMA-TQ Initiative Group (2018). Access to healthcare for trans people in Kazakhstan.

10 Yashenkova, Diana and Kseniya Kirichenko (2016). Violation of transgender people's rights in Russia: research results.

11 Secretaría de Salud de México (2017). Protocolo para el acceso sin Discriminación a la prestación de servicios de atención médica de las personas Lésbico, Gay, Bisexual, Transexual, Travesti, Transgénero e Intersexual y guías de Atención Específicas.

government, and it will require great efforts to implement it throughout the country and reach the communities that need it. In Argentina, since 2015 trans people have had recourse to the Guide for the Comprehensive Healthcare of Trans People.¹² As in Mexico, many of these initiatives encounter difficulties with implementation at state level. Further, the economic crisis in Argentina affects the health system structurally and financially, which also impacts programs focused on trans people.

12 Ministerio de Salud de Argentina (2017). *Atención de la Salud Integral de Personas Trans: Guía para Equipos de Salud*.

Colombia has no protocol or guidelines for trans-specific healthcare, and still pathologises trans people. From Pasto, Colombia, trans activist Darla Cristina González says, “what we have done through the Health Services Providers is to make up a route ourselves. Trans people go to the general practitioner to ask them for a referral to the social worker, then we ask the social worker to send us to the psychologist, who in turn refers them to psychiatry; Psychiatry determines if you have ‘gender dysphoria’ and refers you to the endocrinologist, who makes all the relevant analyses, prescribes hormones, and refers us to general surgery in case it is desired.”¹³

13 Interview conducted in September 2018.

In the Caribbean region there is a lack of standardised access to hormone therapy, and healthcare providers sensitised in providing affirming trans-specific healthcare. Further, there is limited to no access to gender-affirming surgeries in the region. Self-medication or access through private practitioners are common among trans persons who wish to access hormones, and surgery is often sought outside the region. Much of the resources for trans healthcare focus on HIV prevention, treatment, and care. However, the vulnerability and marginalisation of trans people extend well beyond healthcare. Stigma, discrimination, violence, and laws that exclude and/or criminalise trans people significantly impact our access to basic services and jeopardise our wellbeing.



Samoa Fa'afafine Association
Photo credits: SFA

14 Amnesty International's sex work policy defines *sex work* as the exchange of sexual services (involving sexual acts) between consenting adults for some form of remuneration, with the terms agreed between the seller and the buyer.

15 Information about the TMM research project's founding, methodology, and challenges can be found on Balzer, Carsten and Lukas Berredo (2016). TMM Annual Report 2016: 2190 murders are only the tip of the iceberg - An introduction to the Trans Murder Monitoring project.

16 Updated information about the TMM can be found on <https://transrespect.org/trans-murder-monitoring/tmm-resources/> TDoR is the acronym for Trans Day of Remembrance. The TvT project publishes an update with TMM data to support events during this period.

17 Fedorko, Boglarka and Lukas Berredo (2017). The vicious circle of violence: trans and gender-diverse people, migration, and sex work.

18 TMM <https://transrespect.org/trans-murder-monitoring/tmm-resources/>

19 Vergueiro, Viviane (2015). Despatologizar é descolonizar.

20 Imathiu, Kelly, Barbra W Muruga, Dalziel Leone and Jabari Tirop-Salat (2018). Nilinde Nisife: How safety & security affects access to health & HIV services among ITGNC persons in East Africa. EATHAN.

II. Discrimination and violence: 2982 murders reported in less than 10 years

Discrimination and violence against trans people are aggravated by structural factors such as early family rejection, school dropout due to bullying, harassment, and violence. However, the root contributing factor is the cisnormative, heteronormative, gender binary setup of the school system. For many trans people, sex work¹⁴ is the only way to make a living due to the lack of mechanisms and information to demand access to education, employment, and healthcare.

The figures from the latest Trans Murder Monitoring (TMM)¹⁵ update are alarming: 2982 trans and gender-diverse people were reported murdered in 72 countries between 1 January 2008 and 30 September 2018. Of those, 88% murders were reported in the Global South and East.¹⁶ The TMM TDoR 2018 update (1 October 2017 – 30 September 2018) registered 369 cases - 44 more cases compared to 2017, and 74 cases compared to 2016. There is limited information for many countries and regions, and these reports show only a fraction of the actual murder rate.

“Violence against trans and gender-diverse people frequently overlaps with other axes of oppression prevalent in society, such as racism, sexism, xenophobia, and anti-sex worker sentiment and discrimination.”¹⁷ TMM data shows that the victims whose occupations are known are mostly sex workers (62%). In the United States, the majority of trans people reported murdered are trans women of colour and/or Native American trans women (85%), and in Western Europe, migrants make up 46% of the victims.¹⁸

“In addition to these direct and explicit forms of violence, it must be added that other institutional violence in the field of health and education also persists. The incompetence and lack of interest in understanding trans bodies and existences in their complexities implies processes of exclusion from schools and health institutions, limiting their possibilities in life. In the sociocultural context, media coverage and other artistic expressions follow, despite the expansion of trans visibility around the world, with exotifying, pathologising, simplifying, and criminalising perspectives about trans experiences.”¹⁹

Stigma limits access to and discourages trans people from seeking mental healthcare in Africa - we are considered dangerous and unpredictable, with our health issues attributed to being trans. A 2017 study²⁰ by EATHAN (East Africa Trans Health & Advocacy Network) showed that 58.3% of trans men and 64.7% trans women reported that they were denied services after disclosing their gender identity and/or based on their gender expression. Also, 42.2% of trans

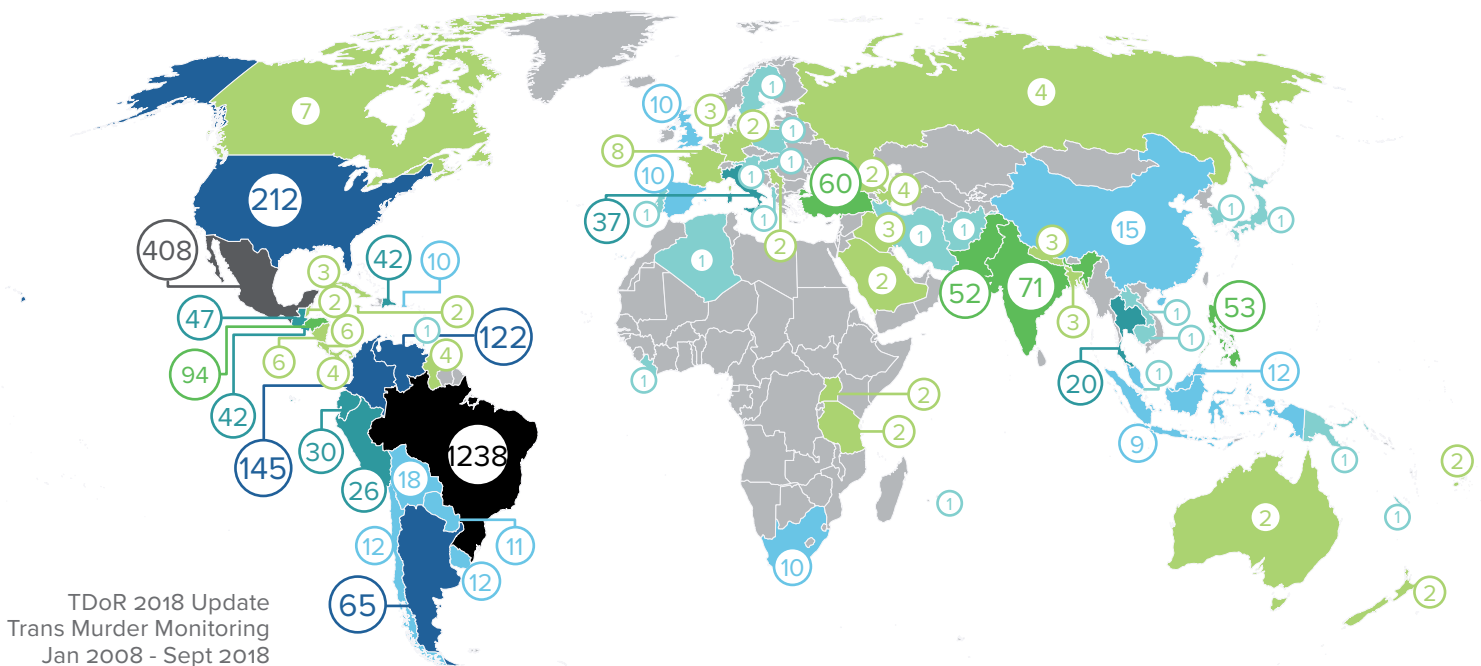
women in East Africa are living with HIV. A trans man working at TIA (Transgender Intersex in Action), in Burundi, stated that, “health caretakers don’t know what trans means, so when a trans man goes in a public hospital seeking help they call him a woman. Most of us end up choosing to not seek care.”

A recent study²¹ on LGBT survivors of violence in Tunisia showed that about half of respondents (including trans individuals) “do not undergo any medical test, because they fear mockery or abuse from medical staff due to their practices, or their ‘minority’ identities.” The same results were echoed by Moroccan, Algerian, Egyptian, Sudanese, Ugandan, and Zambian trans individuals. Anxiety and stress are common among trans people in the Middle East and North Africa (MENA) region. Economic status limits access to mental health: “It’s expensive... We don’t have the money to seek a professional...” Even when some limited financial resources are available, trans people are still subject to stigma from mental health professionals: “I don’t feel valid... Psychologists I’ve been to were moralists more than scientific... Psychiatrists still see me as a walking illness...”²² The media in MENA countries actively limits trans people’s access to healthcare through spreading false information and extremely damaging stereotypes. That puts our lives in danger and isolates us from other communities. Employment discrimination and denial of healthcare push people to self-treatment, putting them at high health risk.

In many countries in Latin America, the fictitious concept of “gender ideology” has been positioned politically as going against religious beliefs and (a misrepresentation of) biology, and is used to create panic, especially concerning “the wellbeing of children.” It spreads misinformation about trans children, enforcement of certain school uniforms, and the use of bathrooms, causing public anxiety and fear, especially during election times.

21 Mawjoudin, Damj, and Chouf (2018). Violence against Sexual and Gender Minorities in Tunisia: Results of a Quantitative Study.

22 Citations in this paragraph are part of interviews with trans activists conducted in several countries in the MENA region.



III. Legal measures: lack of protection

Many countries in the Global South and East lack protections against crimes motivated by real or perceived gender identity or expression, and laws criminalising same-sex activities harm trans people, encourage exclusion from education and employment and mistreatment in healthcare, fuelling stigmatisation and violence.

Africa is caught between cultural traditions and religious fundamentalists who teach and preach that “transgender” is unreal and unafrikan. Homosexuality is illegal in 36 of the 54 African countries, and punishable by death in Mauritania, Sudan, twelve of Nigeria’s northern states, and parts of southern Somalia.²³ As trans people are considered “homosexuals” they are labeled as criminals in countries that punish same-sex relations. Ignorance and lack of understanding about gender identity and expression further negatively impact upon legal procedures for name change and measures against hate speech and hate crimes based on gender identity and/or expression, including in medical settings.

Even in the absence of “anti-homosexual laws,” judges, lawyers, legal aid providers, and human rights defenders do not consider the needs of trans people. Law enforcement is ignorant of the plight affecting trans people. Additionally, organisations and institutions working on trans rights are denied legal registration in some parts of Africa, such as Rwanda. Researchers working on trans-related issues are seen as a threat and hindered in their studies and research. In some African countries, such as Botswana and South Africa, it’s possible to change the name without any gender-affirming surgery. However, the name assigned at birth stays, and the new name is added. In some places, a trans person can legally change their name but not their gender marker, leading to low self-esteem, stigma, rejection, and persecution.

In 2014, India’s Supreme Court made an historic judgement by recognising “transgender” as a legal identity; however, four years later, there is hardly any legal recognition from the State. The Human Rights Commission of Pakistan, recognising the vulnerability of trans people, granted them the status of equal citizens in their 2011 report, but the only job opportunity created as a result of this measure was as tax collectors. This reinforced cultural biases of trans people as a nuisance and affected how they are treated in society. In 2018, the Parliament of Pakistan passed the trans people’s “Protection of Rights” act.²⁴ In 2009, the Supreme Court of Pakistan made a historic rule for the civil rights of trans citizens followed by a further court ruling to increase these rights. A recent report published by the Asia Pacific Transgender Network (APTN)²⁵ refers to Supreme Court judgments or Cabinet decisions recognising a third gender on specific

23 The Guardian (2015). Barack Obama tells African states to abandon anti-gay discrimination.

24 Parliament of Pakistan (2018). Transgender Persons (Protection of Rights) Act. Available at: <http://www.na.gov.pk/uploads/>

25 UNDP & APTN (2017). Legal Gender Recognition: A Multi-Country Legal and Policy Review in Asia.

documents;²⁶ however, in many of these countries, implementation measures have been inconsistent. Although India is the only South Asian country whose Supreme Court decision affirms trans people's rights to identify as male, female, or as a third gender, eligibility criteria are still imposed through administrative practices. Although possible in South Korea, China, Hong Kong, and Singapore, gender recognition can be restrictive and prescriptive. In Malaysia and Indonesia, it is also nominally possible to change one's name and gender marker; however, it is difficult in practice.²⁷

The Pacific region struggles with its colonial history to this day. In particular, outdated, cut-and-paste laws from colonial powers imposed on Pacific Islands are often irrelevant to their context, and absence of anti-discrimination laws, policies, and processes across the region contribute to systemic discrimination regarding legal and citizenship status, human relationships, and personal security. Lack of enforcement and fair and dignified protection and treatment of trans people before the law further compound the injustices. Structural and systemic discrimination and exclusion are evident across sectors and spaces that retain conservative perspectives on who and what is considered part of "development." Under the Crimes Decree 2010, Fiji decriminalised private, adult, consensual, and non-commercial same-sex conduct. In 2012, the Samoa Fa'afafine Association (SFA) successfully appealed to repeal all laws criminalising same sex relations between two consenting adults. However, to repeal sodomy, with a strong biblical reference, goes against the Samoa Constitution, which is founded on Christian principles. In addition, consideration of Fa'afafine and Fa'atama (trans community) in the National Gender Policy 2016-2020 is a milestone for SFA and a major step toward more inclusive legal and policy development frameworks. Nevertheless, discriminatory laws based on gender identity and sexual orientation still exist in Tonga, Tuvalu, Cook Islands, and Kiribati, despite the thriving trans communities in these islands.

The political and economic situation in Central Asia and Eastern Europe is very diverse, and existing legal norms vary from full or partial protection against discrimination on the basis of gender identity (in a number of Balkan countries, Ukraine, Georgia, and Estonia), and pending legal norms that violate the rights and freedoms of trans citizens. Trans people are pathologised in the region, and in most countries there is still a compulsory sterilisation requirement (Armenia, Azerbaijan, Bulgaria, Kosovo, Georgia, Kazakhstan, Latvia, Macedonia, Montenegro, Serbia, Tajikistan, Uzbekistan), which significantly impedes access to change of documents. Because of this, the socioeconomic situation affects access to healthcare and the level of health of trans people, tying together

26 Legal gender recognition is available in only four countries of South Asia: Bangladesh, India, Nepal and Pakistan.

27 Chiam, Zhan, Sandra Duffy, and Matilda González Gil (2017). *Trans Legal Mapping Report 2017: Recognition before the law*. ILGA.

28 Transphobia encompasses a spectrum of violence, discrimination, and negative attitudes towards trans and gender-diverse people or people who transgress or do not conform to social expectations and norms having to do with gender. This includes institutionalised forms of discrimination, criminalisation, pathologisation, and stigmatisation that manifest in various ways, ranging from physical violence, hate speech, insults, and hostile media coverage to more di use forms of oppression and social exclusion.

29 Chiam, Zhan, Sandra Duffy, and Matilda González Gil (2017).

access to healthcare and the quality of life of trans people. The inability to change documents in accordance with their gender identity, coupled with a high level of transphobia²⁸ in society, make it impossible for trans people to receive education and work, get health insurance, etc. In turn, the low financial status and lack of access to state-funded medical care limit trans people's access to general and trans-specific healthcare. In addition, it creates conditions in which trans people are forced to seek medical care that they either do not need at all or is not available.

Legal measures in Mexico City, Argentina, Colombia, and most recently Chile, allow trans persons to change their names and sex or gender markers through simple and fast administrative procedures, without judicial and surgical processes, sterilisation, or psychiatric requirements. Peru's process for legal recognition is still a judicial one (no specific law), while Bolivia's Gender Identity Law of 2016 requires a psychological examination.²⁹ In Brazil, a decision by the Supreme Court ruled that trans people can change their name and gender markers without surgical requirements. In the region, there are usually general laws on access to health that are a basis for making healthcare for trans people effective. However, in practice, the right to access healthcare is only a half reality in a region of inconsistent discourses. It is the communities, civil organisations, activists, and cooperation agencies that have placed the issue on the table and developed human rights initiatives.

The biggest legal challenge in the Caribbean is the lack of legislation recognising trans identities along with protection from discrimination based on gender identity. While trans persons are able to legally change their name in some Caribbean countries, such as Jamaica, the Bahamas, Guyana, and Trinidad and Tobago, the inability to update gender markers on legal documents exposes trans people to undue scrutiny, anxiety and sometimes harassment.



Viviane Vergueiro Simakawa at the Brazilian Trans Health meeting, Sao Paulo, Brazil.

Photo credits: Lukas Berredo

IV. Social and economic situation: alarming data

Trans and gender-diverse people transgress the cisnormative structure that tie genitals to gender. Stigma and marginalisation increase vulnerability, contributing to the already high rates of homelessness, depression, suicide, and substance abuse among trans people. A high number of trans persons live in poverty due to family rejection and lack of access to employment. The level of education among trans people is alarmingly low; young trans people frequently face discrimination at schools, resulting in high dropout rates. Social exclusion, economic vulnerability and lack of employment opportunities mean that sex work is often the most viable form of income available to trans people, and a high proportion of trans people engage in sex work (up to 90% in India, 84% in Malaysia, and 81% in Indonesia.)³⁰

In some parts of Africa, trans people, especially trans women, are caught in cultural traditions and forced to partake in initiation rituals, where they are taught “how to be a man.” When one refuses to attend, they cut every financial support they were getting from their families and/or supporters, further pushing them into sex work. Wandy Onceya, a 27-year-old trans woman who attended the initiation school in South Africa says, “it was not easy. It was a very, very painful thing to go through. You face a lot of things when you are there. You have to, for example, learn a man’s language and if you get it wrong, they beat you with a sjambok. It was so, so, so difficult.”³¹ In other cases, trans men are gangraped and/or married off to cis³² men, which is often said to make them more “womanish.”

Trans people often experience exclusion and marginalisation in the society that they live and, critically, from family and friends. In India, Pehchan project supported by the Global Fund 2016 report states that between 44% and 70% of trans women were either thrown out or felt the need to leave their homes. In the Philippines, paternal rejection during trans women’s transitioning is reported to be as high as 40%.³³ This exclusion can affect people’s self-esteem and self-worth, contributing to depression, anxiety, substance abuse, and self-harm. Lack of social safety nets also make trans people particularly vulnerable to economic instability and homelessness. A study conducted in India found that unemployment rates of trans people were having adverse impact on the country’s GDP.³⁴

Activists in Morocco confirm that the price of hormones in the underground market is rising, putting even more economic burden on trans people. A recent study³⁵ conducted in 22 countries of the MENA region showed that trans persons report a greater level of housing discrimination, often leading to homelessness. The extremely poor economic situation of trans people maintains this vicious circle. With limited resources, no shelter, and few survival options, trans people

30 UNAIDS (2014). The Gap Report.

31 Mail & Guardian (2011). Torment for trans women ‘sent to the mountain’ to learn to be men.

32 Cis(gender) is a term used to describe people who are not trans and/or gender-diverse.

33 UNAIDS (2014).

34 The World Bank (2014). The Economic Cost of Homophobia: How LGBT Exclusion Impacts Development.

35 MOSAIC and Grindr for Equality (2018). The Regional Livelihood of GBTQ Using Grindr.

turn to sex work to survive. Some trans sex workers confirm that they find sex work as the only option to avoid the discrimination that they may face in regular workplaces.

TvT data confirms a high number of trans people among sex workers: 99% of respondents in Colombia, 76% in Turkey, 68% in Venezuela, and 47% in the Philippines stated that they earn their living through sex work.³⁶ UNAIDS also estimates that the proportion of those who sell sex in trans communities is as high as 47% in El Salvador.³⁷ “The large representation of trans people in sex work around the world is undeniably a result of widespread structural, institutional, and interpersonal violence experienced by trans people from early age, lack of support from their families and immediate environments, and poor access to education and employment.”³⁸

In the Caribbean, trans youth are displaced, struggle with homelessness, and lack safe spaces and opportunities. They encounter rigid gender roles in family and schools and are often victimised or isolated. The education system often defines roles for boys and girls, with no acknowledgement or accommodation for trans youth. Likewise, many families struggle to understand that trans identities are valid. Trans youth often leave school early and at times are kicked out of home. From the outset, trans persons are at a disadvantage and their vulnerabilities are further exposed when seeking employment.

36 Balzer, Carsten, and Jan Simon Hutta (eds.). (2015). *Transrespect versus Transphobia: The Experiences of Trans and Gender-diverse People in Colombia, India, the Philippines, Serbia, Thailand, Tonga, Turkey and Venezuela*. Transgender Europe.

37 UNAIDS (2014).

38 Fedorko, Boglarka and Lukas Berredo (2017).



Mona Martin, Brady Anderson, and Terrikay Walker, volunteers at the TransWave Jamaica's Trans Health and Wellness conference, May 2018. Photo credit: TransWaveJamaica

V. Sexual health, STIs, HIV, and AIDS

One of the issues that came to public and political attention regarding trans people's health was HIV, an epidemic lasting over 30 years and claiming thousands of lives:

The World Health Organisation (WHO) affirms that trans women are approximately 49 times more likely to be living with HIV compared to the general adult population;³⁹ in some countries this number rises to 80 times. Globally, around 19% of trans women are living with HIV. Little data is available for trans men or other trans populations, and while trans men are less likely to be HIV positive than trans women, their infection rates are higher than those of the general population.⁴⁰ UNAIDS confirms that social exclusion and marginalisation of trans people contribute to depression, anxiety, substance abuse, and self-harm.⁴¹

Multiple epidemiological studies were needed to respond to the epidemic. In this process the category of “Men who have sex with Men” (MSM) was created. However, this category is wrong as it assumes that trans women are men. Trans communities have been denouncing such a concept, and between the end of the 90s and the beginning of 2000 there was a change in the process of epidemiological disaggregation and the constitution of “key populations,” an umbrella term that includes trans women and sex workers, who, being named, represented significant input for the planning of prevention and outreach activities, for estimates and projections regarding the size of the HIV epidemic, its impact on the population, and as evidence of the importance of this population for public policy processes.

Data suggests that HIV prevalence is up to nine times higher for trans women sex workers compared to cis women sex workers. Community reports suggest that there is low use of condoms among trans sex workers, due to factors such as stigma and discrimination leading to low self-esteem and disempowerment, and fear of rejection.⁴² In Asia and the Pacific, only 50% of trans sex workers are aware of HIV and HIV testing, and only 50% reported using condoms consistently with clients and casual partners.⁴³ In addition, the high costs of transition-related care create pressure to earn more money. Without counselling on safe practices, people who self-inject hormones are vulnerable to HIV transmission through sharing needles with each other.⁴⁴

Trans people can have very diverse HIV prevention needs. Targeted interventions and prevention approaches that address the specific needs of trans individuals are essential for reducing HIV infections. Further, prevention initiatives that empower trans people and enable them to take the lead in meeting the needs of their communities are most effective. Sexual healthcare

39 amfAR (2004). *Trans Populations and HIV: Time to End the Neglect*.

40 HRC. *Transgender People and HIV: What We Know*.

41 APTN, UNDP (2015).

42 Fedorko, Boglarka and Lukas Berredo (2017).

43 UNAIDS (2014).

44 Herbst et al. (2008). *Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review*.

45 UNAIDS (2014).

for trans people is often inadequate, with many policy makers and service providers failing to address the needs of trans women as a population distinct from men who have sex with men. Only 39% of countries in 2014 had specific programmes targeting trans people in their national HIV strategies.⁴⁵

46 MOSAIC and Grindr for Equality (2018).

Trans people in Africa still struggle with HIV/AIDS, where there are no specific sexual health programs targeting trans communities. In Morocco, sexual health awareness trainings are only available for cis gay men, or men who have sex with men. Moreover, trans sex workers who take the initiative to integrate into those spaces, seeking knowledge and awareness, may encounter a hostile environment and drop out. A Moroccan trans individual said, “I feel dominated... They make me feel invalid”. Another person cites the confusion between sexual orientation and gender identity in those sessions. Trans people are considered homosexuals “in disguise.” In this context, the Grindr report⁴⁶ emphasises the sexual health awareness in the MENA: 39% of the participants said they did not have access to sexual health information. Some participants confirmed that they get information from other sources, e.g. students, or people with digital skills to access information online. Prevention programs and tools, along with antiretroviral therapies, are still quite inaccessible for trans communities. In sub-Saharan Africa trans people face a lack of checkpoints, testing materials being temporarily out of stock, and/or mistreatment by the medical and paramedical staff.

47 ASHM, UNDP, UNICEF and the University of New South Wales (2016). Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations.

A study⁴⁷ conducted in the Pacific region indicates that a high percentage of trans people are not receiving adequate HIV awareness and services despite the growing number of HIV cases in trans communities. Economic factors and a booming tourism sector in the region have pushed trans communities into unsafe and unprotected sex work without relevant healthcare services. Transitioning has become a thriving unregulated market with illegal and unprescribed provision of hormones. Most have resorted to self-medication, causing health complications that the existing medical services are ill-equipped to address.

An overwhelming majority of countries in Central Asia and Eastern Europe lack policies and programmes for STI, HIV, and/or AIDS prevention specifically for trans people. In many countries of the region, HIV prevention among trans people is mainly provided through HIV service organisations or friendly offices of state AIDS centres, often under the MSM category. It’s impossible to assess the real situation regarding HIV and STIs among trans people in the region, as statistics collected on this issue do not treat trans people as a separate category. Even where such statistics are available, they don’t reflect the reality - according to studies conducted in the countries of the region, fear about the confidentiality of data and rude treatment by health workers often stop trans people from testing for HIV.

According to a survey,⁴⁸ Azerbaijan has policies and programmes, as well as counselling for trans people. However, according to “Forced out” the taboo related to being a member of the LGBT community affects the available statistics on HIV prevalence in Azerbaijan - the actual number of people living with HIV is 30 times higher than official statistics.

48 van der Veur, Dennis (2007). *Forced Out: LGBT People in Azerbaijan*. ILGA-Europe and COC Netherlands.

An assessment of the needs of trans people in Central Asia showed that in Kyrgyzstan 17.6% of respondents see transphobia, lack of documents confirming gender identity, and lack of financial resources as barriers to accessing HIV prevention. In Kazakhstan, 63% of respondents stated that “the fear that confidentiality will not be respected” is a barrier for trans people to take HIV/AIDS tests or to receive information and support in these matters. 50% indicated a “lack of qualified specialists”, 44% a low level of information, and 25% a high cost of services as barriers.

In 2015, almost 2 million people lived with HIV in Latin America, with 120,000 new cases registered every year. 64% of new cases occur in MSM, sex workers, trans women, and people who inject drugs. The Latin American Network of Trans Women (RedLacTrans) estimates that the prevalence among trans women in the region is very high, between 8% and 23%.⁴⁹ Infection rates are even higher among trans Women of Colour.

49 UNAIDS (2017). *Claiming rights for transgender people in Latin America and the Caribbean*.

Documentation and research are crucial for informing the change in policies and services. Helen Savva, CDC South Africa Key Populations Lead, highlighted the significance of a recent study on HIV prevalence in trans women done by HSRC and CDC in South Africa, and affirmed it will be “used by CDC and PEPFAR to improve services for high-risk women who have been mostly marginalised in HIV epidemic control.”⁵⁰

50 CDC (2018). *HIV prevalence in transgender women*.

Finally, it is necessary to point out that this is one of the most urgent health issues in many regions of the world. The approach must center the context in which the trans communities live; factors such as transphobia, marginalisation, stigma, discrimination, poverty, lack of access to education and adequate housing, lack of family support and, above all, the systematic negative experiences when seeking state health services and programs in the region. Risk factors such as drug and alcohol abuse, incarceration, and sex work as the only life option reinforce the limitations for early access to services, including health services.

VI. Resisting: activism and action

In terms of visibility, the HIV epidemic placed the health of trans people in a public setting, thanks to the great capacities of trans communities around the world, and their resilience in crises, desires and hopes. Their militant and activist selves, speaking for their rights, allowed them to reconfigure the narrative of trans health in the Global South and East beyond HIV and AIDS:

Trans communities all over the world are capable of finding ways to access medical care. When a State fails us, it is our communities that try to creatively resolve the situation, despite pathologisation of trans people. It is now clear how issues are linked together in a vicious circle of exclusion and marginalisation. “Nevertheless, it is incredibly important to point out the different initiatives and organisations amplifying trans resistance around the world.”⁵¹

51 Vergueiro, Viviane (2015).

Peer networks are part of self-care, and social support from other trans people has been shown to moderate the effects of anxiety and depression.⁵² We must acknowledge the incredible courage and enthusiasm of trans activists to make a true and sustainable change in their realities despite everything they go through. We need to recognise what organisations are doing in order to give access to healthcare services, starting from providing free medical consultations to trans communities and giving access to sexual health programs and prevention, to creating spaces by trans individuals to trans communities in order to build bridges and decrease the social exclusion.

52 Bockting, Walter O., Michael H. Miner, Rebecca E. Swinburne Romine, Autumn Hamilton, and Eli Coleman (2013). Stigma, Mental Health, and Resilience in an Online Sample of the US Transgender Population. *American Journal of Public Health* 103, no. 5: 943–51.

In Nairobi, Kenya, the organisation Jinsiangu provides access to competent psycho-social support for intersex, trans, and gender non-conforming people living in the country, giving them access to affirming counselling services and trusted health professionals at affordable prices. In order to find alternatives, activists in the MENA region take initiatives in form of support groups and active listening sessions, supporting trans people in their own circles in an attempt to decrease the risk of depression, anxiety, and suicide. Emerging groups are providing psychological support and counselling to trans people with mental health issues while also mapping trans-supportive experts and mental health professionals for safer and trustworthy services.

Addressing the isolation of the Pacific has been a priority for trans activists in the region, in particular sharing awareness of the importance of its context and approach to change. Navigating the Pacific canoe forward is sensitive to the intricacies of culture, religion, and the law of the land, which are the three pillars that binds the Pacific people. Nevertheless, Pacific trans activists are careful in ensuring that this consideration of the “Pacific way” does not hinder or restrict

further development that needs to happen for every islander to have a full, safe, and improved quality of life regardless of their gender identity, expression, or sexual orientation.

The introduction of APTN's Trans Health Blueprint⁵³ has sparked a transformative domino effect in terms of enlightening providers in the Asia and the Pacific region on non-discriminatory, inclusive, accessible, and safe health services. The tool has opened many doors for trans-specific healthcare that is not only recognised in policy but also in practice. In the Pacific, Samoa, Tonga, Vanuatu, and Fiji are a few of the pioneering islands that are making use of the resource, with reach towards the North Pacific islands, such as the Federated State of Micronesia. In Thailand, Philippines and Singapore, efforts have been made by local trans communities to advocate for medically guided use of hormones.⁵⁴ There was also the establishment of the trans-focused clinics in Bangkok⁵⁵ and Manila.⁵⁶

General practitioners and those providing trans-specific services are not well informed about the provision of medical and social care. The work of informing and sensitising medical specialists is carried out exclusively by trans activists and, accordingly, covers only a tiny percentage of medical specialists. In this case, it is not possible to significantly raise the level of awareness of medical specialists without active actions or assistance from State institutions. In some countries in Central Asia and Eastern Europe, attempts are being made to establish standards for providing medical and social care to trans people at the state level. A positive example is the experience in Kyrgyzstan, where in 2017 the "Manual on provision of medical and social care for transgender, transsexual and gender nonconforming people"⁵⁷ was introduced at the State level. Currently, work is underway to implement this guideline in the healthcare and medical education system in the country.

Between 2011 and 2012, the Pan American Health Organization (PAHO) carried out consultations and analysis alongside trans communities, government institutions, and academia in Latin America and the Caribbean on the health situation of trans people. This project allowed PAHO to systematise the information and offer a base document aiming to "provide guidance to improve access to primary and specialised care for transgender people in Latin America and the Caribbean."⁵⁸ This is a primary, basal document of utmost importance, since it directs its call and recommendations to the States, health systems, cooperation agencies, civil society, but above all, it makes evident the voices of trans people in the region. Following that document, a version was published in 2014⁵⁹ in order to better reflect the specific needs of trans communities from the Caribbean.

53 APTN, UNDP (2015).

54 An example from Singapore: <https://transgendersg.com/healthcare/>

55 amfAR (2017). The Tangerine Clinic: Leading the Way on Transgender Health Care.

56 LoveYourself (2016). LoveYourself Launches The Philippines' First Transgender Health Clinic and Testing Center.

57 Kyrgyz Republic Ministry of Healthcare (2017). Manual on provision of medical and social care for transgender, transsexual and gender nonconforming people.

58 PAHO et al. (2012). Por la salud de las personas Trans: Elementos para el desarrollo de la atención integral de personas trans y sus comunidades en Latinoamérica y el Caribe.

59 PAHO et al. (2014). Blueprint for the provision of comprehensive care for trans persons and their communities in the Caribbean and other Anglophone countries.

While the Caribbean region lags behind in terms of progressive trans-specific policy and laws, the community remains resilient. Across the Caribbean, trans people have been creating safe spaces where they can affirm their gender identities without the threat of violence and discrimination.

For trans activism in the Global South and East, the concept of wellbeing is a new wedge. The culture generated from social volunteering was built through the idea of sacrifice for the other, forgetting themselves on the way. Achievements have been made in the face of exclusion, discrimination, and violence, often at the cost of individuals' lives and organisations' safety, dignity, well-being, and social and economic security. It is necessary to begin the discussion on the subject, not only in the sphere of the intellectual and academic: it is crucial to discover how the idea of wellbeing can have a practical vision and substantive benefits in the work of trans activists.

“Adequate care and attention to trans populations, in our intersectional diversities and health needs, can only be achieved through the continuous and critical questioning of a health paradigm that is extremely limited and built on violent normative grounds. The specificities of this normative paradigm in many countries of the Global South and East – of colonial, racist, elitist history – are deeply articulated with colonialities of power and knowledge in the sciences fabricated in the Global North, and have a negative repercussion against the gender perspectives that are different and more complex than the Eurocentric models that guide the construction of the knowledge about gender identities. The depathologisation of trans experiences should be part of a broad project of sociocultural transformation, with a particular focus on the bodily diversities and gender identities and our specific and complex demands. It is necessary to decolonise, in an intersectional way, the corporal diversities and gender identities.”⁶⁰

60 Vergueiro, Viviane (2015).



The Asia and the Pacific
Trans Health Blueprint
Bangkok Consultation, 2015.
Photo credit: APTN

Conclusion and recommendations

Trans people have difficulties in most aspects of our lives. “Understanding how stigma and discrimination manifest and function in healthcare encounters is critical to addressing health disparities for transgender people.”⁶¹

Decision makers can make a significant impact on the lives of trans people by enacting laws and policies that address our social, educational, economic, health, and safety needs. In order to do that, States, institutions, agencies, and organisations should ensure that trans people are part of the decisions-making processes that affect our lives, among funders, researchers, academics, scientists, politicians.

61 Poteat et al. (2013). Managing uncertainty: a grounded theory of stigma in transgender health care encounters.

Decriminalisation

- Decriminalise all aspects of sex work, same-sex relationships, gender identity and/or expression, drug use, HIV exposure, non-disclosure, and transmission, and bodily modification procedures and treatments.
- Review vague public morality, nuisance, loitering, and decency laws, and take steps to eliminate their disproportionate and subjective application against trans people, including trans sex workers and other marginalised groups, e.g. racial/ethnic minorities.
- Erase prostitution, gender identity/expression, HIV status, and drug use related offences from criminal records.

Health reforms

- Adopt measures for improved access for all trans people and reform trans-specific healthcare.
- Ensure that general healthcare provisions, such as suicide prevention measures and mental health support, are relevant for, and inclusive of, trans people, including trans sex workers.
- Mainstream trans-affirming healthcare into public health facilities
- Provide ongoing training to healthcare providers and incorporate trans-specific healthcare in undergraduate and graduate education in all health-relevant fields.
- Remove the requirement to obtain a disorder diagnosis in order to access gender-affirming healthcare services, and reform legal gender recognition into quick, accessible, and transparent procedures that are based on self-determination.

62 Akahatá, APTN, GATE, ILGA, RFSL, SATF, STP, TGEU (2018). Joint Statement for Depathologization and TDoR 2018.

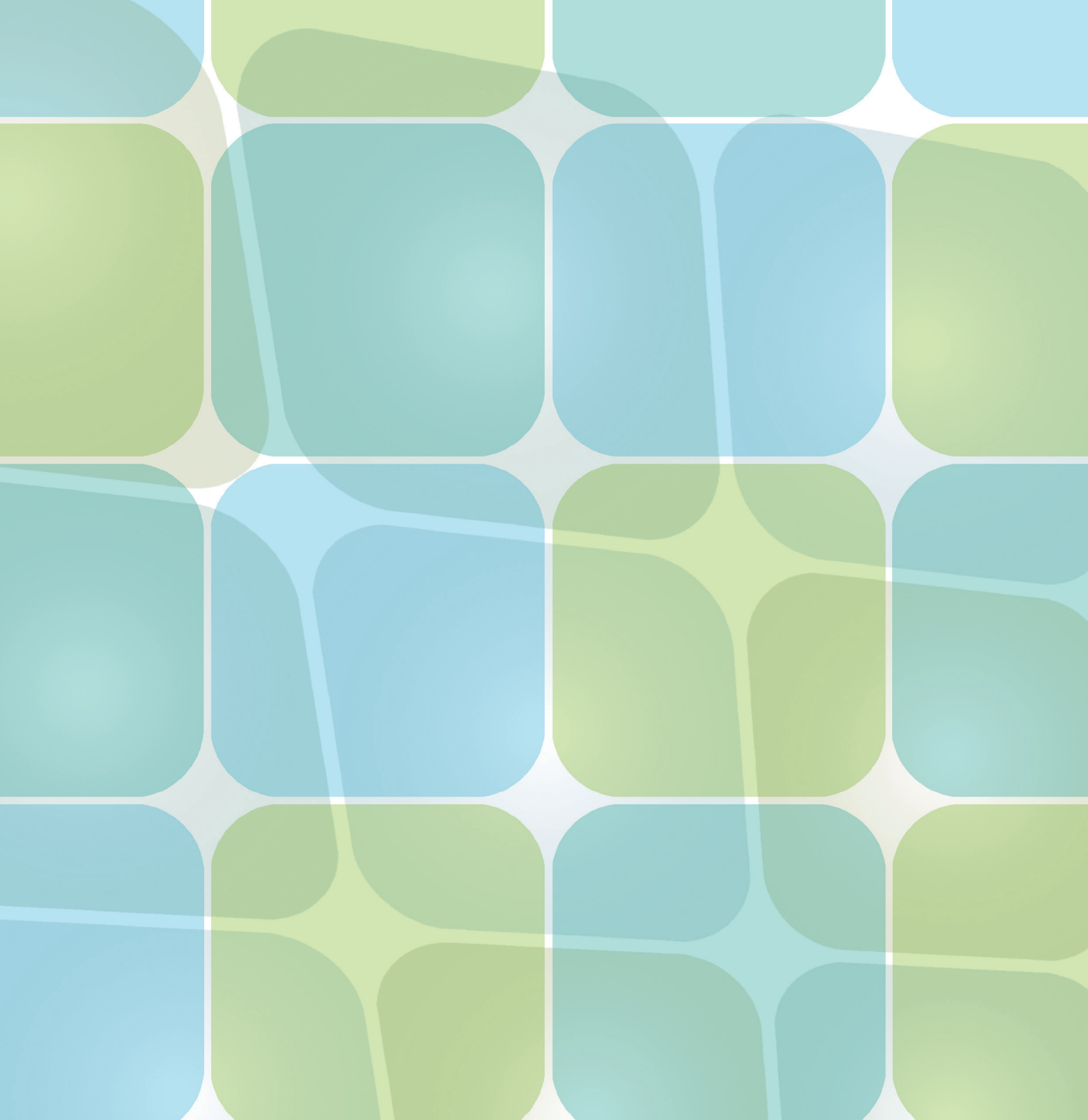
63 WHO, UNFPA, UNAIDS, NSW, World Bank, UNDP (2013). Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions.

64 UNDP, IRGT, UNFPA, UNAIDS, WHO, USAID, PEPFAR, UCSF Center of Excellence for Transgender Health, Johns Hopkins Bloomberg School of Public Health (2016). Implementing comprehensive HIV and STI programmes with transgender people. Practical guidance for collaborative interventions.

- Promote the adoption and implementation of the ICD-11 within the context of universal access to healthcare for trans and gender-diverse people's rights to access to gender-affirming procedures and treatment under conditions fully compatible with human rights standards.⁶²
- Implement the guidelines of comprehensive HIV/STI programmes with sex workers⁶³ and trans people⁶⁴ issued by UN agencies and the WHO.

General reform

- Take progressive changes towards legal gender recognition based on self-determination that allow trans persons the ability to modify their name and gender markers on legal documents.
- Collect trans-inclusive data on gender disparities, intersectional gender-based discrimination and violence, and initiate specific data collection among trans people regarding access to education, employment, health, housing, and justice, in cooperation with local trans groups and organisations.
- Train professionals (victim support providers, police officers, judicial officers, NGO staff, healthcare workers, teachers etc.) on preventing and responding to discrimination and violence against trans people, sex workers, including trans sex workers, and providing sensitive and appropriate support.
- Develop and implement public education programmes and school curricula to eliminate prejudices against trans people and other oppressed groups.
- Create programmes encouraging families to understand and support trans youth and seek out organisations that can provide them with resources to foster a positive relationship.
- Provide funding for trans organisations to support community building, community-based research and services, training, advocacy and campaigning activities. At the same time, funders and donors should be mindful of the impact of oppression in the lives of trans people and direct funding to address self-care and wellbeing.
- Take measures for targeted interventions that is relevant to the context of the different regions to ensure sustainable change that is driven by the regions themselves.



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