

## Human Rights, the Law, and HIV among Transgender People

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### Overview

The term “transgender” is used most often to refer to people whose gender identity differs from their birth sex. Transgender people exist on every continent and are increasingly organising for rights and recognition [1]. Gender presentations and local cultural understandings vary around the world and many different terms are used to describe individuals who live between or outside a male-female gender binary [2-4]. Transgender people typify the potentiation of HIV risks secondary to discrimination by legal systems resulting in human rights violations. Several frameworks have been developed to conceptualise this relationship; all demonstrate a common theme that risk factors that transcend individual level risks including stigma and discrimination create an environment that increases HIV risk among those affected. Gender identities are complex and fluid; the details of which are not addressed in this text. This text focuses on transgender women given that the evidence for disproportionate burden of HIV associated with unprotected receptive anal intercourse is highest among these women as compared to transgender men. While this text will not address the rights violations faced by transgender men, there is a growing evidence base of these violations being documented especially in the context of what has been termed corrective rape, referring to lesbian or transgender men being raped with the supposed intention of ‘converting’ them to being heterosexual. These rapes increase the risk of acquisition of sexually transmitted infections, resulted in unwanted pregnancies, mental health issues and suicide, and have resulted in documented police-mediated negligence and abuse [5].

There are commonalities between higher order risk factors faced by transgender women and gay men and other men who have sex with men (MSM) including the criminalisation of anal sex and other same-sex practices. However, this article focuses on those risk factors that are specific to transgender women including marginalisation at all levels of the life experience including family and social, education, employment, and health. Each level of marginalisation drives HIV risk and is often supported by existing national legal frameworks contradicting international human rights frameworks. This paper explores the evidence supporting these associations and makes evidence-based recommendations related to legal frameworks and enforcement practices that aim to decrease risk factors for HIV infection among transgender women and eventually decrease the burden of HIV disease.

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## Methodology

A systematic review of the peer-reviewed and grey literature as well as policy documents and news reports were used to gather information describing HIV prevalence, risk factors for HIV infection, and sociopolitical and legal context for transgender people worldwide. Furthermore, the authors used several consultations with key informants with expertise in health and human rights issues affecting transgender people in low and middle-income settings. Finally, the authors reviewed the submissions made for the Regional Dialogues of the Global Commission on HIV and the Law that took place during 2011 to supplement the results of the literature reviews and consultations.

## Sources of Data

We searched the following databases: PubMed, EMBASE, Global Health, SCOPUS, PsycINFO, Sociological Abstracts, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Web of Science, POPLINE, and Lexus Nexus. Conference abstracts were searched from the online archives of the International AIDS Conference, the Conference on HIV Pathogenesis, Treatment, and Prevention, and the Conference on Retroviruses and Opportunistic Infections (CROI). The World Health Organisation (WHO) publications database was searched as well as the National Library of Medicine's Meeting Abstracts database. Grey literature was searched using the New York Academy of Medicine's Grey Literature Report. Finally, selected experts in the field were contacted electronically to identify additional information not identified through other search methods.

The following terms were entered into all computer databases:

transgender\* OR "travesty" OR "koti" OR "hijra" OR "MTF" or "male to female transgender" OR transsexual\* OR transvest\* OR "mahuvahine" OR "mahu" OR "waria" OR katoey OR "cross dresser" OR "bantut" OR "nadleehi" OR "mahu" OR "berdache" OR "xanith" AND "HIV" OR "AIDS".

## Limitations

While every effort was made to identify all valid sources of information on the legal and political context for transgender people worldwide, data availability varied widely by geographic region. The most information was available from high-income countries. The low- and middle-income countries with the greatest available information on transgender populations were located in Southeast Asia and Latin America. Little data was available from southern Africa or the middle east and north Africa region.

## Legal and Human Rights Context

The modern human rights movement had its origins in the same atrocities as did modern medical ethics: the crimes against humanity perpetrated by the National Socialists in Germany and their allies during World War II. In response to the Holocaust and the crimes of Nazi doctors, the United Nations General Assembly adopted a visionary set of principles articulating those fundamental rights of human beings, which no state could take away. These were articulated in the 1948 Universal Declaration of Human Rights (UDHR) and supported by all of the existing United Nations member states (1). The UDHR was developed as a founding document of human rights law and policy; an aspirational declaration, however, not an enforceable treaty. The UDHR was intended to set the stage for the development of binding treaties that would support the core tenants included in the UDHR. The UDHR says little specifically in regard to health, but does articulate in Article 25 that all persons have a right to a minimum standard of living, which includes access to health care:

*"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, widowhood, old age or other lack of livelihood in circumstances beyond his control..."*

The human rights document which does speak most specifically to the right to health is the 1976 International Covenant on Economic, Social and Cultural Rights (ICESCR) (11). Article 12 of the ICESCR refines the right to health with new precision:

*"Article 12:*

*The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*

*The steps to be taken to achieve the full realization of this right shall include:*

- a. *The provision for the reduction of the still-birth rate and of infant mortality and for the healthy development of the child*

- b. *The improvement of all aspects of environmental and industrial hygiene*
- c. *The prevention, treatment and control of epidemic, endemic, occupational and other diseases*
- d. *The creation of conditions which would assure to all medical service and medical attention in the event of sickness."*

General Comment 14 (GC 14) of Article 12 of the ICESCR was enunciated by the Committee on Economic, Social and Cultural Rights in 2000, in part to address the special issues raised by the AIDS pandemic and reproductive health more broadly (12). Article 8 of the General Comment 14 speaks both to a more precise explanation of the right to health, and of the right to sexual and reproductive freedom:

*"The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation."*

While GC 14 is traditionally assumed to be focused on sexual and reproductive health rights of women, it is also useful for advocacy for freedoms related to sexual rights for lesbian, gay, and bisexual people. Moreover, it is relevant for advocating for freedoms of gender identities for transgender people as the document explicitly highlights the right to control one's body. While GC 14 contains useful language to support advocacy efforts, these comments are not binding and not developed through a UN member state process.

The International Covenant on Civil and Political Rights (ICCPR) generally deals with political rights, including such basic rights as freedom from slavery, torture, persecution, and discrimination. It includes non-discrimination on the basis of sex as a basic right, but did not originally directly address sexual orientation or gender identities. In 1994, the UN Human Rights Committee offered an opinion in *Toonen v Australia*, a case in which the Australian state of Tasmania overturned legislation allowing discrimination against gay and lesbian citizens [6, 7]. The Committee's conclusion was that discrimination based on sex included sexual orientation, and so the law was in violation of the ICCPR. The opinion suggested that UN member states expand the right to freedom from discrimination to sexual and gender minority populations within international human rights law. Moreover, Article 26 of the ICCPR asserts prohibition of "discrimination ... on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" [8]. The ICCPR has been signed by 174 UN member states including many of the same where state-sponsored discrimination targeting transgendered women is significant. Since there is no specific mention of sexual orientation and gender identity in the ICCPR, state-sponsored discrimination targeting transgender women does not imply violation of the letter of the covenant, even if it does violate the spirit of it.

**The Yogyakarta Principles were developed in 2007 by an ad hoc group of experts on HIV, sexual minorities, and human rights to describe the core components of laws that would affirm the primary obligation of States to implement human rights standards as it relates to sexual orientation and gender identity [9]. In December 2008, the UN General Assembly adopted a statement initially sponsored by the French Government reaffirming "the principle of non-discrimination, which requires that human rights apply equally to every human being regardless of sexual orientation or gender identity."** The statement further condemned killings, torture, arbitrary arrest, and "deprivation of economic, social and cultural rights, including the right to health" based on sexual orientation or gender identity" [52]. In June 2011, the UN Human Rights Council passed a non-binding resolution to support equal rights for all people irrespective of sexual orientation or gender identity. While these resolutions are focused more on addressing the immediate needs of gay and lesbian people, their passing sets the stage to support laws and policies that would fulfill the rights of transgender people as well to lives with non-discrimination.

There are some recent examples of protective and enabling laws, most notably in Asia and the Pacific [10]. Many constitutions in Asia do have specific clauses for non-discrimination based on sex including Indonesia, Bangladesh, Sri Lanka, and Thailand. Furthermore, through precedent-setting court cases, the governments of India and Nepal have been obligated to provide sexual minorities a life guaranteed by non-discrimination[11]. Even as early as 1990, The *Nepal Treaty Act* included the following language:

*"These people have been compelled to appear in the public life with the identity as determined according to their genital instead of their own characteristics and it is very important to rethink the state of affairs in the context of human rights and fundamental rights... We also should internalize the international practices in regards to the enjoyment of the right of an individual, changing world society and practices of respecting the rights of minority gradually. Otherwise, our commitment towards the human rights will be questioned internationally, if we ignore the rights of such people only on the ground that it might be a social stigma."*

Recent court judgments have improved the legal environment for sexual minorities in other countries in the region and beyond including Pakistan, Philippines, Fiji, South Korea and Hong Kong SAR of China. However, non-discrimination for

gender minorities has lagged with only the interim constitution of Nepal including language on non-discrimination for transgender people in Article 13 and Article 33 and 34 of their *Interim Constitution* [11].

*“...people with having third type of gender identity other than the male and female and different sexual orientation are also Nepali citizen and natural person as well, so they should be allowed to enjoy the rights with their own identity as provided by the national laws, constitution and international human rights instruments. The state has the responsibility to ensure appropriate environment and legal provisions for the enjoyment of such rights. It does not mean that only men and women can enjoy such right whereas other people cannot enjoy it only because of their different gender identity and sexual orientation [sic].”*

The core thesis presented here is that transgender women experience discrimination based on the difference between their birth sex and their gender identity. This discrimination violates their basic rights of non-discrimination and manifests through a cascade of events including perceived and experienced stigma, social exclusion, violence, mental health issues and suicide, and a key outcome including disproportionate HIV risk and consequent increased disease burden. Even in settings where the discrimination is not specifically state-sponsored, the lack of recognition of and protections for transgendered peoples interferes with access to comprehensive preventive HIV-related services.

## **HIV Risk among Transgender Women**

In the few places where epidemiological data on transgender women is gathered, they demonstrate disproportionate risk for HIV. A 2008 meta-analysis conducted by Herbst and colleagues at the Centers for Disease Control and Prevention in the United States (US) found 22 studies that reported HIV infection rates for transgender women [12]. The average prevalence was 27.7% (range 16–68%) from the four studies that reported laboratory-confirmed HIV infections. African American transgender women had twice the prevalence of HIV infection (56.3%) compared to white (16.7%) or Hispanic (16.1%) transgender women. When the results were averaged across the 18 studies where respondents self-reported their HIV serostatus, the average dropped to 11.8% (range, 3–60%). The difference in HIV prevalence between studies using laboratory markers and those with self-report only, suggest that many transgender women may not be aware of their HIV status [12].

While much of the world remains unmapped in terms of HIV risk status and burden of disease among MSM, even less is known about risks among transgender women [13]. Transgender women are often included as a subpopulation of MSM in epidemiological studies as many share risk factors with gay men and other MSM including penile-anal intercourse, a much more efficient mode of sexual HIV transmission than penile-vaginal intercourse [14]. However, though there remains a dearth of high quality data on transgender women who have had genital reconstruction surgery and transgender women who do not partner with men, emerging evidence suggests that transgender women tend to carry higher rates of HIV than MSM. The disproportionate risk is driven, in part, by sexual practices that relate to their gender identities such as a higher likelihood of being the receptive partner during anal intercourse[15]. The systematic review demonstrated that sexual risk factors for HIV shared with other gender-conforming MSM such as unprotected receptive anal intercourse and multiple sexual partners are common. Other individual-level risk factors for HIV risk include mental health issues, physical abuse, and higher incarceration rates. Risk factors that transcend individual level practices have also been associated with HIV risk among transgender women including economic marginalisation, social isolation, unmet health care needs, and low HIV-related knowledge [12]. Few health care workers ranging from HIV counsellors to nurses and physicians have received any training on addressing the specific health needs of these women. Consequently, consistent access to competent clinical prevention, treatment, or care services is rare even in many high-income settings and even more so in low- and middle-income settings.

One international systematic review and meta-analysis of HIV risk among transgender women was conducted by Operario et al. in 2008 [16]. This study compared HIV prevalence among transgender female sex workers (TFSWs) with prevalence among transgender women who do not engage in sex work, male sex workers, and biologically female sex workers. They identified 25 studies among 6405 participants (3159 transgender women – 2139 categorised as sex workers and 1020 categorised as non-sex workers, 1633 male sex workers, and 1613 biologically female sex workers) recruited from 14 countries on 5 continents. While most studies were conducted in the US, study sites also included Spain, Singapore, Israel, Netherlands, Brazil, Belgium, Indonesia, Australia, Thailand, Uruguay, India, and Italy. Most sites were large metropolitan cities and all used convenience samples. Participants were recruited at venues that included HIV testing clinics, medical and community-based organisations serving transgender populations, street locations, and social and workplace venues. Six of the twenty-five studies determined HIV status based on self-report.

Overall crude HIV prevalence was 27.3% in TFSWs, 14.7% in transgender women not engaging in sex work, 15.1% in male sex workers, and 4.5% in female sex workers. There was a significant difference in HIV prevalence in TFSWs compared with all other pooled groups (Odds Ratio (OR) = 1.46, 95% CI: 1.02 to 2.09) and a significant difference comparing TFSWs with biologically female sex workers (OR = 4.02, 95% CI: 1.60 to 10.11). This means that transgendered female sex workers

were more than four times more likely to be living with HIV in comparison to female sex workers. Studies conducted outside of the US showed higher HIV prevalence in TFSWs compared with all other groups (RR = 1.90, 95% CI: 1.52 to 2.37), but HIV prevalence was not different in studies conducted within the US (OR = 1.24, 95% CI: 0.72 to 2.12). These data highlight the disproportionate burden of HIV infections among transgender female sex workers as compared to natal female sex workers and further demonstrating the manifestations of the denial of access to comprehensive HIV prevention services.

## Social Exclusion

Most transgender women experience lives filled with ongoing social stigma that supports the discriminatory attitudes that manifest as human rights violations and continued marginalisation. At the social and structural levels, discrimination and social marginalisation limit access to information, services and economic opportunities for transgender persons [17, 18]. For example, an ethnographic study of transgender people (*hijra*) in Bangladesh described their location at the extreme margin of exclusion, having no sociopolitical power [19, 20]. The investigators found that these deprivations were grounded in non-recognition beyond the male-female dichotomy. Being outside this binary, *hijra* and many other transgender people around the world have experienced repeated physical, verbal, and sexual abuse [20, 21]. This abuse often takes place at the hands of those entrusted to protect civil society. For example, a non-governmental organisation (NGO) in India has reported multiple episode of *hijras* being arrested, beaten, and humiliated by police, then being brought up on false charges. In one incident, a young *hijra* was gang-raped by ten men. Instead of arresting the perpetrator, the police arrested the victim, forced her to stand naked for seven hours while being beaten, kicked, and tortured by genital burning. It took a public hunger strike before the police force would register her complaint about the incident [22]. This type of extreme social exclusion and discrimination has been found to diminish self-esteem and sense of social responsibility, thus making it difficult to ensure uptake of safer sex messages aimed at reducing HIV-related risk among transgendered women.

A recurrent theme for transgender women is the lack of legal access to official identification cards and passports that reflect the person's gender rather than their genetic makeup. In Colombia, several studies have demonstrated that the health care centres within the national health care system specifically exclude transgender women, in part, because of the lack of national identification cards [23]. Lack of access to legal identification cards has also been associated with indiscriminate arrests of transgender women and policy brutality [23]. In 2005, OHCHR reported that gender non-conforming individuals in Colombia were *"frequently the victims of abuses and discrimination by the authorities. Allegations were received against members of the National Police in Medellín, Bucaramanga and Santa Marta"* [24]. While the Constitutional Court has taken action on behalf of the right of equality, the OHCHR still reported that there *"was a lack of appropriate policies for guaranteeing the rights of lesbians, gays, bisexuals and transsexuals, as well as explicit legislative initiatives to provide criminal and disciplinary sanctions for discrimination against people based on their sexual orientation"* [24]. The denial of care and government-sponsored brutality both would function to limit the provision and uptake of HIV preventive, treatment, and care services for transgender women [23]. In most settings around the world, it is legally and/or financially prohibitive for transgender women to obtain legal documents that allow a match between their gender identity and their legal gender. For example, many states in the US do not allow for a change of sex on a birth certificate. Often a change of sex on the birth certificate is required for a change of gender marker on identity documents. Even if such a change is allowed, government entities require documentation from a medical professional that the individual has had medical interventions to transition to female. Access to willing and knowledgeable health care providers who could offer such treatment and documentation is out of reach of most of the world's transgender women. Lack of acceptable identity documents has a host of consequences for the health and wellbeing of transgender women. For example, Vietnam's *Decree 88/2008/ND-CP* forbids sex reassignment according to an individual's perception of their identity or their desire to change sex. As a result, transgender people cannot undertake sex reassignment surgery in Vietnam. If they have such surgery outside Vietnam, they cannot register their identity or renew their personal identity papers. Thus when a transsexual woman who had completed genital reconstruction surgery reported being raped, the crime was not prosecuted because she was legally male, despite her female body. Legally, only females can be victims of rape in Vietnam. [22]

Social exclusion need not rise to the level of targeted violence to potentiate HIV risk status among transgender women. The Trans PULSE Project implemented in Ontario, Canada is a community-based research project that responds to problems identified within Ontario trans communities regarding access to health and social services. This project demonstrated the phenomenon of erasure of transgender women from the conscious realm producing a health system in which a trans patient or client is seen as an anomaly limiting quality of health services and uptake of services, when available [25]. This group identified two forms of erasure or social marginalisation including informational erasure, which encompasses both a lack of knowledge regarding transgender women and associated health needs and the assumption that such knowledge does not exist even when it may. In the PULSE programme, which serves the 13 million people of Ontario, informational erasure was manifested in an absence of targeted research studies and exclusion of transgender women in textbooks used to teach health care providers and policy makers [25]. The second type of erasure was

identified to be institutional erasure and occurred through a lack of policies that accommodate transgender women within the health care system. Moreover, institutional erasure includes the lack of knowledge that such policies are even necessary within a comprehensive health care system. The manifestations of institutional erasure involve exclusion from bureaucratic applications such as texts and forms ranging from referral forms and administrative intake forms to prescriptions. While this study was completed in Canada, the lessons of marginalisation transcend this country. A study of transgender women of colour in San Francisco demonstrated many of these same themes [26]. The state is intended to not just respect and protect human rights of its citizens, but also to fulfill them; hence erasure is a rights violation in the state's failure to fulfill these rights.

## **Economic Exclusion and Sex Work**

Without acceptable identity documents, it is nearly impossible to secure legal employment. When transgender women seek employment, they experience systematic exclusion from the workforce because of deeply ingrained stigma and discrimination and also because their gender presentation does not match their documents. This employment discrimination severely limits their economic opportunities. A recent survey of over 6,450 transgender people in the US found that respondents experienced twice the national rate of unemployment. 47% had been fired, not hired or denied a promotion and 26% had lost their jobs due to their gender identity or expression. 15% lived below the federal poverty threshold compared to 7% of the general population [27]. This survey demonstrates that transgender stigma provides a substantial barrier to a legal employment with resulting high rates of poverty.

Exclusions from income-generating opportunities tend to result in high rates of poverty and un- or under-employment. In combination with systematic prohibitions from state-sponsored social support mechanisms including social welfare programmes, transgender people have turned to sex work in multiple settings. Involvement in sex work has been reported by as much as 44% of transgender populations [28, 29]. A recent study among male-to-female transgender persons in El Salvador found that transgender women may be more likely than MSM to engage in sex work and more likely to report HIV risk behaviours as well as low knowledge of HIV despite higher exposure to HIV education [30]. A qualitative study conducted among transgender sex workers in the US examined why and how the participants became involved in sex work and explored what motivated participants to remain in sex work. In addition to other factors, participants reported that experiences of stigma in traditional workforce settings related to their transgender identity influenced their decisions to enter sex work and the risks encountered in sex work [31]. Specifically, 90% of participants in the National Transgender Discrimination Survey (NTDS) reported experiencing harassment, mistreatment, or discrimination in the workplace. For many, sex work may be the only way to pay for expensive hormonal and surgical interventions needed to modify their bodies to match their gender identity.

Unlike male or female sex workers, transgender sex workers face unique risks for violence from clients who discover that they are transgender. As a transgender sex worker in South Africa described, *"... to survive, I have to portray a double image on the road. So my life is always in danger. Regular clients will become violent when they find out. They threaten our lives, take back the money."*[5] Transgender sex workers also report facing humiliation and abuse at the hands of police and medical providers when they attempt to seek help after violent crimes are committed against them. For example, another transgender sex worker in South Africa described how police laughed at her and refused to take her complaint after she was brutally beaten and raped by a client. [53] Yet another transgender woman described going to a clinic to get post-exposure prophylaxis after being raped by a client who discovered that she was transgender. The clinic nurse told her to leave and come back when she was not wearing women's clothing. The transgender woman was so traumatised that she never returned. She later tested HIV-positive. [54]

Because sex work is criminalised in many settings, transgender women who do this work face arrest, detention, and police abuse, which are additional known risk factors for HIV transmission. In a study of street-involved transgender youth in New York City, USA, 63% reported prior arrests [32]. Transgender women report profiling by police as well as verbal and sexual harassment and violence, including the extortion of sex or money in exchange for release from custody [22, 32]. Law enforcement officers routinely confiscate condoms from suspected sex workers, sometimes submitting them as "evidence" and sometimes arresting people based solely on their possession of condoms [22]. Transgender women, who are commonly profiled as doing sex work, are especially targeted by this practice. In addition to abusing the rights and safety of sex workers, these policing practices directly undermine HIV prevention efforts [32]. When transgender women are arrested, they are routinely placed in men's prisons and jails. Once detained, they are 13 times more likely than other inmates to be sexually abused in prison. They are also likely to be subjected to harassment, prolonged isolation, and denial of medical care [32].

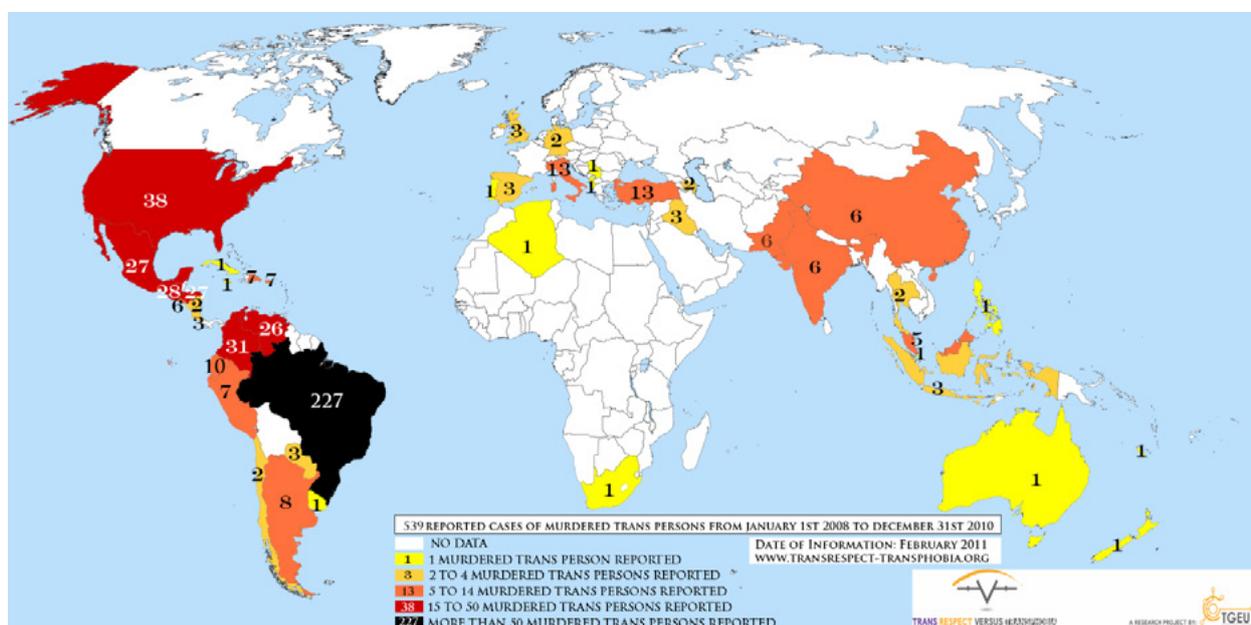
The legal history associated with arrests for sex work further limits the employment opportunities for transgender women. The NTDS found that in addition to sex work, those without a high-school diploma, those with incomes below the federal poverty threshold, and those who had lost a job due to bias were more likely to report having HIV [27].

## Social Exclusion and Sexual Risk-taking

At least one Caribbean country, (Guyana) and four countries in Asia and the Pacific (Afghanistan, Malaysia, Tonga, and Samoa) have laws that criminalise cross-dressing [10, 22]. The enforcement of these laws limits the ability of transgender people to seek health care or even walk in their own communities. Examples of disproportionately low HIV prevention, treatment, and care services has been observed in a variety of settings in Asia secondary to “extreme hostility” [33]. For example, the People’s Union For Civil Liberties-Karnataka completed a study in Bangalore, India that highlighted the many forms of legal discrimination that manifest from these laws [55]. Extortion was the most common police-mediated violation perpetuating fear among transgender people of having their sexual orientation or gender identity disclosed. Other police-mediated examples of violations also include illegal detention and abuse resulting in transgender people resorting to living even further hidden lives and thus limiting uptake of prevention services exacerbating risk.

“Transrespect versus Transphobia Worldwide” is a recently launched research project conducted by Transgender Europe focused on assessing human rights contexts for transgender persons across the world. This research group has catalogued the murder of over 600 transgender people since 2008 across the world. However, 80% of cases reported by this project have taken place in Central and South America with 227 transgender people killed in Brazil alone from 2008-2010 (Figure 1). Where reported, over 80% of transgender people murdered were working as sex workers.

**Figure 1 - Map of the Number of Transgender People Murdered from January 2008-December 2010.**



Transgender women’s social exclusion can impact their ability to find partners and to maintain healthy relationships. Many transgender women desire relationships with men [34]. However, the pool of men willing to enter into ongoing relationships with transgender women may be limited. Secondary to this power asymmetry, the condom negotiation skills of transgender women is limited and many may forgo condom use in order to retain their partners [34]. Sexual relationships with men are important to many transgender women who may attempt to receive the support they do not get from others through these relationships and because they affirm the transgender woman’s feminine identity [35].

## Social Exclusion and Health

Discrimination has been associated with mental health problems for transgender people [36]. Exposure to violence and transphobia has been associated with increased risk for depression and even suicide among transgender women sex workers [37]. In addition, experiences of transphobia have been associated with the substance use and HIV risk for transgender women in general [38-40].

Many transgender people experience difficulty accessing health care; those who were able to access health care reported abuse from health care providers [27]. Specifically, 28% of transgender people are likely to postpone medical care when sick or injured due to discrimination and 48% report postponing care due to financial constraints. In a US-based national study of over 6,000 transgender people, 19% reported being refused care due to their transgender or

gender non-conforming status, 28% of respondents were subjected to harassment in medical settings and 2% were victims of violence in doctors' offices.

There are several outcomes to perceived and experienced stigma in health care settings including the aforementioned limited effectiveness of targeted preventive services such as education and condom distribution. However, there is also an increasing body of evidence highlighting significantly higher rates of mental health issues ranging from depression to suicidal ideation to completed suicides [41]. Mental health issues are well-established risk factors for higher risk sexual practices among sexual minorities giving further credence for the role of health outcomes as a result of social exclusion [42, 43].

Few health care providers receive education and training on the health needs of transgender people. Half of the transgender people surveyed in the US reported having to teach their medical providers about transgender care [27]. While there has been some improvement in medical provider attitudes and knowledge over time, bias and lack of knowledge persist [44]. Provider attitudes towards transgender people are barriers to care and limit access to early testing and treatment for HIV [45-47]. Lack of access to legitimate medical sources for transition-related care leads many transgender women to use and share syringes for illicit hormone and silicone injections, which may increase risk of HIV [47].

## Conclusions

A submission made by Valentina Riascos Sanches, Santamaría Fundación, Colombia, for the Latin America Regional Dialogue of the Global Commission on HIV and the Law (on transgender rights) stated:

*"According to the Trans Citizen Observatory (OCT in Spanish) of the Santamaría Fundación, there were 45 registered and denounced homicides against TW (trans women) in Santiago de Cali between 2005 and March 2011, the great majority of whom were sex workers. This situation must be considered as a public health problem. To date, the processes put forth by the competent authorities do not demonstrate any significant advances. This situation of social violence is also accompanied by political violence, impunity and disregard towards our organisation's demands and selective enforcement of the law. In cases which implicate TW as perpetrators, the system is diligent and operational; in situations in which TW are victims, it is inefficient and lax."*

The legal environments of many countries remain either repressive of transgender people, or at minimum fail to fulfill their human rights. As discussed in another paper in this series, sexual practices among transgender women including sex with another biological male are already criminalised in a large proportion of UN member states. However, even in countries where same sex practices are legal, transgender people experience a range of cumulative discrimination in all aspects of life including employment, housing, education and health care – leading to social and economic insecurities. In the absence of full legal recognition and protection for marginalised transgender people, repressive and non-fulfilling legal environments and social exclusion significantly impede HIV responses by contributing to existing stigma in health care settings, limiting access to health and HIV services, and restricting the provision of culturally and medically appropriate materials and publications relating to sexuality and the promotion of sexual health for transgender people.

There are guidance documents of how human rights for transgender people can be achieved developed by a number of international bodies including enabling laws in Asia and the Pacific, the Yogyakarta Principles, and the UN Human Rights Council's June 2011 non-binding resolution to support equal rights for all people irrespective of sexual orientation or gender identity [56.] In 2009, UNAIDS included the targeting of transgender people in their key priority areas for action stating *"by ensuring that men who have sex with men, sex workers and transgender people are empowered to both access and deliver comprehensive and appropriate packages of HIV prevention, treatment, care and support services and by ensuring that law enforcement agencies and the judicial system protect their rights"* [10]. In addition, UNAIDS developed an action framework highlighting a path towards universal access for MSM and transgender people [48]. The majority of action that has resulted from these reports has focused on MSM and female sex workers rather than transgender women. This lack of response is most likely a result of the dearth of information available describing the burden of disease and associated risk factors for transgender women in comparison to the other most at risk populations. In 2009, the board of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) approved a sexual orientation and gender identities strategy (SOGI strategy). This strategy was focused on increasing the attention and programmatic response to those most at risk for the sexual transmission of HIV, including transgender women in national proposals submitted to the GFATM. Strategies such as this that involve multilateral funding streams such as the GFATM are important components of an advocacy strategy to increase evidence-based services for transgender women [10, 49].

The following recommendations organised around laws, policies and practices are intended to be a reference for stakeholders to help design country-specific advocacy and policy plans, tailored to local conditions. Above and beyond all the recommendations below, governments and donors must ensure the awareness and dissemination of evidence-

based information on the epidemiology of HIV and should be sensitised about the harmful public health and human rights impacts of laws, policies and practices relating to transgender people.

### **Practice: Support efforts to improve law enforcement practices in all sectors**

Anti-transgender bias negatively impacts the enforcement of laws or policies that lead to harassment, mistreatment, discrimination and violence in medical, social, legal and workplace settings. Governments should examine the spirit in which their own laws embody the non-discrimination ideas of international human rights treaties and be encouraged to enact explicit non-discrimination protections for trans and lesbian, gay and bisexual people. They should urgently remove criminal penalties related to sexual orientation and gender identity where those exist. In addition, the UN Human Rights Committee's opinion in *Toonen v Australia* supporting non-discrimination for sexual orientation and gender identity should be reexamined in light of the human rights conventions of Africa, Europe and the Americas. Governments should financially support and sponsor the organisation of training initiatives for police and other public safety officials, magistrates, judges, local and national elected officials, government employees and officials from ministries and departments within the government on the relationship between HIV and human rights contexts among transgender women. In all aspects to support the improvement to law enforcement practices, governments should partner and work cooperatively with civil society, including with transgender people, to design and implement awareness campaigns and training curriculums that are locally adapted and country-specific.

### **Laws: Implement comprehensive legal protections on the grounds of sexual orientation and transgender status.**

Many of the risk factors discussed in this article would be addressed with the UN developing a binding resolution in response to the June 2011 UN Human Rights Council non-binding resolution to support equal rights for all people irrespective of sexual orientation or gender identity. Countries can also use the Yogyakarta Principles as a model upon which to build non-discriminatory legal systems [9]. Specifically, governments should enact legal protections and prohibit discrimination with functional mechanisms of redress and compensation on the grounds of gender identity and sexual orientation, particularly in the areas of reducing employment discrimination, increasing access to health and wellness services, education, welfare and housing opportunities [9]. Governments must also recognise the gender identity of transgender individuals who have completed or and have not gone through sex reassignment surgery and work to reduce barriers to receiving legal recognition for purposes of identification documents including passport and other social services. Furthermore, governments should repeal any laws that prohibit or criminalise the expression of gender identity or expression, including through dress or speech. The aforementioned non-binding resolution of the UN Human Rights Council provides guidance for countries to develop such protections for transgender people.

### **Policies: Develop and sufficiently resource evidence-based national HIV plans that specifically addresses the needs of transgender persons.**

Governments should adopt national HIV strategies that support advocacy and improvements to the enabling legal environment in line with best practices in HIV prevention, treatment, and care guidance documents developed by UNAIDS, WHO and other global strategies developed by global funding mechanisms such as the GFATM (SOGI Strategy) and publications by the World Bank, WHO, and US President's Emergency Plan for AIDS Relief programme. National plans should ensure that HIV service providers, community-based organisations, and transgender people are not prosecuted on the basis of evidence of possession of materials properly used in promoting sexual health, such as safe sex literature, condoms and lubricant. Finally, national plans should include human rights-affirming surveillance systems that include all at risk for HIV, including transgender women, allowing the improved characterisation of burden of HIV disease and associated risk factors among transgender women. These data can be used to advocate for evidence-based and rights-affirming comprehensive HIV prevention, treatment, and care programmes for transgender people.

Governments must also ensure inclusion of HIV prevention, care and treatment activities specifically tailored to meet the needs of transgender people who may not be comfortable or feel safe accessing general population health services, as well as to embed services in general health systems. National HIV data collection systems must also be revised to include opportunities for proper identification of transgender people. Furthermore, governments should repeal or reform any laws that restrict community-based organisations from obtaining legal status and facilitate capacity building (including technical and financial management) and organisational development support to address gaps and build robust institutional capacity to support and sustain HIV programming for transgender individuals.

Additionally, governments should support civil society to play a variety of roles in the response to HIV among transgender women. Governments should first support the development of civil society supporting transgender people by adopting the aforementioned non-discriminatory laws allowing these groups to sensitise other stakeholders, including the media, churches, educators and members of the health workforce – namely doctors, nurses, community health workers, and other members of the health management teams. Civil society can support addressing issues of social discrimination in health practice by providing support to the implementation or directly implementing HIV care

and treatment for transgender individuals. While marginalisation potentiates HIV risk, community involvement, peer education, and affirmation of transgender identities are essential components of HIV prevention for transgender women [50, 51]. Moreover, engaging civil society is essential to help overcome the dearth of education for health professionals and to facilitate the access to and delivery of competent and sensitive clinical care for transgender women.

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