FACT SHEET – TRANSGENDER PEOPLE AND HIV

Transgender People in the HIV epidemic

- Worldwide, transgender women are known to be disproportionately affected by HIV/AIDS. A systematic review and meta-analysis of studies published between 2000 and 2011 found a pooled HIV prevalence of 19% in transgender women worldwide. Transwomen are 49 times more likely to be living with HIV than adult non trans males or females (according to data recorded from studies in the US, 6 from Asia and the Pacific, 5 LAC countries and 3 European countries)
- Disparate prevalence rates of HIV are particularly pronounced in the U.S. for African American transgender women when compared with transgender women of other races and ethnicities.
- Transgender men at risk for HIV are those that report sex with non-transgender men (trans MSM), a subgroup that has only recently begun to receive attention in public health research.

Barriers to HIV prevention, treatment, care and support for transgender people

Socio- economic and legal barriers

- High rates of violence and human rights violations against trans people has been recorded in a number of countries, despite enormous gaps in reporting. For instance, the UN Free and Equal Campaign reports that "Transgender persons, especially those involved in sex work or in detention, face an especially high risk of deadly and extremely cruel violence."
- Transgender people often lack of employment opportunities leading to homelessness and/or living in poverty.
- Many countries lack adequate legal provisions in recognition of diverse gender identities, such as gender identity laws. Most countries that have gender identity laws initiate barriers including the requirement of sterilization, divorce, hormonal treatments and/or surgical procedures and/or psycho-medical diagnoses as prerequisites of legal recognition. Most countries lack adequate legal protections from stigma, discrimination and other human rights violations based on gender identity and gender expression. Other

countries criminalize transgender people because of their gender expression, or because they are (or are perceived as) sex workers.

- Access to general and specific healthcare is impeded by institutional violence, lack of appropriately trained health providers or misinformed providers (for example, lack of awareness of drug interactions when integrating antiretroviral medication with hormonal treatment) and/or inaccessibility due to lack of healthcare coverage.
- Transgender people who are incarcerated face particular challenges in accessing HIV prevention, treatment, care and support in detention facilities.

Evidence-related barriers

- Transgender women continue to be classified as a subpopulation of men who have sex with men or as a LGBT umbrella term.
- For the first time in 2015, WHO guidance for HIV prevention and treatment among transgender people (separate from MSM) was published.
- Geopolitical challenges affect access to information from key regions, such as Sub-Saharan countries.
- Absence of evidence due to lack of resource allocation and or proper research is usually considered as "evidence of absence", naturalizing the gaps in data collection and analysis.
- The lack of standardized data collection methods of gender identity variables leads to invisibility in global public health efforts.

Political Barriers

- Transgender people have almost never been meaningfully engaged in HIV funding processes. As of 2015, there have been 21 individuals who identify as transgender sitting on 17 CCMs out of a total of over 150 GF funded countries.
- Only 29% of countries reported to UNAIDS that their national AIDS strategies addressed transgender people.
- The Global Fund decision of ending support for many middle-income countries in the upcoming years will affect access to services for transgender people, were the HIV epidemic is concentrated in those countries.
- Transgender women living with HIV face culturally unique and substantial challenges to adhering to HIV care and treatment regimens, such as limited access to and avoidance of healthcare due to stigma and past negative experiences, prioritization of gender-related

healthcare, and concerns about adverse interactions between antiretroviral therapy and hormone therapy.

Recommendations:

Paragraph 36 (concern over rising numbers among key populations): transgender people should be included in the rising numbers in the Middle East and North Africa.

Justification: while studies fully inclusive of transgender people are rare in these countries, gender identity and/or gender expression is very likely to be a very strong aspect in HIV transmission for transgender people and feminine men in the Middle East and North Africa. Subsuming transgender people under 'men who have sex with men' – the most common practice – ignores the specificity of HIV risk and vulnerability faced by transgender women.

Paragraph 61 b (removing legal barriers): include laws that criminalize transgender identity or expression, as well as laws that impede trans people from access to ID documentation and laws that are primarily used to target key populations.

Justification: A number of countries have laws directly criminalizing 'cross-dressing', thus increasing stigma and discrimination against transgender people and hampering their access to HIV services. Moreover, lack of access to ID documentation is a key impediment for trans people to work legally; lack of access pushes many trans people of all genders into the underground economy and makes them more vulnerable to HIV as a result. ID documentation has to be accessible to all people, regardless of gender identity or expression, and where sex is recorded it must be a simple, quick and cheap administrative act without the need for third party intervention (for example a doctor's letter) for trans people to change it.

Paragraph 68 (data collection) include gender identity/gender expression in the data to be collected.

Justification: Given high rates of HIV among transgender women, gathering more information is crucial to ending the AIDS epidemic.

References

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