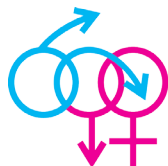


**BLUEPRINT FOR THE PROVISION
OF COMPREHENSIVE CARE FOR**

**TRANS PEOPLE AND TRANS
COMMUNITIES IN ASIA
AND THE PACIFIC**



This document was produced in partnership with



WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH



PROJECT DIVA
Diversity in Action Supporting communities. Reducing vulnerabilities.

Suggested citation: Health Policy Project, Asia Pacific Transgender Network, United Nations Development Programme. 2015. *Blueprint for the Provision of Comprehensive Care for Trans People and Trans Communities*. Washington, DC: Futures Group, Health Policy Project.

ISBN: 978-1-59560-118-6

The Health Policy Project is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-10-00067, beginning September 30, 2010. The project's HIV activities are supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). HPP is implemented by Futures Group, in collaboration with Plan International USA, Avenir Health (formerly Futures Institute), Partners in Population and Development, Africa Regional Office (PPD ARO), Population Reference Bureau (PRB), RTI International, and the White Ribbon Alliance for Safe Motherhood (WVRA).

The information provided in this document is not official U.S. Government information and does not necessarily represent the views or positions of the U.S. Agency for International Development.



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Blueprint for the Provision of Comprehensive Care for Trans People and Trans Communities in Asia and the Pacific

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Acknowledgements

The Coordinating Group would like to thank all of the trans community participants and organisations, health workers and professional bodies, and other individuals and organisations who contributed to this resource. Many people played a role by attending consultations, providing potential case examples, and reviewing drafts. This Blueprint would not have been possible without your input.

We are indebted to the Pan American Health Organization and all involved in developing the first Trans Health Blueprints for Latin America and the Caribbean. In particular, we acknowledge JoAnne Keatley, Walter Bockting, and Rafael Mazin for their leadership in developing these initial documents. The Asia and the Pacific Blueprint relies heavily on the clinical protocols in the Caribbean Blueprint, which are based on the work of the University of California, San Francisco (UCSF) Center of Excellence for Transgender Health. These were revised by Dr Asa Radix and reviewed by medical reviewers from this region, who are listed below.

In addition to those acknowledged below, lists of participants at the initial project meeting and two subsequent consultations are attached as Appendices A, B, and C. All reviewers of the March 2015 draft are listed in Appendix D.

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Acronyms and Abbreviations

APF	Asia Pacific Forum
APTN	Asia Pacific Transgender Network
ART	Antiretroviral therapy
ARV	Antiretroviral
ASEAN	Association of Southeast Asian Nations
BDS	Blue Diamond Society
BSWS	Bandu Social Welfare Society
CBO	Community-based organisation
DSD	Disorders of sex development
FPAI	Family Planning Association of India
FtM	Female to male (trans man)
GBV	Gender-based violence
HPV	Human Papillomavirus
LGB	Lesbian, gay, and bisexual
LGBT	Lesbian, gay, bisexual, and trans
LGBTI	Lesbian, gay, bisexual, trans, and intersex
MSM	Men who have sex with men
MtF	Male to female (trans woman)
NGO	Non-governmental organisation
NHRI	National human rights institution
NMHA	Naz Male Health Alliance
NNRTI	Non-nucleoside reverse transcriptase inhibitor
PAHO	Pan American Health Organization
PI	Protease inhibitor
SEARO	WHO Regional Office for Southeast Asia
SOGI	Sexual orientation and gender identity
SOGIE	Sexual orientation, gender identity, and (gender) expression
STI	Sexually transmitted infection
TMM	Trans Murder Monitoring
UCSF	University of California, San Francisco
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UPR	Universal Periodic Review
WHO	World Health Organization
WPATH	World Professional Association for Transgender Health
WPATH SOC	World Professional Association for Transgender Health's Standards of Care
WPRO	WHO Regional Office for the Western Pacific

Executive Summary

The *Blueprint for the Provision of Comprehensive Care for Trans People and Trans Communities in Asia and the Pacific* (the Blueprint) is a document with far-reaching potential and applications in trans health and human rights in the region. The purpose of the Blueprint is to strengthen and enhance the policy-related, clinical, and public health responses for trans people in Asia and the Pacific.

The primary audience for the Blueprint is health providers, policymakers and governments. The information within the Blueprint could also serve donors, bi- and multilateral organisations and trans and other civil society organisations.

The Asia Pacific Transgender Network (APTN), the United Nations Development Programme (UNDP), and the USAID-funded Health Policy Project (HPP) collaboratively developed the Blueprint. This document is the third in a series of regional trans health Blueprints, and builds on what was produced in Latin America and the Caribbean by the Pan American Health Organization, the Regional Office of the World Health Organization for the Americas.

The term “Asia and the Pacific” covers a large geographic area that has considerable cultural and linguistic diversity. This fact is conveyed in the Blueprint as much as possible, though considerably less research and data are available from the Pacific. A rich diversity of trans identities and terms also exists across the region, including those who use culturally specific terms and may identify as a third gender. This Blueprint uses the umbrella term “trans” to encompass that diversity, for example in terms such as trans health and trans people.

Many trans people across the region have a strong sense of pride in their identity. Unfortunately they also share common negative experiences of discrimination. These experiences include the extent of invisibility, isolation and exclusion from families, schools, the formal workforce and mainstream economy, and from recognition as equal citizens. High levels of stigma and discrimination and very few legal protections push trans people to the margins of society, including a narrow range of often exploitative, underpaid and insecure jobs. Some communities have established resilient forms of peer support, whether based on cultural traditions or through the ability to link with others through social media. However, trans people still need to participate fully in the legal and policy decisions that so powerfully affect their lives.

A second common experience is poor emotional wellness and mental health outcomes, which are linked to high and chronic levels of stress. Available data in this region show the detrimental mental health outcomes related to bullying, harassment, and isolation of trans students. There have been some positive initiatives for trans students in a number of countries in the region, including engagement of trans youth in national youth policy development and inclusion of gender identity in school-level curriculum and in-service training for teachers.

Trans adults in this region also experience high levels of gender-based violence (GBV), and a few countries in Asia now include trans women in programmes responding to such violence. However, some of the factors increasing the risk of violence to trans people require specific structural and legal solutions. For trans women, criminalisation of sex work and prosecution under cross-dressing and public nuisance laws place them at risk of harassment and extortion, with no form of legal redress. They are then much more likely to be detained in prisons, frequently with male prisoners, where they are at risk of further physical and sexual assaults. Violence against trans men remains hidden, though there is some evidence from Australia that trans men experience high levels of intimate partner violence.

To date, governments’ periodic reporting on their human rights obligations seldom mentions trans people. To some extent, this is because trans people are rarely counted in official statistics. They are either invisible or buried in conflated data about men who have sex with men (MSM) (for trans women) or under a lesbian, gay, bisexual, and trans (LGBT) umbrella term. Trans men are even less likely to be counted.

Yet there are some UN experts and mechanisms that have investigated human rights violations against trans people, including trans people in detention. Greater use of those mechanisms by trans advocates and national human rights institutions (NHRIs) in this region could start to build a stronger evidence base and make governments more accountable for reporting on trans human rights outcomes.

Behaviour that stigmatises or discriminates against trans people often stems from ignorance or fear. Frequently it is based on stereotypes and limited contact with trans people. One of the aims of this Blueprint is to start to fill some of those knowledge gaps and promote dialogue between trans people, health professionals and their organisations, government officials, and others wanting to address inequality and discrimination.

Necessary legal protections involve both the introduction of anti-discrimination provisions and the removal of laws that criminalise trans people, including for “cross-dressing,” sex work, or public nuisance or vagrancy. In addition, legal gender recognition is vital for trans people to have access to many basic services.

The vast majority of trans people in Asia and the Pacific cannot obtain official documents under their appropriate names and/or sex to match their gender identity. In many countries, there are no laws or policies allowing a trans person to change these details. Those that do exist typically limit gender recognition to a minority of trans people, with strict stipulations, including medical requirements, that violate other human rights.

In South Asia, four countries have recognised the specific status of *hijras*, *metis*, *Khawaja siras* and other trans people who identify as a third gender. However implementation has typically been very slow. There is a wider debate within the region about how to recognise the rights of those who identify as third gender, while also enabling trans women to identify as female and trans men to identify as male—and providing them with the same legal protections.

One key aspect of the right to health is that it requires that health systems and services are available, accessible, acceptable, and of quality. General health services are frequently not accessible to trans people because of prohibitive costs or discriminatory treatment by service providers or other service users. The Blueprint looks at a small number of specific health issues for which there are enough data available to provide a regional overview of health outcomes for trans people. This includes data that consistently show trans women as disproportionately affected by HIV—yet there are still insufficient programmes or services targeted to meet trans-specific needs.

The biggest health gaps are in the provision of medically necessary, gender-affirming health services. These gaps are compounded by significant gaps in basic information about biomedical and surgical interventions for transitioning, with very little material available in local languages, particularly about the health needs of trans men. In communities with few visible trans men, there may be no other trans person to approach for such information.

In this region, with the exception of Hong Kong SAR, China and parts of India, the costs of most gender-affirming health services are not covered by public health systems or private health insurance. As a result, trans people have to pay to access counselling, a diagnosis, laboratory tests, hormone treatment, hair removal, surgeries, and/or other. The lack of coverage, absence of specialist expertise, scarce protocols for trans healthcare, and the negative attitudes of many healthcare personnel drive trans people into the arms of unregulated and non-qualified practitioners. As a result, silicone and other soft tissue fillers may seem to be the only accessible form of body modification for some trans people.

The policy considerations articulated in the Blueprint and summarised in Box 1 are developed out of promising good practices and expert advice about addressing the health needs and human rights of trans people in Asia and the Pacific. Chapter 6 contains the full list of all policy considerations and provides greater detail on specific actions and responsibilities.

Some of the policy considerations are practical steps that health professionals can incorporate in their work. These are based on the examples of clinical protocols and good practice in the second half of this document. Other policy considerations suggest legislative and policy changes needed to improve health outcomes for trans people.

BOX 1: HIGH-LEVEL POLICY CONSIDERATIONS FROM THE ASIA AND PACIFIC TRANS HEALTH BLUEPRINT

The 13 identified high-level priority policy considerations are listed below. Further details of suggestions and actions under each heading, and those most well placed to take action, are in Chapter 6 of the Blueprint.

Participation of Trans People in Research, Advocacy and Policy

- Ensure greater participation of trans people in decisions that affect their lives
- Increase public awareness about trans people and their human rights issues
- Undertake research, in collaboration with trans people, to address significant data gaps

Health Services and Public Health for Trans People

- Address discrimination and improve the responsiveness of health services to trans people
- Address significant information gaps about trans people's health
- Ensure trans people's equal access to general health services
- Improve trans people's access to medically necessary gender-affirming health services
- Improve the quality of gender-affirming healthcare for trans people

Ending Violence Against Trans People

- Take comprehensive measures to tackle violence against trans people

Move from Discrimination to Protective Laws for Trans People

- Ensure that trans people have legal protection from discrimination and are not criminalised
- Protect trans students' right to education and safety at school
- Protect and fulfil trans people's right to decent work

Promoting Legal Gender Recognition

- Ensure that trans people are legally recognised and protected under their self-defined gender identities

Using and Navigating the Asia and the Pacific Trans Health Blueprint

The authors recognise the volume and breadth of information contained in the Blueprint, and that the document may not be read from cover to cover. Readers are encouraged to use the Blueprint to guide initiatives to increase, enhance, strengthen, and sustain trans health and human rights efforts in the region. This could include creating and updating advocacy toolkits, adapting good practices from other countries for local implementation, or revising an organisation's policies for providing gender-affirming care. The authors suggest reviewing the Policy Considerations (Chapter 6) for more insights into where and how the Blueprint can support next steps.

The Blueprint is organised into two components. The first half outlines the history and background of this document and summarises the health and human rights context of trans people in this region. The second half collates good practice advice, including examples of primary care protocols for health professionals working with trans people.

- **Chapter 1** is an introduction to trans health broadly and details the origins and development process of the Blueprint.
- **Chapter 2** summarises binding international human rights standards, regional commitments, and the role played by national human rights institutions.
- **Chapter 3** outlines the priority health and human rights issues for trans people in the region. These priorities focus on addressing violence, discrimination, general health needs (including HIV and other STIs, substance use, and mental health), gender-affirming services, and legal gender recognition.

- **Chapter 4** provides clinical advice about supporting trans adults' health needs.
- **Chapter 5** gives additional advice for health professionals working with trans and gender-nonconforming children and youth.
- **Chapter 6** outlines policy considerations to improve trans people's rights to health and gender recognition, and to ensure freedom from discrimination and violence.

Case examples are punctuated throughout to highlight promising practices in trans health, advocacy, and human rights. The majority of these examples are from trans-led initiatives to further highlight the resiliency and innovation of trans-centered and trans-led efforts.

Colour-coded boxes indicate where information is more relevant for certain stakeholders. For example, information for health providers is labelled in a blue box.

FOR HEALTH PROVIDERS

FOR TRANS PEOPLE

FOR POLICYMAKERS

General information for all stakeholders is in orange boxes.

The Terminology section below outlines terms and definitions for trans identities, including those that are culturally specific, and distinguishes between trans and intersex people.

Terminology

Transgender and trans

The umbrella term **trans** covers a diversity of gender identities and forms of gender expressions. The following non-exhaustive list explains some common terms used to describe trans identities and how they are used within the Blueprint. The definitions and their level of use vary significantly across this region, within specific countries or cultures, and amongst individual trans people. Every person has the right to use the term or terms that best describes their gender identity.

In this region, the words transgender and trans are each used frequently as an umbrella term to describe people whose gender identity is different from their assigned sex at birth. In its presentation to the initial regional meeting about this Blueprint, APTN included the following definition of the term "**trans/transgender**," which is based on discussions held at a regional consultation in Manila in 2012:

Persons who identify themselves in a different gender than that assigned to them at birth. They may express their identity differently to that expected of the gender role assigned to them at birth. Trans/transgender persons often identify themselves in ways that are locally, socially, culturally, religiously, or spiritually defined.

The Blueprint is using this definition, and the word trans, as its umbrella term to convey this diversity of gender identity or expression. When it is appropriate to be more specific, the Blueprint uses the following additional terms:

Trans woman: Term used to refer to a trans person who identifies as female (i.e., someone whose sex was assigned male at birth but who identifies as female). The acronym **MtF (Male to Female)** is also used to describe a trans woman.

Trans man: Term used to refer to a trans person who identifies as male (i.e., someone whose sex was assigned female at birth but who identifies as male). The acronym **FtM (Female to Male)** is also used to describe a trans man.

Cisgender is a term used to describe someone who is not transgender; that is, their gender identity corresponds with their sex assigned at birth.

OVERVIEW

CULTURALLY SPECIFIC TERMS

This document also uses the umbrella term trans to encompass many culturally specific identities. In this region, some culturally specific terms have very long histories and are best understood within their evolving cultural context. They should not simply be translated as trans women or trans men and, in some cases, the term “third gender” is a closer translation.

The majority of the older culturally or linguistically specific terms apply to people whose sex was assigned male at birth but who do not identify with that sex or gender. Some examples are given below.

Regional terms used for people assigned male at birth who identify as female or as a third gender include the following, for example: *hijra* and *thirunangai* (India), *khwaja sira* (Pakistan), *meti* (Nepal), *kathoey* (Thailand), *waria* (Indonesia), *mak nyah* (Malaysia), *transpinay* (the Philippines) and *bin-sing-jan* and *kwaa-sing-bit* (Hong Kong) in Asia; and *fakafine* (Niue), *fa’afafine* (Samoa and Tokelau), *leiti* (Tonga), *palopa* (Papua New Guinea), *akava’ine* (Cook Islands), *whakawahine* (New Zealand) and *Sistergirl* (Australia) in the Pacific.

Regional terms used for people assigned female at birth who identify as male include the following, for example: *bandhu* (Bangladesh), *transpinoy* (the Philippines), *thirutambi* and *kua xing nan* (Malaysia) in Asia; and *fa’afatama* (Samoa), *tangata ira tane* (New Zealand) and *Brotherboy* (Australia) in the Pacific.

Other key terms

As the term trans describes someone whose **gender identity** is different from their **sex assigned at birth**, it is important that these additional concepts also are clearly defined. This section provides brief definitions of how these and other key related terms are being used in the Blueprint. These definitions are based on consensus definitions used in World Health Organization (WHO) guidelines and other UN documents.¹

Sex: Biological and physiological characteristics (genetic, endocrine, and anatomical) used to categorise people as members of either the male or female population (see also the definition of intersex). These sets of biological characteristics are not mutually exclusive, as they occur naturally in various degrees and combinations. However, in practice, they are used to differentiate humans as supposedly opposite extremes within a polarised binary system (male and female). Typically, a distinction is made between primary sexual characteristics (an individual’s reproductive organs) and secondary sex characteristics. The latter describe other non-genital physical traits, such as breast development, that are used to differentiate females from males.

Sex Assigned at Birth: The sex to which a person is assigned at, or soon after, birth. This assignment may or may not accord with the individual’s own sense of gender identity as they grow up. In medical and sociological literature, this often is referred to as a person’s “natal sex” or “biological sex.” For most people, gender identity and expression are consistent with their sex assigned at birth. For trans people, gender identity or expression differ from their sex assigned at birth (Coleman et al., 2011).

It is not appropriate to refer to a trans woman as a natal male or a trans man as a natal female. The term “natal sex” should be used only to refer to someone’s sex assigned at birth, not to who they are as a person. When necessary, it is more appropriate to talk about people who were assigned male (or female) at birth. This approach makes the distinction between a past classification by others and a person’s self-defined identity now.

1. Other documents include the Pan American Health Organization (PAHO) Blueprint, which drew heavily on Version 7 of the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) and on the World Association for Sexual Health (WAS) document Sexual Health for the Millennium.

Gender identity: A person's internal sense of being a man, a woman, or some alternative gender or combination of genders. A person's gender identity may or may not correspond with their sex assigned at birth.

Gender expression: A person's ways of communicating culturally-defined traits of masculinity or femininity (or both or neither) externally through physical appearance (including clothing, accessories, hair styles, and the use of cosmetics), mannerisms, ways of speaking, and behavioural patterns in interactions with others.

Gender-nonconforming or gender variant: Describes someone whose gender identity or gender expression is different from societal expectations or stereotypes. Not all trans people are gender-nonconforming. Some trans people, like other people, are comfortable conforming to societal expectations of what it means to be a woman or a man. Conversely, some people who are not trans may identify as gender-nonconforming, based on their gender expression rather than their gender identity.

Gender dysphoria: "Refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). Only some gender-nonconforming people experience gender dysphoria at some point in their lives" (Coleman et al., 2011).

Transition: The process many, but not all, trans people undergo to live authentically in their gender identity. This may involve changes to a person's gender expression, such as their outward appearance, clothing, mannerisms, or to the name they use in everyday interactions. These types of changes are sometimes called "social transitions." Transitioning may also involve biomedical and surgical steps that help to align a person's anatomy with their gender identity. These steps are sometimes called "medical transition" and can include feminising or masculinising hormone therapy and/or surgeries.

Transitioning is a unique journey for each person. Many trans people will consider that they have transitioned from the point at which they live publicly in their authentic gender identity. Others may use the term to describe a longer period of time that encompasses some form of medical transition.

Gender-affirming health services: The umbrella term is used in the Blueprint to encompass any of the biomedical, surgical or health interventions a trans person may undertake to physically transition. This includes, for example, access to counseling, hormone therapy, and hair removal, and a range of surgeries. The term "gender-affirming surgeries" is preferred in this document, rather than the older term "sex reassignment surgery" (SRS).

Transphobia: Prejudice directed at trans people because of their actual or perceived gender identity or expression. It can also have an impact on non-trans people who do not fit societal expectations for males or females. Transphobia can be "structural"—reflected in policies and laws that discriminate against trans people. It can be "societal" when trans people are rejected or mistreated by others. Transphobia can also be "internalised" when trans people accept such prejudicial attitudes about themselves or other trans people.

Sexual orientation: Each person's capacity for profound emotional, affectional, and sexual attraction to, and intimate and sexual relations with, individuals of a different gender (heterosexual) or the same gender (homosexual) or more than one gender (bisexual or pansexual) (International Commission of Jurists, 2007). (People who identify as asexual do not experience any sexual attraction.)

A person's physical sex, gender identity, gender expression, and sexual orientation represent four distinct individual characteristics. They are conceptually independent of each other and may occur along a vast range of possible combinations. Yet in most parts of the world, including this region, there is a wide cultural assumption that conflates these categories. This leads to the further assumption that someone assigned a male sex at birth will grow up and identify as a man, have a masculine gender expression, and be solely attracted to women (heterosexual). For someone assigned female at birth there is an equivalent assumption that she will identify as a woman, have a feminine gender expression, and be heterosexual.

Trans people, like anyone else, may have a feminine and/or masculine gender expression, or be attracted to individuals of a different gender, the same gender, or more than one gender.

OVERVIEW

Intersex: A term used to describe people whose innate physical sex characteristics (such as chromosomes, gonads, and genitals) are considered to be either male or female at the same time, only partially male or partially female, or neither male nor female.

The Blueprint authors contacted intersex organisations in Asia and the Pacific to identify relevant terminology for this region. The organisations' views were that a document such as the Blueprint, with a broader focus on human rights, should respect people's right to self-determination. Thus, just as trans people are not being defined by medical diagnoses, it would be inappropriate to refer to intersex people in that way. The definition above is one frequently used by intersex organisations in this region.

Knowledge of gender and sex is evolving, so readers may expect further linguistic changes in the future.

Trans Cultural Competence: Trans cultural competence refers to the ability to understand, communicate with, and effectively interact with trans people. It can be measured by awareness, attitude, knowledge, skills, behaviours, policies, procedures, and organisational systems.²

Distinguishing Between Trans and Intersex

The term “trans” and its linked concepts of gender identity and expression are distinct from the term “intersex,” which is about sex variations.

Being intersex does not equate to a person being trans. Some people with intersex variations may identify as trans or gender variant, whereas others may not. Although some people with intersex variations describe their sex or gender identity as non-binary, most identify as either male or female.

Limitations of Medical Terms for Intersex People

In the medical literature, the term “disorders of sex development” (DSD) is used to refer to the different chromosomal, gonadal, or anatomical forms that such a variation may take. Critics of the term “disorder” stress that intersex variations are a natural part of human diversity and advocate for more descriptive concepts, such as the continued use of the word intersex, or the phrase “differences of sex development.”

The World Professional Association for Transgender Health (WPATH) has developed “Standards of Care (SOC) for the Health of Transsexual, Transgender and Gender-Nonconforming People” (Coleman et al., 2011). In these SOC, WPATH acknowledges that some people object strongly to the “disorder” label and provides this explanation for its use of the term DSD:

In the SOC, WPATH uses the term DSD in an objective and value-free manner, with the goal of ensuring that health professionals recognise this medical term and use it to access relevant literature as the field progresses. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery (Coleman et al., 2011, p. 68).

In this region, a 2013 Australian Senate Committee report recommended that state governments use the term “intersex” and not DSD (Community Affairs References Committee, 2013). It also recommended that health professionals and health organisations confine their use of the term DSD to appropriate clinical contexts. For “genetic or phenotypic variations that do not necessarily require medical intervention in order to prevent harm to physical health,” it recommended using the term “intersex” or “differences of sexual development” instead.

2. Wilkinson, W. (2014) “Cultural Competency” in TSQ, *Transgender Studies Quarterly*, Volume 1, Number 1-2, pp. 68-73. Available at: <http://tsq.dukejournals.org/content/1/1-2/68.full>



INTRODUCTION

This introductory chapter of the *Blueprint for the Provision of Comprehensive Care for Trans People and their Communities in Asia and the Pacific* (the Blueprint) provides background information about both the size of the trans population in this region and the level of marginalisation and social exclusion trans people experience. It summarises the origins of this regional Blueprint—the third of its kind internationally—its purpose, and the collaborative process by which it was developed.

Although consideration of the health and human rights of intersex people is outside of the scope of this Blueprint, this chapter notes that some material may be relevant to people with intersex variations and may inform any future research undertaken in partnership with intersex people.

1.1 Number of Trans People

It is difficult to measure the size of global, regional, or even national trans populations. Most estimates are based on the number of trans people who have approached specialist clinics that provide gender-affirming health services. Such estimates do not count the majority of trans people in this region who do not have access to publicly funded clinics, cannot afford private clinics, or choose not to medically transition.

Winter (2012) has speculated that 0.3 percent of the adult population in Asia and the Pacific may be trans. Using 2010 UN population data, he calculated that there may be between 9.0 and 9.5 million trans people in this region. Winter notes this estimate is broadly in line with community-based estimates in four countries, though these focused exclusively on either the number of trans women or *hijra* in those communities.

A 2012 nationally representative survey of 8,166 high school students in **New Zealand** found that 1.2 percent reported being transgender and 2.5 percent reported not being sure about their gender (Clark et al., 2014).

1.2 Social Exclusion

In Asia and in the Pacific, trans people face significant barriers in exercising their human rights, including their right to health. The level of social exclusion they experience demonstrates the compounding impacts of exclusion from family, schools, and broader social and cultural participation; from employment and the right to an adequate standard of living; and from full recognition as equal citizens (UNDP, 2010).

In all but a handful of countries in the region, trans people lack access to basic healthcare, including HIV services. There is even less access to publicly funded gender-affirming health services required by those who wish to medically transition. Trans people face high levels of violence and discrimination, and criminalisation (under laws prohibiting “cross-dressing” and sex work and through targeted harassment under public nuisance or vagrancy offences). Conversely, trans people in this region have extremely limited protection under anti-discrimination laws or policies, and the majority have no legal recognition of their gender identity.

Furthermore, trans people experience high and chronic levels of stress linked to such social exclusion. This includes disproportionately low emotional wellness and poor mental health, resulting in relatively high rates of depression, anxiety, and suicidal ideation and behaviour. Social stigma limits trans people’s access to appropriate and sensitive mental healthcare. Health providers may also be stigmatised by their professional colleagues for providing health services to trans people. They may lack resources, knowledge, or the necessary experience to fully meet the health needs of trans people.

1.3 Previous Regional Blueprints

In 2011, the Pan American Health Organization (PAHO) prepared the *Blueprint for the Provision of Comprehensive Care for Trans Persons and their Communities in Latin America and the Caribbean*. PAHO developed that Blueprint through a review of available research and by consulting representatives from academia, the health sector, multi- and bilateral agencies, governmental and nongovernmental organisations (NGOs), trans communities, and other stakeholders from that region. A 2015 version was published in English for the Caribbean, incorporating revisions and new material drawn from regional consultations.

In 2012, WHO, the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNDP, and APTN hosted a consultation in Manila on the HIV, sexually transmitted infection (STI), and other health needs of trans people in this region. One of its key recommendations was to develop “comprehensive standards of care for ... and evidence-based guidelines on the holistic needs of transgender people in Asia and the Pacific” (WHO WPRO, 2012). This Blueprint is an initial step in addressing that Manila recommendation.³

1.4 Purpose of Blueprint

The main purpose of the Blueprint is to improve access to competent primary and specialised care for trans people in Asia and the Pacific. A comprehensive evidence-based guide is an essential step in that process. This Blueprint will be a resource enabling health providers, programme planners and managers, policymakers, community leaders, and other stakeholders to promote and address the health needs of trans people. At the same time, enhancing trans people’s health and well-being requires a human rights approach that seeks to end discrimination and recognises the dignity and equality of all. For that reason, the Blueprint builds the case for changing laws, policies, and practices to bring trans people back from the margins of society and ensure their full social inclusion in the life of the community at large.

APTN, the USAID-funded Health Policy Project (HPP), and the UNDP Regional Bureau for Asia and the Pacific have coordinated development of the Blueprint. It builds upon the innovative work from the Latin American and Caribbean Blueprints, as well as previous research within this region.

The Blueprint provides comprehensive information on human rights issues and trans health needs in Asia and the Pacific. Its geographic scope focuses predominantly on countries covered by the WHO Regional Office for South-East Asia (SEARO) and WHO Regional Office for the Western Pacific (WPRO). In addition, it incorporates input from trans people and health professionals from Pakistan, who participated in a Blueprint consultation in Nepal and reviewed drafts. It also includes primarily technical information from health professionals and trans people in Australia and New Zealand, who reviewed drafts.

The Blueprint describes examples of progress in addressing trans people’s health and human rights and details examples of clinical care protocols. These protocol examples are based on primary care protocols developed by the UCSF Center for Excellence in Transgender Health.⁴ They reflect the WHO Key Population Consolidated Guidelines (2014), WHO Policy Brief on transgender people and HIV (2015), the WPATH SOC7 (Coleman et al., 2011), and other relevant guidelines. This medical material was updated by Dr Asa Radix, Senior Director of Research and Education, Callen-Lorde Community Health Center, New York, and reviewed by Asia and the Pacific regional health professionals, who are acknowledged at the beginning of this report.

1.5 Process

The development process for the Blueprint involved consultations, literature reviews, and inputs from expert reviewers on drafts. The initial Blueprint development meeting was held in Bangkok, Thailand in October 2014. Participants included trans advocates, academics, donor and multilateral agencies, implementing partners, and two regional trans networks—Asia Pacific Transgender Network and the Pacific Sexual Diversity Network. Trans participants came from Australia, Hong Kong SAR (China), India, Indonesia, Malaysia, Nepal, the Philippines, Thailand, and Tonga.

Participants agreed that the success of the project would depend on it being inclusive, owned by communities, and complementary to other initiatives such as the Trans Implementation Tool (TRANSIT). TRANSIT is a global, practical programming guidance document for trans HIV and STI programmes. The Blueprint focuses on a wider range of both health and human rights issues, with a narrower geographic focus on Asia and the Pacific.

3. Available at: www.who.int/hiv/pub/transgender/blueprint-trans-paho/en/.

4. Available at: www.transhealth.ucsf.edu/protocols.

Participants discussed what is needed in the region and agreed that the priority was to develop a Blueprint document, which would stand as a comprehensive evidence base on trans health and human rights issues in this region. In addition, there was strong commitment to further ongoing work after this project to develop practical toolkits. These tools will enable trans communities to use the Blueprint to bring about local change, including identifying measurable goals for action by their governments. Participants further emphasised the need for local language translations of the entire or key sections of the Blueprint and any subsequent toolkits.

Participants agreed that the best use of current resources was to develop a Blueprint that covered both Asia and the Pacific. They then planned consultations alongside existing regional and subregional meetings. These were a subregional UNDP South Asia meeting in Nepal and the USAID/UNDP *Being LGBT in Asia* regional dialogue in Bangkok, both in February 2015. A larger group of Pacific trans people was invited to the February 2015 Bangkok consultation.

The February 2015 consultations in Nepal and Thailand focused on identifying information gaps, case examples, quotes, and potential areas for action. Workshop participants also provided contact details for health professionals who could provide quotes or comments. The Blueprint authors circulated draft chapters of the report for comment in December 2014, and then circulated the first full draft in March 2015. Sixty-six individuals and organisations submitted feedback, including an expert medical review from providers of trans health in the region. The authors circulated the final draft in June 2015 to the core partners, including WHO, HPP, USAID, UNDP, and APTN, and it was endorsed for publication.

1.6 Intersex People and Gender Dysphoria

The focus of the Blueprint is on the health needs of trans people. However, some intersex people may not identify with the sex they were assigned to and raised as, and may experience gender dysphoria. Amongst this group, some are likely to seek medical interventions to address this gender dysphoria. The WPATH SOC7 include a short section on their applicability to intersex people in those circumstances.

Health professionals assisting intersex clients who experience gender dysphoria need to be aware that the medical context in which these clients have grown up is typically very different from that of people without an intersex variation. Intersex people's medical histories may include a great variety of genetic, endocrine, and somatic variations, as well as a range of hormonal, surgical, and other medical treatments. The health consequences of those interventions may include trauma, loss of sexual function and sensation, infertility, and a reliance on hormone replacement. For all of these reasons, many additional issues need to be considered in providing appropriate psychosocial and medical care for intersex clients, regardless of the presence of gender dysphoria.

1.7 Other Health Issues for Intersex People

The statement of the Third International Intersex Forum, held in Malta in December 2013, provides a summary of human rights issues faced by people with intersex variations. The Forum included participants from Asia, Australia, and New Zealand.⁵

In this region, some of the issues raised by the Intersex Forum were addressed by the Australian Senate Committee's report on involuntary or coerced sterilisation of intersex people. For example, the Senate Committee recommended that "all medical treatment of intersex people take place under guidelines that ensure treatment is managed by multidisciplinary teams within a human rights framework. The guidelines should favour deferral of normalising treatment until the person can give fully informed consent, and seek to minimise surgical intervention on infants undertaken for primarily psychosocial reasons."

5. Public statement by the Third International Intersex Forum, Malta, 1 December 2013. Available at: <https://oii.org.au/24241/public-statement-by-the-third-international-intersex-forum/>.

Further consideration of health and other human rights issues for intersex people is beyond the scope of what can be covered in this Blueprint. However, some of the Blueprint material also may be relevant to people with intersex variations. In particular, the Blueprint documents how international human rights bodies are increasingly speaking out against coerced sterilisations of trans people. At the same time, those statements condemn forced sterilisations of intersex people (Méndez, 2013). It is hoped that this Blueprint can inform future research in Asia and the Pacific focused on the needs and aspirations of intersex people.



HUMAN RIGHTS

2.1 Introduction

This chapter of the Blueprint briefly summarises the international human rights standards that are binding on countries in Asia and the Pacific, and how these apply to trans people. It also profiles work being done by national human rights institutions (NHRIs) to promote and protect the rights of gender and sexual minorities, working in partnership with trans civil society groups.

As the Global Commission on HIV and the Law has identified in the context of HIV, effective, sustainable solutions for trans people must address both the right to the highest attainable standard of health and other human rights violations that trans people experience (Global Commission on HIV and the Law, 2012).

All human beings are born free and equal in dignity and rights ... (Article 1)

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind ... (Article 2)

—Universal Declaration of Human Rights

2.2 Commitments under International Human Rights Law

The Universal Declaration of Human Rights (UDHR), adopted by the United Nations (UN) General Assembly in 1948, is the foundation of international human rights law. It was conceived as a common standard of achievement for all peoples and all nations.

Most of the rights already enshrined in the UDHR are set out in the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. States that have ratified these covenants are bound by their human rights obligations. They include everyday rights, such as the right to life, privacy, equality before the law, and the rights to work and education, as well as the right to the highest attainable standard of health. The UDHR and the two covenants collectively are referred to as the International Bill of Human Rights.

Over time, further international human rights treaties have been developed, focusing on specific issues or population groups. In Asia and the Pacific, there is wide variation in the extent to which countries have ratified these human rights treaties. More recent treaties—for example, those that focus on the rights of women and children—have very high levels of ratification in this region.

In November 2006, an international panel of human rights experts met in Indonesia and developed the Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity (International Commission of Jurists, 2007).⁶ These Yogyakarta Principles provide clear recommendations for applying existing international human rights standards to the barriers faced by trans people.

2.3 Monitoring Countries' Compliance with these Human Rights Obligations

Once states ratify a UN convention or treaty, they are required to periodically report on how they are meeting these obligations. Increasingly, the UN committees monitoring countries' compliance with these treaties have focused on how they apply to trans people, including children and youth.

6. The definition of gender identity in the Yogyakarta Principles is broad and also encompasses gender expression.

Other UN mechanisms also have played a growing role in drawing attention to the human rights violations faced by trans people. The Universal Periodic Review (UPR) introduced in 2006 requires each UN member state to review its full human rights record and respond to recommendations from other countries about ways to better meet its human rights obligations. UN Special Rapporteurs have developed expert reports on issues pertinent to the rights of trans people. These have included highlighting that forced or coerced sterilisation, as a requirement for gender recognition, violates the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (Karsay, 2014).

In this and other regions, countries do not always meet their obligations to report to treaty bodies. Those that do report seldom address human rights issues for trans people. The UPR process has been utilised by some sexual orientation and gender identity (SOGI) activists in Asia and the Pacific, partly because all countries are required to respond to recommendations made by other countries. However, the effectiveness of the UPR process depends on other countries being aware of the human rights situation of trans people in the country under review and prioritising those issues in its recommendations.

To date, it has been even harder to get such engagement around human rights issues related to gender identity or expression issues than on sexual orientation ones. Trans advocates and groups in this region require resources to be able to monitor human rights violations and raise them using domestic, regional, and international human rights mechanisms (Karsay, 2014).

One exception is the comprehensive UPR recommendations to **Nepal** in 2011, calling for full implementation of the 2007 and 2008 Nepal Supreme Court decisions recognising the citizenship rights of sexual and gender minorities. Nepal accepted all of these recommendations and finally started to implement some of the Supreme Court rulings about third-gender options in 2013 and 2014.⁷ In 2013, **Tonga** accepted a recommendation that it examine the possibility of strengthening measures to eliminate all discriminatory treatment related to gender identity or sexual orientation.⁸

In some instances, repeated attention by UN mechanisms has been needed to maintain pressure on governments to amend domestic laws. After his mission to **Mongolia** in 2012, the Special Rapporteur on extreme poverty and human rights noted that a high proportion of trans people and other members of the lesbian, gay, bisexual, and trans (LGBT) community lived in poverty due to difficulties in finding employment or receiving an education. He urged the government to implement the 2010 UPR recommendations to address discrimination and attacks based on a person's gender identity or sexual orientation, and protect the rights of LGBT people (Carmona, 2013). In the previous year, the UN Committee Against Torture and the Human Rights Committee both had urged Mongolia to take urgent measures to investigate and address hate crimes against people because of their gender identity or sexual orientation. Progress remains slow. In 2012, the National Human Rights Commission of Mongolia for the first time included a chapter on LGBT rights in its annual report. Reportedly, this action played a role in Parliament's Standing Committee on Legal Affairs adopting Resolution No. 13, urging the government to implement the UPR and Committee Against Torture recommendations (UNDP and USAID, 2014d). As Section 3.3.7 notes, legal protection against hate crimes, violence, and discrimination is now being considered in Mongolia.

2.4 Regional Commitments

In 2012, various human rights and LGBT groups in the Association of Southeast Asian Nations (ASEAN) countries made unsuccessful attempts to include gender identity, gender expression, and sexual orientation in the non-discrimination clause in the ASEAN Human Rights Declaration. Other unsuccessful demands included requiring national laws and policies to be harmonised with the Yogyakarta Principles (CCHR, 2012).

These proposals were opposed by some ASEAN member states, which, for example, cited cultural sensitivity. The final Human Rights Declaration was heavily criticised by governments and civil society organisations. The International

7. A/HRC/17/5. Analysis available at: <http://arc-international.net/global-advocacy/universal-periodic-review/n/nepal>.

8. A/HRC/23/4.

Commission of Jurists described the declaration as “fatally flawed” because it challenged the principle of universality of human rights by allowing broad limitations on rights and making them subject to regional and national contexts.⁹

The ASEAN Sexual Orientation, Gender Identity and Expression (SOGIE) Caucus, comprising many LGBT groups in ASEAN member states, continues to call for these states to recognise lesbian, gay, bisexual, trans, intersex, and queer (LGBTIQ) rights as human rights.¹⁰ These calls were reiterated by the ASEAN Civil Society Conference/ASEAN People’s Forum in March 2014.¹¹

Member states at the UN Economic and Social Commission for Asia and the Pacific (ESCAP) have adopted two resolutions on HIV.¹² The second of these, in 2011, noted for the first time that trans people were one of the key affected populations that experienced continuing barriers limiting their access to HIV prevention, treatment, care, and support. In June 2011, the UN General Assembly adopted the *Political Declaration on HIV/AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*.¹³ In this region, the “ESCAP Roadmap to 2015” calls for greater regional cooperation to accelerate progress towards meeting these global commitments in partnership with civil society and key populations, including trans people.¹⁴

2.5 Role of National Human Rights Institutions

The Asia Pacific Forum (APF) is the regional body for NHRIs. In December 2010, the APF’s Advisory Council of Jurists published an in-depth study assessing domestic laws and policies affecting gender and sexual minorities across each of 17 countries in which the APF had members at that time. The report outlined inconsistencies with international human rights standards and made recommendations (Advisory Council of Jurists, 2010). These recommendations provide a framework for NHRIs in the region to promote and protect the rights of trans people and sexual minorities.

In 2013, APF published a regional report on the capacity of eight NHRIs to address human rights in relation to sexual orientation and gender identity (UNDP and IDLO, 2013). This research report focused on **Bangladesh, India, Nepal, Pakistan, Indonesia, Sri Lanka, the Philippines, and Timor Leste**. It found that there have been a growing number of initiatives from NHRIs in these South and Southeast Asian countries, including the following work done specifically with trans, *hijra*, and *meti* communities:

- In 2012, the National Human Rights Commission (NHRC) **Nepal** responded to a request from the Blue Diamond Society (BDS) by writing to the Nepal Electoral Commission, noting the security issues trans people experienced in gender-segregated voting queues. It called for a safe and secure environment for trans voters. The NHRC Nepal also resolved to amend its complaints form to stipulate “other” gender as well as “male” and “female.” The BDS nominated a community representative, who joined the NHRC Nepal as an intern.
- In 2010, the **Indonesian** NHRC, Komnas HAM, partnered with the Forum for Transgender Communications of Indonesia (FKWI) to facilitate a human rights training. From this training, one trans participant was chosen to become an Ambassador for Transgender Human Rights. Komnas HAM also successfully advocated for a trans man charged with fraud because he lived and married as a man despite having a female identification card (see case study in Section 3.3.3).
- In 2012, the NHRC **Bangladesh** submitted a report for the 16th UPR session, stating “it is now time to ensure that all groups, including those who are transgender, intersex or sexual minority, are protected from discrimination.”¹⁵

9. Available at: <http://www.icj.org/icj-condemns-fatally-flawed-asean-human-rights-declaration>.

10. Available at: <https://aseansogie.wordpress.com/page/2/>.

11. Available at: http://iglhrc.org/sites/iglhrc.org/files/acsc_apf__2014_Statment_FINAL.pdf.

12. UNESCAP Resolution 67/9 on Asia-Pacific regional review of the progress achieved in realising the Declaration of Commitment on HIV/AIDS.

13. United Nations General Assembly (2011) *Political declaration on HIV/AIDS: intensifying our efforts to eliminate HIV/AIDS*, June 2011.

14. ESCAP Roadmap to 2015 (2012).

15. Stakeholder Report Universal Periodic Review – 2nd Cycle, National Human Rights Commission, Bangladesh, October 2012; available at: http://lib.ohchr.org/HRBodies/UPR/Documents/Session16/BD/NHRC_UPR_BGD_S16_2013_NationalHumanRightsCommission_E.pdf.

PRIORITIES FOR NHRIS' WORK WITH TRANS PEOPLE IN THIS REGION

APF's 2013 regional assessment noted that trans communities themselves still have limited understanding of NHRIs' processes and capacity to take on SOGI-related issues. It stressed the importance of NHRIs maintaining momentum, particularly in the following four priority areas:

1. Building institutional capacity and sensitising NHRI staff, including by creating opportunities for them to interact with trans people
2. Continuing to engage, liaise with, and partner with trans groups, and embed these relationships so they are not dependent on personal ties or linked to specific leaders
3. Using their convening and advocacy powers—for example, by advocating for trans rights with other state bodies, particularly the police
4. Increasing human rights education for trans communities, the broader community, and the media

Other NHRIs in the region have focused on trans human rights issues. In 2006 and 2007, the **New Zealand** Human Rights Commission held a Transgender Inquiry looking at access to health, discrimination and legal gender recognition (New Zealand Human Rights Commission, 2008). It subsequently undertook a public education programme and advised government agencies on ways to implement many of the Inquiry's recommendations. In 2009, the Australian Human Rights Commission published the final report of its project on legal recognition of sex in documents and government records (Australian Human Rights Commission, 2009). Outstanding legal gender recognition concerns are listed as recommendations in the Commission's June 2015 report from its national consultation on SOGII rights (Australian Human Rights Commission, 2015). Other recommendations focus on access to health services (including hormone treatment for youth under the age of 18), and safety and health issues for trans people in detention.

In February 2015, a major regional workshop involving representatives from NHRIs and civil society groups was held in Bangkok, Thailand. It concluded with a call for greater efforts to advance the rights of LGBTI people in Asia and the Pacific. These efforts were set out in a "*Programme of Action and Support—the role of NHRIs in promoting and protecting human rights in relation to sexual orientation and gender identity, including health in Asia and the Pacific*" (APF, APCOM, and UNDP, 2015). This *Programme of Action and Support* sets out a wide range of practical steps for NHRIs to bolster their work in the following areas:

- *Capacity building*, including establishing focal points on sexual orientation and gender identity within their organisations and developing clear work plans for them
- *Research*, including documenting discrimination and human rights violations against LGBTI people, and reviewing existing and proposed laws against international standards
- *Education*, promotion, and dialogue, including initiatives involving LGBTI communities, government agencies, law enforcement officers, the judiciary, and faith leaders
- *Monitoring*, by including a focus on LGBTI people in activities to monitor access to justice, health, housing, and education, as well as monitoring places of detention
- *Advocacy*, including for changes to national laws to conform with international standards and changes to government policies and community attitudes

Some NHRIs attending the *Being LGBT in Asia* regional dialogue in February 2015 used this as an opportunity to confirm their commitment to trans human rights issues (UNDP, 2015). Komnas HAM from **Indonesia** noted it has trained police, law enforcement officials and religious leaders to recognise the Yogyakarta principles as the platform for addressing LGBTI issues. The Commission on Human Rights of **the Philippines** reiterated its support for a national anti-discrimination bill to address LGBTI issues. In addition, the Commission stated it would be supportive of a case under the women's equality law (known as the Magna Carta of Women) to clarify whether trans women are able to change sex details on their birth certificates. This has been identified as a potential alternative legal avenue after a Supreme Court decision that trans people cannot amend such details.

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**PRIORITY HUMAN
RIGHTS ISSUES
FOR TRANS
PEOPLE IN THIS
REGION**

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3.1 Introduction

The health information in the Blueprint must be understood within the context of the day-to-day lives of trans people in this region. For many, this involves significant levels of violence, stigma, and discrimination, and other violations of their physical and mental integrity and human rights.

In both Asia and the Pacific, trans people and men who have sex with men (MSM) have critiqued a predominantly biomedical approach to HIV programming for failing to look at underlying causes, such as unequal social structures, inadequate legal frameworks, and violence (Moala, 2014; Winter, 2012).

Stigma and discrimination typically mean that trans and other gender or sexual minorities are at high risk of poverty within their communities (Elias and Lee, 2012; Carmona, 2013). Even within more affluent countries in Asia and the Pacific, relative poverty still affects many trans people living in them, including those who have migrated to major cities seeking work. Having enough food and finding shelter thus become the highest priorities for many trans people.

As the Blueprint was being completed, WPATH was finalising a Declaration of Gender Rights to be issued in conjunction with the World Association for Sexual Health (WAS). This Declaration addresses an extensive range of human rights including, but limited to equality and non-discrimination, free expression of gender, and freedom from psychopathologising diagnoses. The full text of the Declaration of Gender Rights soon will be available on both the WPATH (<http://www.wpath.org/>) and WAS (<http://www.worldsexology.org/>) web sites.

The Global Commission on HIV and the Law has highlighted that the right to the highest attainable standard of health must be coupled with attention to other human rights violations. It recommended that countries do the following:

- Amend national anti-discrimination laws to explicitly prohibit discrimination based on gender identity (as well as sexual orientation)
- Ensure that transgender people are able to have their affirmed gender recognised in identification documents without the need for prior medical procedures such as sterilisation, gender-affirming surgery, or hormonal therapy
- Repeal all laws that punish cross-dressing¹⁶
- Remove legal, regulatory, or administrative barriers to the formation of community organisations by or for transgender people (Global Commission on HIV and the Law, 2012)

This chapter of the Blueprint is organised around the priority human rights issues that have emerged through APTN's consultations with its members (Asia Pacific Transgender Network, 2015) and previous regional reports (WHO 2014a; APCOM/APTN, 2013; Winter, 2012; WHO, 2013a, 2013b; WHO WPRO, 2012). These are as follows:

- Freedom from violence
- Freedom from stigma and discrimination
- The right to the highest attainable standard of healthcare
- Legal gender recognition and other progressive laws and policies

It identifies barriers and provides examples of how effective solutions can be developed in partnership with trans communities. These human rights priorities are intersecting. For example, gender recognition laws not only provide legal protection but can be essential in order to reduce violence and discrimination against trans people and to ensure their access to health, education, employment and other services.

16. Although these are frequently referred to as cross-dressing laws, they can also be framed as provisions against female impersonation.

3.2 Violence

This section highlights the level of gender-based violence (GBV) against trans people, including their vulnerability in places of detention. It also identifies significant information gaps, such as levels of intimate partner violence, particularly against trans men.

3.2.1 Gender-based violence

Trans people who are gender-nonconforming or whose trans identity is more visible to others may be particularly vulnerable to violence because they challenge binary gender norms or do not conform to gender role stereotypes. Violence against trans people because of their gender identity or gender expression is a form of GBV (Betron and Gonzalez-Figueroa, 2009).

DEFINING GENDER-BASED VIOLENCE

In the broadest terms, “gender-based violence” is violence that is directed at an individual based on their biological sex, gender identity, or perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life (Khan, 2011).

GBV is a fundamental human rights violation and a serious public health concern that primarily affects women and girls, but can be directed against anyone who violates sex or gender norms. Rooted in gender inequalities and power imbalances between men and women, an estimated one in three women is affected by violence in her lifetime. This vulnerability also extends to trans women, *hijras*, and *metis*, who are punished for violating gender norms (WHO, 2014a; WHO, 2013a; Tamang, 2003).

Social norms that emphasise dominant notions of masculinity pressure men and boys into ways of behaviour that are both the cause and consequence of GBV. These “masculinities” are equally harmful to those who do not conform to them, and a root cause of transphobia and homophobia.

In some parts of the region, trans boys who grow up socialised as girls may have had less access to public spaces as a child. In these circumstances, the violence they face because of their gender nonconformity is more likely to occur at home, at the hands of family members. There are reports that trans men in Asia are at risk of forced marriage and sexual violence, including being raped because of their gender identity. Australian research, discussed in Section 3.2.2, found that trans men had experienced high levels of intimate partner violence (Pitts et al., 2006). Violence also is often directed at lesbians and other women for stepping outside of the gender roles assigned to them at birth (International Gay and Lesbian Human Rights Commission, 2010, 2014).

Some governments in Asia have started to include trans people—predominantly trans women—in programmes to address GBV. For example, the Ministry of Women’s Affairs in **Cambodia** has recently involved trans women in its draft National Plan of Action for Prevention of Violence against Women (UNDP and USAID, 2014a). In Maharashtra state in **India**, the Women and Child Policy includes a separate chapter on transgender issues.¹⁷

3.2.2 Regional data on violence against trans people

Around the world, trans-specific data on murder and other forms of violence are rarely collected by national authorities, including their law enforcement agencies. Many cases are not investigated properly by the authorities, and their visibility is dependent upon monitoring by trans organisations themselves.

17. Available at: <http://indianexpress.com/article/cities/mumbai/state-to-begin-drive-to-register-transgender-voters-soon/>.

This is also the case in Asia and the Pacific. In addition, there are many factors likely to reduce the likelihood that such violence is reported to authorities in the first place. These include the high levels of stigma attached to being trans or gender diverse; the criminalisation of gender identity or expression through laws prohibiting cross-dressing; the absence of anti-discrimination protections; and inaction or violence from state actors, including police.

Frequently there is limited or no means of redress for acts of violence. Trans people face multiple barriers, including few sympathetic lawyers, lack of money, hostile media, and state impunity. In many countries, there are no community-based organisations with resources to track such violence or offer support to those who have been attacked. Despite all of these constraints, all countries have human rights obligations to protect every individual against violence or bodily harm. This includes a role for health workers, who are well placed to document the effects of such violence.

3.2.2.1 Killings of trans people

The global Trans Murder Monitoring (TMM) project is a trans-led initiative developed to systematically monitor, collect, and analyse reported killings of trans people. The details of many of these murders indicate high levels of hatred towards trans people because of their gender identity or expression. The TMM project has noted particularly high degrees of violence in individual cases reported from Asia (Balzer and Hutta, 2012).

The TMM project acknowledges that these data represent just a fraction of the trans people killed around the world. In most countries, such data are not systematically produced, and it is impossible to estimate the numbers of unreported cases.

Between January 2008 and December 2014, the TMM project identified 1,731 killings of trans people in 62 countries.¹⁸ These included 155 murders across 16 countries in Asia and a further two in the Pacific.¹⁹ In Asia, the highest numbers of murders recorded since January 2008 were in India (48), the Philippines (35), Pakistan (22), and Thailand (14).

When compared to a country's total population, the per capita rate of reported killings is particularly high in **the Philippines**.²⁰ In part, this is likely to be because trans and LGBT organisations monitor these murders.²¹ In 2013, the Commission on Human Rights of the Philippines signed a Memorandum of Understanding with the LGBT community, which includes a commitment to address killings or hate crimes committed against people because of diverse gender identities or sexual orientations. In the wake of the high-profile killing of trans woman Jennifer Laude on 11 October 2014, some politicians in the Philippines have supported trans community calls to pass a long overdue anti-discrimination bill. There has also been a wider community debate about whether harsher punishments for hate crimes would be effective in reducing the levels of murder and other forms of violence against trans women (Tan, 2014).

3.2.2.2 Other forms of violence

All forms of physical, sexual, and emotional violence create a climate of fear for many trans people. Studies in Asia have documented rape and physical abuse of trans women, including those selling sex (Jenkins, 2006; Khan et al., 2008; FHI 360, 2013).

In the Pacific, a 2011 community-based study highlighted lack of safety for trans women in **Fiji**. Trans women were targeted for abuse; 40 percent had previously been forced to have sex against their will. This research recommended training for healthcare workers on transphobia, homophobia, and GBV, and the need for mental health and support services for trans women (Bavinton et al., 2011).

18. 8 May 2015 Update for IDAHOT 2015, available at: www.transrespect-transphobia.org/en_US/tvt-project/tmm-results/idahot-2015.htm.

19. In addition, there were two recorded killings in Australia and one in New Zealand over this period.

20. In this region, this per capita rate is also high in New Zealand, but is based on just one reported killing.

21. This monitoring is done by the Philippines LGBT Hate Crime Watch and the trans organisation Society of Transsexual Women of the Philippines (STRAP).

In **Bangladesh**, a 2006–2007 survey found that 28 percent of *hijra* and trans women reported having been raped or beaten in the previous year (Ministry of Health and Family Welfare of Bangladesh, 2009). In Pattaya, **Thailand**, 89 percent of trans women reported experiencing violence as a result of their gender identity and/or behaviour (Policy Research and Development Institute Foundation, 2008).

Similarly, the 2014 *Being LGBT in Asia* country reports document the high levels of sexual and physical violence against trans women. The following is just one example, from **Mongolia**.

In 2009, trans girls who go by the names “E,” “Kh,” and “B” were kidnapped ... and brought to ... a graveyard, where they were severely physically and sexually assaulted. They were tortured, forced to suck the sexual organs of the youth and one another’s [and] raped by cramming a bag of rocks into the sexual organ of one of the girls. Because of their interview in the documentary “Lies of Freedom” by the LGBT Centre, they became subject to death threats, and eventually E and Kh fled Mongolia with the assistance of the LGBT Centre (LGBT Centre, 2012, cited in UNDP, 2014d).²²

The following case example describes the cumulative impacts of violence and discrimination for a trans woman in **Papua New Guinea**.

CASE EXAMPLE: IMPACTS OF VIOLENCE AND DISCRIMINATION IN PAPUA NEW GUINEA

Sharon Stone was a *palopa* (trans woman) in Papua New Guinea. She was smart, finished year 12 at secondary school and got a place to study at the University of Papua New Guinea. However, because of her identity, her family did not support her in continuing her education. Sharon was 20 at that time and ended up on the street doing sex work and drag shows at night clubs.

Sharon cared about her family. When she earned money, she always bought food for the house and fed the entire family.

One night, after doing a drag show, Sharon was trying to get home in a taxi. She gave the taxi driver directions, then fell asleep because she was drunk and tired from working. She did not realise where the taxi driver was taking her. Sharon woke up when five men dragged her out of the cab, and started bashing her and raping her. They dumped her in the bush, covered in her own blood.

Sharon was found by two women who brought her to the hospital. However, she felt judged and discriminated against by other clients and healthcare workers there because of her gender identity. So Sharon got up from her seat in the hospital waiting room without getting any treatment and left for home. She treated herself at home with antibiotics.

Three months later, Sharon came to the Poro Sapot community clinic for an HIV test and it was positive. When she found out she cried and cried. Sharon was scared to tell her family so she moved out of her home and stayed with sex workers on the streets. She was approached by peer educators from Poro Sapot to come for antiretroviral therapy (ART) but she felt that she “had had enough.” Sharon declined ART and eventually died after contracting tuberculosis (TB). When Sharon died, her body was not claimed by relatives.

Source: Obert Samba (Elizabeth Taylor), Coordinator, Poro Sapot clinic.

Data about bullying of trans children and youth at school are analysed in Section 3.3.4 of this Blueprint, in the discussion about discrimination and its impact on the right to education. The impact of such bullying and harassment on mental health outcomes is discussed in Section 3.4.7.1.

There are no quantitative data in Asia or the Pacific on violence against trans men. It is likely that some trans men who experience sexual violence are incorrectly recorded as women. Interviews with trans men in **Malaysia, the Philippines,**

22. E’s personal account of her experiences, including other sexual and physical violence from family members, neighbours, and the police, is on the Transgender ASIA website, available at: www.transgenderasia.org/enkhriimaa-story.pdf.

Sri Lanka, Pakistan, and Japan identified that they faced high levels of violence and abuse from family members, including “corrective rape” and forced marriage. This abuse occurs in private and is unreported (International Gay and Lesbian Human Rights Commission, 2014).

In a 2009 survey of 900 lesbian and bisexual women in **China**, almost half reported violence and abuse from parents and relatives, including involuntary committal to psychiatric wards (Common Language, 2009). Anecdotal evidence suggests that this is a significant issue for trans boys and young men in China as well.

A 2007 Australian LGBTI health study reported high levels of intimate partner violence, particularly against trans men. Overall, 33 percent of LGBTI participants reported being in a relationship in which their partner had abused them. The rates were highest for trans men, with 62 percent of the 34 trans men surveyed reporting experience of abuse from a partner. In particular, this abuse involved physical assault and injury, insult, and isolation. Of the 100 trans women surveyed, 36 percent had experienced such intimate partner violence (Pitts et al., 2006).

There is a need for specific research on how GBV affects trans people, particularly men and gender-nonconforming people who were assigned female at birth.

3.2.3 Trans people in detention

The UN Special Rapporteur on torture has raised concerns that trans people are one of the groups at the bottom of the prison hierarchy, and that trans women detained within the general prison population are at risk of physical and sexual abuse (Office of the High Commissioner for Human Rights, 2011).

Trans women are likely to be over-represented within the prison population in those countries within the region that criminalise sex work or cross-dressing, or use public nuisance and vagrancy laws to harass trans women. The following example from a 2014 report illustrates the links between such laws and grave violence against trans women detained in male lockups or prison cells in **Malaysia** (Human Rights Watch, 2014).

CASE EXAMPLE: FOR POLICYMAKERS—GENDER-BASED VIOLENCE IN PRISON

In 2000, Nisha Ayub was sentenced to three months of imprisonment after being arrested under the Malaysian state of Malacca’s cross-dressing law. At the prison, she was subjected to an anal exam by the warden, told to strip naked, and paraded from one cell to another so other inmates could look at her breasts.

The next morning, Nisha was attacked by six or seven inmates in the breakfast queue, who forced her to perform oral sex on them. Nisha came from a conservative family; this was her first sexual experience.

I was molested by six or seven inmates. They actually forced me to do oral sex with them, and it was done openly ... And from there, I took the advice from [an] elderly trans woman [in prison] to get someone to protect me. I met a warden who basically protected me and in return, I had to give him sexual favours. It’s not something that I’m proud to talk about. But it’s something that I had to do, just to protect myself.

Source: Human Rights Watch, 2014.

Incarceration must not undermine a trans person’s ability to live in accordance with their gender identity. This is necessary to safeguard trans people’s mental health and well-being in prison, as well as their broader human rights. As a result of human rights complaints in other regions, risk assessment models within some places of detention are putting greater focus on respect for trans people’s gender identity and personal autonomy, along with their right to safety. These principles have been applied to decisions about where a trans person is housed; whether they are searched by a male or female officer; and applicable prison uniform codes, including use of binders, prosthetics, and makeup (United Kingdom Immigration and Border Policy Directorate, 2015).

In recent years, the human rights of trans people in prison have been raised by civil society groups, including those of **Hong Kong SAR, China and New Zealand**, using UN mechanisms (UNDP, 2013; Aotearoa/New Zealand’s SOGII UPR Coalition, 2014). In New Zealand, some aspects of the UK policies have been applied to decisions about whether trans

people are detained in male or female prisons.²³ Section 3.4.8.7 of the Blueprint looks at access to gender-affirming health services for trans people in prisons, including WPATH's guidance that these medically necessary treatments should not be denied to trans people detained in prison or a long-term health facility (Coleman et al., 2011).

3.3 Discrimination

3.3.1 Introduction

The stigma attached to gender diversity and nonconformity has a significantly negative impact on trans people's

"Transphobia is a health risk."

—J.V.R. Prasad Rao, 2012

UN Secretary-General's Special Envoy for AIDS in Asia and in the Pacific

Source: APCOM/APTN, 2013.

lives. In Asia and the Pacific, the model of a "stigma-sickness slope" has been used to describe how stigma leads to discrimination, violence, and abuse, which push many trans people to the margins of society (Winter, 2012). This increases trans people's involvement in risky situations and reduces their physical and emotional well-being. In other words, stigma leads to the compounding impacts of social, economic and legal marginalisation and results in worse health outcomes (Winter, 2012). This includes internalised stigma, when trans people have a very low sense of their own value and worth (WHO, 2014a).

Similarly, the Minority Stress Model describes how stigma affects minority groups (Brooks, 1981; Meyer, 2003). Minorities experience constant stress from being in a hostile environment in which their behaviour, values, appearance, and actions are different from the dominant majority. For trans people, this means that transphobia, stigma (including self-stigma), isolation, and secrecy are likely to cause chronic stress. Often this has very negative impacts on trans people's health outcomes (Coleman et al., 2011).

Stigma and discrimination frequently are based on ignorance, stereotypes, and lack of familiarity with trans people. As Section 3.4.2 notes, the classification of gender diversity as a mental illness contributes to the stigma experienced by trans people.

It is hoped that this Blueprint will start to fill some of these knowledge gaps and promote dialogue between trans people and their families and communities, health professionals and their professional bodies, government officials, and others wanting to address inequality and discrimination.

3.3.2 Visibility and invisibility

This region has some of the most visible trans populations in the world. In **Thailand**, the visibility of trans women in the entertainment and hospitality industry is often misconstrued as equality. Instead, such acceptance is frequently constrained, with limited protections against prejudice and institutionalised discrimination (UNDP and USAID, 2014e).

As noted in Section 3.2, visibility can also bring heightened vulnerability. Nor does the relative visibility of trans women in the region mean that trans peer support services always exist. In addition, whereas trans women may be visible as individuals, their wider family and community responsibilities may go unnoticed. After flooding in the Sunsari district in eastern **Nepal**, trans women reportedly were not given disaster relief food supplies because they did

23. Department of Corrections Prison Operations Manual, *M.03.05 Transgender and Intersex Prisoner*. Available at: www.corrections.govt.nz/resources/Prison-Operations-Manual/Movement/M.03-Specified-gender-and-age-movements/M.03-4.html.

not fit into conventional definitions of families with children (Knight and Welton-Mitchell, 2013). Yet trans people may have their own children, be expected to look after children within their extended family, or have significant responsibilities to each other—for example, within *hijra* communities.

Invisibility affects trans men both before and after transitioning. The absence of local terminology or concepts defining or identifying trans masculine identities means that most trans men have grown up very isolated, not possessing the ability to express why they feel differently from their peers. Such invisibility, coupled with having no one to connect with who shares similar feelings and experiences, can have very significant impacts on a person's ability to develop a coherent sense of their identity (Devor, 2004).

Families and communities may not make distinctions between diverse sexual and gender identities, sometimes because local terms combine the two concepts. For example, in some parts of Asia and the Pacific, the same terms are used to describe anyone assigned female at birth who has a masculine gender expression or gender identity, or who is sexually attracted to other females. In this context, using such a local term or identifying as a lesbian may be part of the transition journey for some trans men. However, conflating these identities means there is very little information in this region about the specific experiences of either lesbians or trans men, or their distinct health needs.

This invisibility becomes self-perpetuating. Education for health professionals on the diversity of gender and sexual identities could play an important role in enabling them to better support trans people and address their health needs. In the absence of a visible trans male community that provides acceptance and safety, it is understandable that many trans men choose to be “stealth,” not disclosing their pre-transition identity. This can pose significant risks of discrimination if their gender identity is (voluntarily or involuntarily) disclosed.

3.3.3 Family and community acceptance

A 2014 **Singapore** online survey conducted by FTM Asia found that 52 percent of people thought society was unable to accept trans people.²⁴

Across Asia and the Pacific, a trans person's identity is based not solely on who they are as an individual but also incorporates their role within an extended family or community. Thus, family acceptance or rejection has a crucial impact on a trans person's health and well-being. A 2012 study about LGBT street children in Ho Chi Minh City, **Viet Nam** described the impact of family rejection, including the psychological stress from lack of family sympathy or support. Those forced to leave their family home typically faced further rejection from shelters and healthcare providers. Depression and loneliness meant that use of psychoactive substances and self-laceration was common (Save the Children, 2012).

The following example conveys how family influence and control over a trans person's life can extend into adulthood for trans people in Asia.

CASE EXAMPLE: FOR POLICYMAKERS—CHARGES OF IDENTITY FRAUD AGAINST A TRANS MAN IN INDONESIA

In 2009–2010, Komnas HAM, the Indonesian National Human Rights Commission, supported a case concerning criminalisation of “HR,” a trans man. HR underwent gender-affirmation surgery in 2006. In 2009 he married a woman, “DH.”

The couple did not get permission from DH's parents before getting married. DH's parents subsequently reported HR to the Jakarta police and he was arrested. As his identity card was female, HR was detained in a female detention center on charges of fake identity, kidnapping, and fraud.

HR and DH lodged a complaint with Komnas HAM, which recommended that he be removed from the female detention center and that the detention be postponed. In response to Komnas HAM's recommendation, HR was eventually moved to a community clinic where he was held in isolation. When HR's matter went to trial, Komnas HAM became an *amicus curiae* and advocated that the state was not authorised to regulate a person's gender. The court confirmed HR's gender status as male.

Source: UNDP and IDLO, 2013.

In Asia, trans people who are still able to perform their family or community responsibilities may be more likely to retain family acceptance (Winter, 2006). Yet this can be a form of constrained acceptance, as noted in the following quote from the Pacific Sexual Diversity Network about the position of trans people and MSM in the **Pacific**.

Support is sometimes conditional and only based on their capacity and willingness to act as entertainers, to organise charity functions or voluntarily engage in other community activities. This kind of support does not recognise ... their own personal needs, desires and concerns, does not value them as whole people, and ignores the fact that they are full human beings who deserve to be treated equally and fairly in their countries (PSDN, 2009).

The absence of family support can have particularly negative implications for older trans people, particularly in many parts of this region, where families provide most aged care support.²⁵ Older trans people may face high levels of isolation and poverty. There have been some community-based initiatives in Asia to support older trans people, including a home set up for *waria* in **Indonesia** (Henschke, 2013). In **India**, a number of community groups have a focus on supporting older trans people. For example, Kinnar Maa has sought government funding and a building to establish an ashram for older *hijra*.²⁶

Religion plays a significant role in many countries across the Pacific and Asia. In consultations for this Blueprint, trans people gave examples of many faith traditions that excluded them from praying with either women or men. In addition, trans women are typically required to dress as men when they pray. Trans people in both Asia and the Pacific highlighted the struggles they faced in trying to be themselves in the face of physical, sexual, and mental violence against them, justified under the guise of religion. In **Malaysia**, Human Rights Watch has reported how raids by state religious departments and religious edicts from the *fatwa* council have eroded the right to bodily autonomy, including for trans people (Human Rights Watch, 2014). In many parts of the region, trans people prioritise the importance of working with faith-based leaders to ensure that trans people also are protected by the universal right to freedom from discrimination.

25. Internationally, there is increasing attention given to the aged care needs of LGB people, particularly to ensure that people in residential care are not forced back into hiding their sexual orientation. There is yet to be the same attention paid to the specific needs of trans people, including privacy and respect for a person's gender identity and bodily diversity.

26. See <http://queer-ink.com/kinnar-maa-samajik-sanstha-trust/>, accessed 30 June 2015.

3.3.4 Education

Discrimination and a failure to respect the gender diversity of trans children and youth undermine their right to education. In the words of the United Nations Committee on the Rights of the Child, “children do not lose their human rights by virtue of passing through the school gates” (United Nations Committee on the Rights of the Child, 2001, para. 8).

This section of the Blueprint focuses primarily on bullying and other forms of violence against trans and gender-nonconforming students. A child or young person who is bullied, abused, or assaulted has rights, regardless of the age of their perpetrator or where the incident occurs. Any failure to treat bullying, abuse, and violence seriously because it occurs between students and within schools is a violation of a child’s human rights.

3.3.4.1 Primary and secondary education

In **Viet Nam**, reportedly 85 percent of trans girls drop out and are not able to graduate from secondary schools because of assaults and bullying (Hoang and Nguyen, 2013). In **Thailand**, research undertaken in 2012/13 found that more than half of students who self-identified as trans or same-sex attracted were bullied in the previous month. Being bullied for these reasons was linked with higher rates of absenteeism, depression, unprotected sex, and suicide attempts (Mahidol University, Plan International and UNESCO, 2014).

A 2012 Save the Children report identified that one of the major challenges faced by trans and LGB youth in **Nepal** is poor mental health due to transphobic or homophobic bullying at school or within their families or communities (Sharma, 2012). A 2014 study in **Australia** found that two-thirds of the 189 trans and gender-diverse young people had experienced verbal abuse in response to their gender presentation or nonconformity, and one-fifth had experienced physical abuse. Physical abuse occurred most often at school, on the street, or on public transport. More than 90 percent of young people who experienced physical abuse had thought about suicide in response to that experience (Smith et al., 2014).

School boards, principals, and teachers reinforce hostile school environments when they support norms that exclude or punish trans students. This includes passively failing to act against the bullying of trans students by peers; asking uncomfortable questions about students’ personal lives; or through belittling, offensive, or threatening language or actions. Such behaviour by students, teachers, or school officials is tacitly endorsed and perpetuated when not punished by authority figures (IGLYO, 2012).

In Asia, school uniform and hairstyle regulations are very different for boys and girls. This strict sex segregation is very hard for trans children and youth, and also for others who are gender-nonconforming. Students who dress or behave differently from these gender norms are routinely punished and denied the right to sit for exams.

Trans students are often not safe in sex-segregated spaces, including using the toilet at school. In 2008, there was significant international publicity when a secondary school in **Thailand** introduced a unisex toilet after a survey showed 200 of the school’s 2,600 students were *kathoey* or transgender. Other *kathoey* students in Thailand have asserted their right to use female toilets (Likhitpreechakul, 2008).²⁷

In May 2012, **the Philippines’** Department of Education issued an order that seeks to protect children from any violence, abuse, or exploitation at school because of their gender identity or sexual orientation. However, there is no monitoring done to see whether this order has been effective. At the same time, some schools in the Philippines still ban trans and gender-nonconforming students from enrolling (UNDP and USAID, 2014f).

Violence and discrimination against trans students leads to lower levels of educational achievement, absenteeism, and early school leaving. This has negative impacts on access to further training and educational opportunities that provide access to a greater range of employment opportunities.

27. This term can also be spelt as *kathoey*.

FOR POLICYMAKERS—HARASSMENT AND VIOLENCE AT SCHOOL

“In school, even as I was a young child, there were many problems and classmates insulted, teased, and threw chalk at me. The teachers did not do anything to stop them, and they did not like how I expressed myself, how I walked and talked. I only finished up to fourth grade.”

—Sheila (pseudonym), trans female, **Cambodia** (Source: UNDP, 2014a).

“I was threatened and beaten up by friends just for expressing my true gender. Over time, it became their habit to bully me, and even our teachers were unable and unwilling to do anything. The boys formed a circle at recess, took off my pants, ‘scanned’ my private parts, and sexually harassed me.”

—L.L., trans woman, Ho Chi Minh City, **Viet Nam** (Source: UNDP, 2014h).

3.3.4.2 Progress within schools

There are also examples of progress in this region. In **Nepal**, the National Youth Policy includes trans youth, and there is a school-level curriculum that includes SOGI issues. The BDS has trained more than 600 teachers on SOGI terms and human rights, including by developing a teacher training manual. It is now calling for the Ministry of Education to include this training as a formal component of mandatory in-service training for teachers.

In **Thailand**, research about transphobic and homophobic bullying in schools is being used for in-service training with secondary education teachers (Mahidol University et al., 2014). In **Fiji**, the SOGI community is talking with the Ministry of Education about adopting anti-discrimination policies for schools that would protect gender-diverse students.

Dechen Selden, a trans woman from **Bhutan**, “came out” very publicly in 2008 when she dropped out of school after being forced to dress in male clothes. After seeing a television interview with Dechen, the Ministry of Education offered its support in allowing her to wear her preferred dress at school. The school also organised a meeting amongst students and staff to stress that people should not discriminate and should be accepting.

A 2014 survey conducted by the Ministry of Education, Culture, Sports, Science, and Technology in **Japan** looked at 13.7 million students enrolled in national, public, private, and special educational institutions across the country. It found that 60 percent of the 606 gender-variant children recognised by schools are receiving some level of support to live as their preferred gender (MEXT, 2014).

Participation in sports has positive effects on children and youth’s self-esteem, inclusion, and physical and mental health. However, trans youth are often excluded from sex-segregated sports teams. They are seldom able to play on teams based on their gender identity or wear a uniform that matches their gender expression. As a result of its inquiry into discrimination experienced by trans people, the **New Zealand** Human Rights Commission produced resources for schools about supporting trans students, including their participation in sports.²⁸ Participants at a 2014 LGBT Law Conference in **Cambodia** developed a draft policy, to be proposed to the government, which would allow more flexibility in school uniform policies (UNDP and USAID, 2014a). In **Australia**, the “Gender is Not a Uniform” campaign advocates for school uniform policies that are inclusive of gender-diverse children.²⁹

3.3.4.3 Tertiary education

There are also gaps in the attainment of higher education. Research in **Cambodia** shows that only 6 percent of trans girls continued their education after secondary school (compared to 11.6 percent of other girls and 23.2 percent of males). Almost a third (30 percent) of trans girls reported that their family pressured them to stop schooling or to start work (Salas and Srorn, 2013).

28. FAQ: Supporting Trans Students, available at: www.hrc.co.nz/files/4014/2378/4858/HRC_A_Trans_SupportStudentV3.pdf.

29. Available at: <http://safeschoolscoalitionvictoria.org.au/ginu/>.

In a number of Asian countries, trans students have been refused entry into educational programmes for appearing at intake interviews wearing clothes matching their gender identity. Others have been barred from classrooms or from sitting exams because of their gender expression. The trans woman quoted below is now a sex worker, after being excluded from nursing training because of her gender expression and gender identity.

My [nursing school] clinical instructor won't allow me to have long hair ... I didn't want to cut my hair and so I gave up the Bachelor of Science in Nursing to be what I am ...

—Trans woman, Manila, **Philippines** (Source: WHO, 2013b).

A number of universities in **Thailand** have granted some flexibility, allowing trans women to wear skirts in class or when graduating.³⁰ However, this is still discretionary. Trans men have also challenged dress codes that force them to wear skirts.

A trans man who was routinely barred from sitting exams because he refused to wear a skirt successfully challenged this ban as a violation of his right to freedom of expression. This complaint was filed with the National Human Rights Commission of Thailand. Students at his university now have the option of applying each semester to wear their uniform of choice during examinations.

3.3.5 Employment and social protection

Internationally, studies of discrimination against trans people typically highlight the prevalence and severity of employment discrimination (Hyde et al., 2014; Grant et al., 2011; NZHRC, 2008; Whittle et al., 2007). When trans people cannot get a job, or they experience discrimination at work because of their gender identity or expression, it has potentially huge impacts on all aspects of their lives.

Across Asia, workplaces typically require citizenship or other official identification documents when hiring employees. This can be an insurmountable barrier for trans people, who do not have an identification document that matches their appearance, even in countries where legal gender recognition exists. Many are still forced to disclose their gender identity because their educational qualifications cannot be updated to their new name and gender marker (UNDP and USAID, 2014a). Incongruent identification heightens the chance of discrimination and is used as a justification for denying trans people access to employment.

A recent International Labour Organisation (ILO) report on employment discrimination in **Thailand** found that “in the private sector, transgender job applicants are often given psychological tests not given to other applicants” and subsequently denied the job. Discrimination continues for those in employment or training as well, with less access to employment opportunities, segregation in stereotypical jobs, and lower job security. In the absence of any dedicated agency to tackle employment discrimination, trans people frequently opt out of mainstream jobs (ILO, 2014).

Recent **Hong Kong SAR, China** research found an unemployment rate of 15 percent amongst a group of 91 trans people. This was more than four times the rate of the general population (Chan, 2013, cited in Winter, 2014). Trans women are regularly identified as particularly vulnerable to discrimination because of their visibility (UNDP, USAID, 2014d, 2014e). Many are unemployed or underemployed, limited to a narrow range of undervalued or stigmatised jobs (UNDP and USAID, 2014g, 2014h). Even in communities where they are largely accepted, such as **Tonga**, many jobs do not allow *leititi* (trans women) to have long hair or wear makeup.

As adults, trans men in this region are frequently “stealth”; that is, they live as men and avoid disclosing their gender identity to anyone. Yet in the absence of legal gender recognition, most will be routinely forced to do so when applying for jobs or travelling as part of a current job. This can be particularly dangerous for trans men working in male-dominated workplaces or industries.

30. Available at: www.pinknews.co.uk/2015/06/10/top-thai-university-changes-uniform-guidelines-to-accommodate-trans-students/.

In **India**, the Maharashtra State Women's Policy for the first time acknowledged trans people and sex workers as vulnerable populations whose needs are to be prioritised by the state through welfare schemes and activities. This was approved by the state cabinet in March 2014. Maharashtra was the first state to set up a board after the April 2014 Supreme Court Judgment.³¹

"Employment for transgender girls? No way ... We have a certain level of knowledge, and people with qualifications should be able to work, but we aren't accepted and our only way of living becomes hustling. So employment [for us] is impossible in Mongolia"

—Lai et al., 2013, cited in UNDP, 2014d.

"It's hard to get a job," said one transgender woman in **Viet Nam**. *"We have to work as [a] sex worker, [do] makeup or sing in funerals"* (Youth Voices Count, 2013).

Trans women who are sex workers are subjected to increased levels of discrimination and violence. They face a double layer of stigma because of who they are and the work they do (Human Rights Watch, 2014). Data from the TMM project show that 65 percent of all trans and gender-diverse people killed since January 2008, whose occupation is known, were sex workers.³² Trans women who are sex workers may face multiple forms of criminalisation. They may be prosecuted under laws prohibiting sex work, "cross-dressing," and homosexuality, despite identifying as women who are having sex with men. Frequently this leaves them with few legal means of redress against such intimidation and violence. Criminalisation also hinders use of condoms, as these can become incriminating evidence of sex work (Poteat et al., 2014). Trans sex workers may be excluded from working in brothels and be dependent on street-based sex work. This can leave them more visible and vulnerable to violence from state and religious police and the public.

Trans sex workers are doubly stigmatised and criminalised in countries where sex work is illegal. Trans sex workers experience a higher degree of intimidation and violence, with almost no legal means of redress (Poteat et al., 2014).

This 2015 report on abuse of trans sex workers in **Singapore** found that criminalisation produced lasting difficulties in healthcare, employment, safety, and financial security (Project X et al., 2015). It also deprived trans sex workers of the protections afforded by licenced brothels. In addition, trans sex workers were subjected to abuse by the police, such as taunting, excessive force during arrests and, in at least one documented case, rape. As it is not possible to change sex details on a Singapore identity card without having genital surgery, many risked being charged under harsher sodomy laws as well.

FOR POLICYMAKERS—IMPACT OF CRIMINALISATION IN SINGAPORE

One young trans woman recalled an incident that she attempted to report to the authorities:

"He was a man in a car, I got in, we drove off, and he said he was police. He said he'd charge me for soliciting. I said, 'If you're police, why are you alone?' He said if I sucked him off, he'd let me go."

The man took a wrench and threatened her, forcing her to engage in oral sex before robbing and leaving her. When she attempted to report the incident to the police—along with his license plate number, but without divulging that he was a client, they said it was his story against hers, and that she was responsible for willingly getting in his car.

As she recalls, "I was so scared that the client would twist and turn the story, and accuse me of soliciting, that I'd have to pay a fine." As a result, she dropped the claim.

Source: Project X et al., 2015.

31. Maharashtra Government – Government Resolution 2013/CR 205 (Part 2)/PR 6.

32. 8 May 2015 Update for IDAHOT 2015, available at:

www.transrespect-transphobia.org/en_US/tvt-project/tmm-results/idahot-2015.htm.

The Singapore report identified that trans sex workers who were unlicensed migrant workers were particularly vulnerable to extortion, as they faced deportation if arrested. Typically, they were also reluctant to be tested for HIV and other STIs, as most clinics were not anonymous and asked for the individual's identity card or passport number.

The harsh criminalisation of prostitution in **China** and **Mongolia** also leaves trans sex workers there vulnerable to discrimination, violence, and HIV transmission (UNDP and USAID, 2014a, 2014d; Peitzmeier et al., 2014).

There is some evidence that, compared to cisgender female sex workers, trans and MSM sex workers may be at higher risk of violence and of being targeted by actions to enforce laws against sex work. A 2009 report analysing the Law on Human Trafficking and Sexual Exploitation in **Cambodia** critiqued its disproportionately negative impact on trans entertainment workers.³³ It found that the arrests of trans women and MSM entertainment workers increased threefold between 2007 and 2008. Over the same period, arrests of cisgender female entertainment workers decreased considerably. More than half (55%) of trans women and MSM who were arrested paid money or gave valuable items to the police to be released. This compared to 34 percent of cisgender female entertainment workers (CACHA et al., 2009). A baseline study of trans women in the sex industry in Phnom Penh also found high levels of violence and abuse, particularly from police (Davis et al., 2014).

In the Pacific, a 2012 survey of 298 sex workers in **Fiji**, including 112 trans women (38%), found little evidence that they had felt coerced or forced into sex work. However, in the preceding 12 months, trans sex workers were significantly more likely than other female sex workers to have been raped by a client, verbally or physically abused by members of the public, blackmailed by a person in authority (typically the police), or to have had clients who refused to pay (Mossman et al., 2014).

There is anecdotal evidence of trans men doing sex work in Asia, but studies are lacking. One study in the United States found that almost a quarter (23.6%) of the 69 trans men who attended the San Francisco City Clinic (which treats sexually transmitted infections) between 2006 and 2009 had received drugs or money for sex, compared to 56 percent of the 223 trans women (Stephens et al., 2011).

3.3.7 Anti-discrimination laws

Few laws in Asia and the Pacific prohibit discrimination on the grounds of gender identity or gender expression. The absence of legal protection leaves trans people vulnerable to extortion and violence—especially those living on the margins of the law as sex workers. As discussed in Sections 3.3.4 and 3.3.5, discrimination in education and employment is commonplace. Trans women are also frequently singled out and barred from public places (UNDP and USAID, 2014a). So it is not surprising that many of the *Being LGBT in Asia* national consultations in 2013/14 prioritised the need for anti-discrimination laws.

In recent years, **the Philippines**, **Malaysia**, **Samoa**, and **Papua New Guinea** have all rejected or ignored UPR recommendations to prohibit gender identity discrimination. However, civil society efforts have been successful at the local level in the **Philippines**. In 2012, the Cebu Rainbow Coalition successfully pushed for the Cebu City Anti-Discrimination Ordinance, which prohibits discrimination based on gender identity or sexual orientation (alongside discrimination faced by other marginalised groups). Subsequently, further local ordinances have been passed in the Philippines. At the *Being LGBT in Asia* regional dialogue in Bangkok in February 2015, the Commission on Human Rights of the Philippines reiterated its ongoing support for a national anti-discrimination bill to address LGBTI issues (UNDP, 2015).

India's proposed Rights of Transgender Persons Bill 2014 is a potentially significant national development.

33. "Entertainment workers" were defined as workers in massage parlours, beer gardens, and karaoke bars who either occasionally or regularly sell sex.

CASE EXAMPLE: INDIA'S RIGHTS OF TRANSGENDER PERSONS BILL

In **India**, the Rights of Transgender Persons Bill 2014 passed a significant initial milestone on 24 April 2015. This private bill was unanimously passed by *Rajya Sabha* (the Upper House). If the Bill passes other stages of the legislative process, it will provide comprehensive human rights protections for trans people in India.

The Bill, as proposed, would apply to trans women and trans men, as well as cultural identities, such as *hijra*. The Bill includes, for example, a right to inclusive education for trans children; anti-discrimination provisions; and special measures in employment, social security, and health. The reported health initiatives are for separate HIV clinics and free "sex reassignment surgery." The Bill's proposed enforcement mechanisms include national and state commissions for transgender persons.

There are further hurdles that this private bill will need to overcome to become law. It has to be passed by *Lok Sabha* (Lower House) as well, where it could be significantly amended. The final step would be obtaining presidential assent.

Source: <http://orinam.net/resources-for/law-and-enforcement/rights-of-transgender-persons-bill-2014/>.

In some countries, it is unclear whether protections against sex or gender discrimination apply to trans people. Such protections are likely to be ineffective unless rights are clearly defined, widely publicised, and enforced.

In other countries, progress is slow. In **Nepal**, the 2007 Supreme Court ruling called for anti-discrimination laws. The Supreme Court reiterated in 2008 that equal rights, identity, and expression must be ensured, regardless of sex at birth. Broader political tensions have meant that the new constitution is yet to be developed, including these anti-discrimination protections (UNDP and USAID, 2014e). The devastating earthquake in April 2015 may result in further delays.³⁴

In 2013, **China** accepted a UPR recommendation to prohibit discrimination based on both gender identity and sexual orientation, stating it considered that such protections already existed.

In **Mongolia**, draft revisions of the Criminal Code were submitted to its Parliament in April 2014. These would provide legal protection for the first time for LGBT people from hate crimes, violence, and discrimination. The following commitments were made by politicians from **Mongolia** and **Bangladesh** at the February 2015 *Being LGBT in Asia* Regional Dialogue in Bangkok.

"In response to the Dialogue I intend to propose a law on equality and anti-discrimination for LGBTI people. I have been discussing this with LGBT community representatives. I am also eager to educate other parliamentarians from Mongolia. We have ignored these issues for too long."

—Member of parliament, **Mongolia**

"I ask other members of parliament, 'How many of you have visited the communities where sex workers and transgender people live? We need to go and stay with them to understand their pain and anguish so we can fight for their cause in an informed way. . . . I have raised the importance of rights for hijra and third gender in the political process, and I will try to introduce an Anti-discrimination Act when I go back to my country."

—Member of parliament, **Bangladesh**

Source: UNDP, 2015.

34. However, the litigation strategy by advocates arising from the Supreme Court decision has led to other progress, such as Nepal's comprehensive review of gender categories on all official documents. This is discussed further in Section 3.5, Legal Gender Recognition.

In the **Pacific**, only **Fiji** has anti-discrimination protections for trans people. In its UPR review in 2012, **Tonga** agreed to a relatively weak recommendation to “examine the possibility of strengthening measures to eliminate discriminatory treatment” based on gender identity or sexual orientation.

Persistent follow-up is required to ensure that recommendations and proposals in this region are implemented in practice.

3.3.8 Other laws and policies

This section of the report gives examples of other laws and policies that can have a disproportionately negative impact on trans people’s lives—conscription, cross-dressing, and public nuisance and vagrancy laws. It ends with a discussion on the opportunities offered by gender-neutral laws.

3.3.8.1 Conscription

Thailand, **Singapore**, and **South Korea** require all males to serve in the military. In **Thailand**, trans women who have undergone any feminising surgery are exempt from military service. Until 2011, the reason stated in the exemption letter was that the trans person had a “permanent mental disorder.” Thailand’s National Human Rights Commission and community organisations petitioned the military to remove this stigmatising label. In September 2011, following a court decision, the Ministry of Defence replaced the wording with “Gender Identity Disorder.” APTN and the Thai Transgender Alliance are developing an up-to-date, standardised manual for trans people regarding military conscription, based on human rights standards. The community welcomed this move. However, as sex details still cannot be changed on identity documents, it remains very hard for trans people to obtain employment in **Thailand** (ILO, 2014).

Conscription applies to any male over the age of 19 in **South Korea**. In a pending case, a trans woman is being investigated for evading military service because, due to family pressures, she now lives as a man. In this climate, a Gender Identity Disorder diagnosis alone, without surgery, does not always guarantee an exemption from conscription. Thus, fear of military service is driving some trans women to undergo early orchiectomies (removal of testicles) to avoid conscription.³⁵

Conscription applies to any male over the age of 18 in **Singapore**. Trans women with M on their National Registration Identity Card are categorised under Category 302, a medical code given to personnel who are “homosexuals, transvestites, paedophiles, etc.” Being grouped with paedophiles is stigmatising for both gay and trans people. In these situations, a trans person is referred for a thorough psychiatric assessment. This involves parents being called in for an interview if the person is under the age of 21.³⁶

Trans men will be called up for military service in **Singapore** once the gender marker on their identification card is changed to male if they are under the age of 40. They are required to undergo the standard medical and psychological clearance together with other national service recruits. Anecdotal evidence suggests that medical officers may suggest exemptions once they are aware of a trans man’s gender identity. In other countries in Asia, trans men are commonly excluded from conscription, as they are not recognised as male.³⁷

3.3.8.2 Female impersonation or cross-dressing laws

In many Pacific countries, colonial administrations introduced “cross-dressing” laws, which sought to prohibit a person from dressing or presenting as the “opposite” of their biological sex. This imported strict European gender roles and distinctions between men and women into **Pacific** cultures (PSDN, 2009).

35. Personal conversation with Seung-hyun Lee, 5 September 2014.

36. This has employment implications for trans people, as they are medically downgraded and put through modified Basic Military Training. On graduation, they are deployed in a vocation which has no security risks, posted to non-sensitive units, and given a security status that restricts their access to classified documents.

37. Trans people are able to serve in both New Zealand and Australian defence forces.

Recently, cross-dressing or female impersonation laws have been successfully challenged in both the Pacific and Asia. In March 2013, **Samoa** repealed Section 58N of the *Crimes Ordinance Act*. On 7 November 2014, the Court of Appeal of **Malaysia** declared that Section 66 of the Syariah Criminal Enactment of Negeri Sembilan State was unconstitutional. This provision had made it unlawful for Muslim trans women to wear women's clothes or present themselves as women, which is punishable by fines and up to six months of imprisonment. In February 2015, the Federal Court gave the state government permission to appeal this ruling. The appeal is limited to arguments about whether Section 66 contravenes the Federal Constitution. The Federal Court will not accept from the state government that the Appellate Court has no jurisdiction over Shariah law.

3.3.8.3 Public Offences

In many parts of Asia, including **Thailand, Singapore, Indonesia, Cambodia, Nepal, Malaysia** and **the Philippines**, public nuisance and vagrancy laws have been used to arbitrarily harass trans women. In some countries, including Malaysia and Indonesia, dedicated religious police are charged with arresting trans people under these laws (Human Rights Watch, 2014). In the past, trans women have been arrested under the vagrancy section of the Philippines Penal Code for walking the streets at night. This section was repealed in 2012. A separate “public scandals” provision has also been used against trans women who held an impromptu beauty contest at a cemetery (Balzer and Dutta, 2012).

In **Cambodia**, the Village and Commune Safety Policy 2011 (VCSP) is frequently used to justify arrests and harassment of trans people and sex workers. This security and public order provision calls on local authorities to eliminate all forms of crime at the village level, with specific reference to illegal offences such as drugs, prostitution, and domestic violence. However, the Cambodian Center for Human Rights has claimed that this policy is used to control the population and round up people pre-emptively, including trans and LGB people sitting in a park, and anyone police presume is a sex worker. Trans people who have been arrested have typically been required to give money or valuables to the police to be released from custody. Concerns about harassment and extortion are heightened because the VCSP is not a formal piece of legislation but rather an executive edict from the Ministry of Interior, with no guidance for law enforcers and the public about its appropriate use (CCHR, 2012; UNDP, 2014a).

In **Nepal**, generic laws such as the Public Offences Act (1970) have been used to harass *metis* and LGB people. In February 2013, Human Rights Watch reported that four trans women were arrested and charged under this “vaguely worded law that can result in up to 25 days in detention and a fine amounting to more than US\$300.” During the previous two months, the BDS reportedly documented dozens of arrests of trans and LGB people, resulting in nearly US\$6,500 paid in bail. Complaints to the police had not been investigated (Human Rights Watch, 2013; UNDP, 2014e).

CASE EXAMPLE: FOR POLICYMAKERS—JUSTICE FOR SISTERS, MALAYSIA

Justice for Sisters (JFS) is a trans-led advocacy volunteer organisation in Malaysia. It was set up in 2010 to investigate allegations of abuse against the trans community by religious authorities in Seremban, Negri Sembilan.

At the early stage, many were confused and wondered who JFS was. A lot of trans communities, when you start using English or fancy words, you automatically create that barrier. So you have to blend in ... I also speak the community dialect. The language gives us a sense of belonging and ownership ... It's also a security measure for us.

JFS challenged the constitutionality of section 66 of Negri Sembilan Shariah law, which criminalises cross-dressing, initially through a case in the Seremban High Court. Trans women were repeatedly being arrested, sometimes four or five times. They would go to court and be sentenced to a male prison.

When you keep pleading guilty, you have criminal records, being repeat offenders, and you're vulnerable ... There's a complete breakdown in terms of access to justice, in terms of self-recognition, in terms of living in dignity—violation of so many rights.

JFS developed a card with practical advice about trans women's rights if they are arrested so as to reduce the pressure they faced to plead guilty.

Most of them ended up pleading guilty because ... they thought who they are and what they are is wrong ... Most of them wanted to settle the case quickly, and the only way to do that was to plead guilty ... There were so many cases where the judges were not neutral. They should be judging the case, not us.

Eventually, in November 2014, JFS won its case. Despite the ruling, arrests for cross-dressing continue, as the Shariah law is still being enforced at a civil level by police. JFS runs workshops with the community about SOGIE and their rights. It has conducted an online and face-to-face survey on abuse and other issues faced by community members.

There have been other positive outcomes from the litigation. The case has brought much attention to trans issues in the country. Other media (in both English and Chinese mainstream media) now use the term "transgender people" and other appropriate language. Community groups and embassies came out in public support. Subsequently, JFS has been invited to colleges and universities in Malaysia to talk about gender. Some universities have introduced trans-friendly policies, such as gender-neutral toilets. More trans women and trans men are becoming active, and there are between 3,000 and 4,000 people in the JFS Facebook group.

Source: Interview with Nisha Ayub.

Parts of the case example were drawn from this Malaysian media interview, available at: www.themalaymailonline.com/malaysia/article/10-things-about-justice-for-sisters-defenders-of-transgenders#sthash.qp1r0Q0T.dpuf.

3.3.9 Gender-neutral, inclusive laws

In contrast to the negative impacts of the laws cited above, gender-neutral laws can potentially extend legal protections to trans people and remove the barriers they experience when it is unclear whether or how sex-specific or gender-specific laws apply to them.

In **Thailand**, the government worked with leaders of the LGBT community in 2013 to draft a civil partnership bill for same-sex couples. However, this bill was stalled after it was introduced into a Parliamentary Committee, partly because the term "same-sex marriage" can exclude trans people from the right to marry. Participants at the *Being LGBT in Asia* national dialogue in Thailand recommended amending the Civil and Commercial Code so that its language is gender neutral and provides all Thai citizens with equal access to protection and opportunities under the law (UNDP and USAID, 2014g). This was the approach **New Zealand** took in its 2013 amendments to the Marriage Act. These amendments clarified that a marriage is between two people, regardless of their sex, sexual orientation, or gender identity.³⁸

38. Marriage (Definition of Marriage) Amendment Act 2013. These provisions also repealed Section 30(2) of the Births, Deaths, Marriages and Relationships Registration Act 1995, which explicitly excluded someone who was married from amending the sex details on their birth certificate.

In Asia, trans people's ability to make complaints about rape and other forms of sexual violence can be limited by laws that narrowly define such crimes as occurring by men against women, or that list specific bodily anatomy that does not include all trans bodies. This means that the sexual assault of many trans people is not criminalised (Youth Voices Count, 2013). In **Nepal**, for example, sexual assault of a trans woman or someone who identifies as a third gender is not defined as rape and is treated as a lesser offence (UNDP and USAID, 2014e). In **Hong Kong SAR, China**, rape laws cover trans women who have had genital surgery and trans men who have not had genital surgery.

In countries where trans people are unable to change their legal sex or gender markers, such as **Viet Nam**, laws criminalising male violence against women do not protect trans women. Gender-neutral sexual violence laws clarify that trans people have the right to such protection, whatever their legal sex or the sex of their attacker. They also provide legal redress for anyone assaulted by a same-sex partner. In 2007, amendments to the definition of rape in **Thailand** extended such protection to trans and LGB people (Sanders, 2011, cited in UNDP, 2014g).

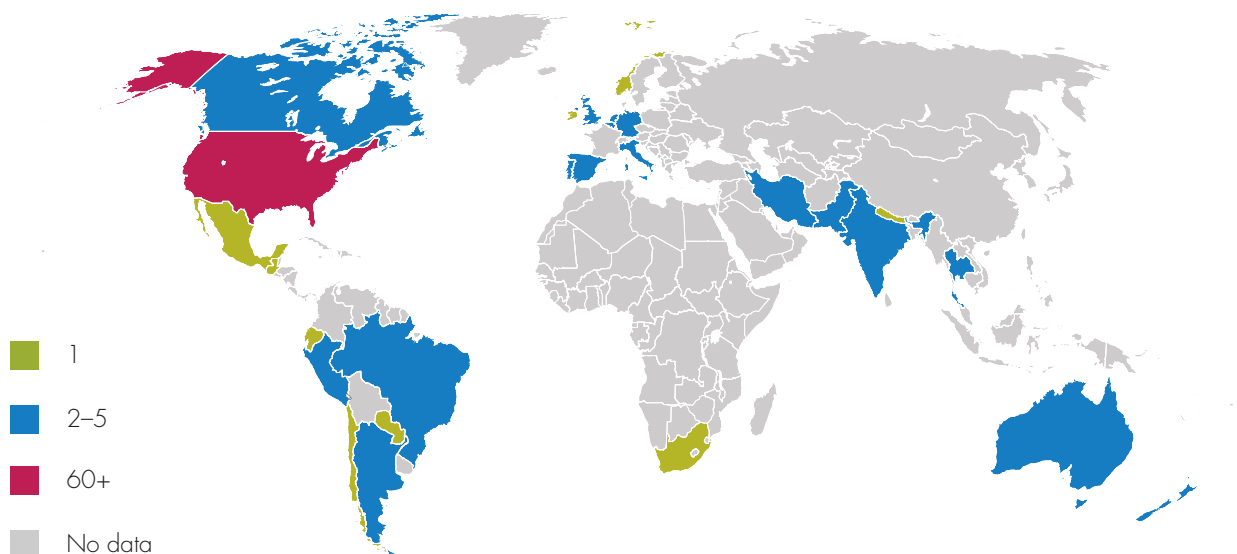
3.4 The Right to Health

Trans people have the same rights as others to the highest attainable standard of health. These obligations are set out in international covenants and conventions, most significantly the International Covenant on Economic Social and Cultural Rights (ICESCR). They are also reflected in the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC), which have been widely ratified in this region. The widely accepted framework for assessing compliance with these obligations focuses on the availability, accessibility, acceptability, and quality of health systems and services (CESCR, 2000) as well as ensuring respect and adherence to principles of dignity, equality, non-discrimination, accountability and participation. In this region, there are significant gaps in all the above areas.

3.4.1 Introduction and key knowledge gaps

This section summarises the very limited information available about trans health outcomes in Asia and the Pacific. A recent systemic review of trans health studies identified no such research in the Pacific and many parts of Asia (Reisner et al., 2015). Where research did exist, as with most parts of the world outside of the United States, it was limited to between two and five studies, as shown in Figure 3.1.

Figure 3.1: Map of the Distribution of Studies in Global Transgender Health
(n = 116 quantitative studies from 2008–2014)



Source: Reisner et al., 2015.

In recent years, there have been a number of pivotal reports on the health status of trans people, predominantly trans women, in Asia (Winter, 2012; WHO, 2013a, 2013b). There is very little information about the position of trans people in the Pacific, and what does exist focuses solely on trans women (WHO, 2013b). The minimal data from the **Pacific** are predominantly only from one sub-region, **Melanesia**, and do not cover Polynesia or Micronesia.

Much of the data about trans women are drawn from HIV and STI research initially conducted amongst MSM. This has significant impacts on the types of health indicators measured and the population groups and countries. Many countries in this region inappropriately combine trans women within an MSM category. This makes invisible not only trans women's identity, but also the extent to which they bear the disease burden of HIV. A recent WHO/UNAIDS biregional meeting called on member states to recognise, and collect data on, trans people as a population distinct from MSM (WHO WPRO and UNAIDS, 2015). This reflects WHO recommendations about the importance of setting and monitoring targets disaggregated for and by key population(s) (WHO 2014a; WHO 2015e).

Similarly, the failure to disaggregate sex worker data has obscured the cumulative impact of stigma and exclusion on trans women who are sex workers, or the positive impact of community development programmes that show higher HIV knowledge amongst these communities. Trans men who are sex workers are completely invisible.

Across Asia and Pacific, there is no quantitative evidence about the experiences of trans men, despite community knowledge that the size of trans masculine communities and the number of Asian countries where they have become established are growing fast. Trans-masculine identities have emerged very recently in the Pacific.

Most available trans data come from urban samples likely to over-represent specific age cohorts within trans communities. Yet trans people in small towns or rural areas are likely to have less access to health services or peer support.

Existing data are typically limited to the adult population, at a time when trans youth are increasingly visible and highly vulnerable to stigma and discrimination within their families, school communities, and workplaces.

3.4.2 De-psychopathologisation: Gender diversity is not a mental illness

Internationally, including within Asia and the Pacific, trans people, supported by many health professionals, are strongly advocating for trans health needs to no longer be defined by a mental health diagnosis. This is sometimes referred to as “de-psychopathologisation.”

In May 2010, the WPATH Board of Directors issued the following statement “urging the de-psychopathologisation of gender variance worldwide” (WPATH Board of Directors, 2010).

The expression of gender characteristics, including identities that are not stereotypically associated with one's assigned sex at birth, is a common and culturally diverse human phenomenon which should not be judged as inherently pathological or negative. The psychopathologisation of gender characteristics and identities reinforces or can prompt stigma, making prejudice and discrimination more likely, rendering transgender and transsexual people more vulnerable to social and legal marginalisation and exclusion, and increasing risks to mental and physical well-being. WPATH urges governmental and medical professional organizations to review their policies and practices to eliminate stigma toward gender-variant people.

Regionally, in 2011, the Psychological Association of the **Philippines** spoke out in support of “global initiatives to remove the stigma of mental illness” that long has been associated with trans and LGB people (UNDP and USAID, 2014f).

WHO is responsible for the *International Classification of Diseases and Related Health Problems* (ICD). The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is published by the American Psychiatric Association. Both are used by public health systems around the world to code, and thus fund, health services.

The health services that trans people seek so as to medically transition are currently coded as mental health diagnoses in both the ICD and DSM. Until recently, both used the term “gender identity disorder.” In 2013, the DSM reverted to an older term—“gender dysphoria.” This has largely been seen as a positive step. Gender identity disorder was typically

viewed as a negative label placed on trans people's very identity, whereas gender dysphoria focuses more specifically on the distress some trans people feel when their gender identity does not match their body. It describes psychological distress that can disappear as a person's relationship to their body changes (perhaps a result of taking hormones or having surgeries). Arguably, the new DSM term "gender dysphoria" offers a route to healthcare coverage without imposing a permanent label such as "gender identity disorder."³⁹

WHO is in the process of revising the ICD, currently in its 10th version (ICD-10). Since the ICD covers all health conditions, it provides an opportunity to consider placing trans health codes outside of the category of mental disorders. Current recommendations include that "gender identity disorder" (classified as a mental health disorder in ICD-10) be replaced by "Gender Incongruence of Adolescence and Adulthood" (GIAA) in ICD-11. This code would also move to a newly created chapter on Conditions Related to Sexual Health (ICD-11 Beta draft).⁴⁰ If adopted, this proposal would enable access to trans health services without the label of a mental health disorder.

In 2013, a civil society expert working group convened by Global Action for Trans* Equality (GATE) strongly supported the removal of gender identity from the Mental and Behavioural Disorders chapter of ICD, and said that the new proposed category of GIAA required further scrutiny. The expert working group focused its critique on opposing a proposed category of "Gender Incongruence of Childhood" (GIC). It provided a detailed alternative proposal for addressing the issues that gender-variant children experience without pathologising their gender diversity (GATE, 2013).

WPATH convened a working group and issued a policy brief on the ICD proposals. It has also surveyed its members about the proposed GIC diagnosis.

At the time this Blueprint was finalised in 2015, there were indications that the World Health Assembly will submit ICD-11 for approval in 2017/2018.

3.4.3 General health services

Trans people require access to the same general health services as other people at all levels of the healthcare system (primary, secondary, and tertiary). Health professionals can be very strong advocates for trans people's right to health. Unfortunately, many lack familiarity with trans people's life experiences or the background training or knowledge to respond appropriately to trans people's general health needs. One of the main aims of this Blueprint is to fill some of these information gaps.

Many trans people have been turned away from general health services or have been judged because of their gender identity or expression. Frequently, this includes trans people being inappropriately referred to as "it," trans women being referred to as men, or trans men being called women.

"I can't get dolled up like this putting on lipstick and makeup. The health workers would be screaming at me. Not only are we discriminated by the health workers but also the other clients as well."

—Trans woman, **Papua New Guinea** (Interview, February 2015)

39. For others, access to trans health services through a diagnosis in the DSM remains inherently problematic, given that the DSM is a manual of mental disorders.

40. Available at: <http://apps.who.int/classifications/icd11/browse/l-m/en>.

As already noted, in many parts of this region, trans people do not have any legal protections against discrimination or are criminalised under other laws. Health records typically disclose a trans person's sex assigned at birth and potentially expose that person to judgements or discrimination from health providers. This includes being refused care or denied access to the appropriate sex-segregated hospital wards or clinics (Salas and Sorn, 2013; UNDP, 2014g, 2014h; WHO, 2014b).

In addition, approaching a doctor, clinic, or hospital to ask for health support can be particularly difficult for many trans people. The vulnerabilities associated with being unwell are compounded by health appointments that may require some form of physical examination. For many trans people, showing parts of their body to a health professional can trigger discomfort or dysphoria about having a body that does not match their gender identity. This problem is heightened if comments or terms used by a health professional negate the trans person's sense of self. As a result, many trans people avoid seeking care or receive little attention to their specific health needs. Section 4.1.1 provides guidance for health professionals on these important initial interactions with a trans person.

In the following example, a Thai trans woman describes how her experiences of going to a government hospital discouraged her from seeking necessary healthcare.

"I was sick with an incredibly high fever of 40 degrees Celsius, to the point where I needed to be admitted to the [government] hospital. I told [the doctor] I had already undergone sexual reassignment surgery, to please let me stay in the women's ward. He said that he was just the on-call doctor and did not have the authority to make that decision. The nurse also said it was not possible—because I had a man's name. I tried to hold on to the doorframe so that they couldn't push me through..."

After that sickness, I fell ill very frequently, but I never wanted to go to the hospital. Unless I was so sick that I couldn't withstand it, I would not go ... There was always an issue about using the restrooms [and] the kind of bedpan they would provide for me ... The lack of protocol on how to deal with a transgender woman like me was so taxing and deflating.

There was one time, a nurse asked me 'Why do you wait until your sickness and symptoms get so bad before coming to the hospital?' I told the nurse it was because every time I had come I was harassed. I also felt like I was causing hardship for the healthcare professionals that were taking care of me, to have to deal with someone like me."

Source: Boonprasert, 2011, cited in UNDP, 2014g.

Trans women in both the Pacific and Asia regions have reported further discrimination in healthcare settings based on the fact or perception that they are sex workers or HIV positive (UNDP and USAID, 2014e). There is no research in this region regarding trans men who are HIV positive or do sex work.

Trans men who retain their internal reproductive organs and are not on hormones or other contraceptive medications may still have menstrual cycles until they reach menopause. This can cause significant body dysphoria for someone who identifies as male. Trans men in **Nepal** have described how they find it hard to access sanitary pads from pharmacies and retailers (UNDP and USAID, 2014e). Health professionals also have refused to prescribe medication or devices to enable trans men to stop their menstrual periods.

The next sections of the Blueprint look at specific health issues for which there are enough data available to provide a regional overview of health outcomes for trans people. As almost all of this information comes from HIV research, it primarily focuses on the prevalence of HIV and other STIs and, to a lesser extent, substance use, amongst trans women in Asia and the Pacific. The fourth health issue briefly examined is mental health and well-being, particularly for trans and gender-nonconforming youth.

3.4.4 HIV

3.4.4.1 HIV burden for trans women

Available data consistently show that trans women are disproportionately affected by HIV. They are more likely to be HIV positive than the general adult population. A 2013 meta-analysis of studies published globally between 2000 and 2011 shows that the pooled HIV prevalence rate for trans women is 19.1 percent, and they are 49 times more likely to acquire HIV than the general adult population (Baral et al., 2013).

There are multifaceted vulnerabilities experienced by trans women that increase their likelihood of HIV infection. For example, in the United States, higher rates of HIV infection amongst trans women have been linked to higher rates of harmful drug and alcohol use, homelessness, incarceration, attempted suicide, lack of familial support, unemployment, sex work, violence and stigma, inadequate access to healthcare, and negative healthcare encounters (Centers for Disease Control and Prevention, 2015). The limited research that exists suggests that almost all of these vulnerabilities also are common for trans women in Asia and the Pacific.⁴¹

A global systematic review revealed a 27.3 percent HIV prevalence amongst trans women engaged in sex work (Operario et al., 2008). A greater prioritisation of trans sex workers in HIV research, prevention, care, and treatment is needed to address gaps in data and services for this population (Poteat et al., 2014).

Regarding sexual behaviour, the related HIV risks are highest for those trans people who have condomless receptive anal sex. For some trans women, receptive anal sex with a cisgender male partner may be strongly linked to personal or community perceptions of a female gender identity. In this region, one study has found that trans women in the **Philippines** reported a desire to receive a partner's semen—"getting wet"—during condomless receptive anal sex. This was an important way they expressed their femininity during sex (Health Action Information Network and UNDP, 2013). Dispensing with protection may also be a way that trans women distinguish between a casual partner and a potential relationship (Winter, 2012). There are no data available in this region on HIV transmission amongst trans women who have sex with other women. These include trans women engaged in sex work primarily with men but who may have female sexual partners.

The term "neovagina" typically is used in medical literature to refer to a trans woman's vagina constructed through vaginoplasty surgery. There are currently no published data on neovaginal transmission or acquisition of HIV; however, such studies are in development.

"... all countries should recognize and accept transgender communities. In the current context, access to healthcare service for transgender people is not only difficult, but impossible... Countries should initiate an essential healthcare service package for transgender people that includes the meaningful involvement and engagement of the beneficiary community. Likewise, empowerment of the community is crucial to minimize self-stigma and increase the utilization of available healthcare services."

—Mr. Shambhu Kafle, Senior Public Health Officer
National Centre for AIDS and STD Control, **Nepal**

Source: Email correspondence, April 2015

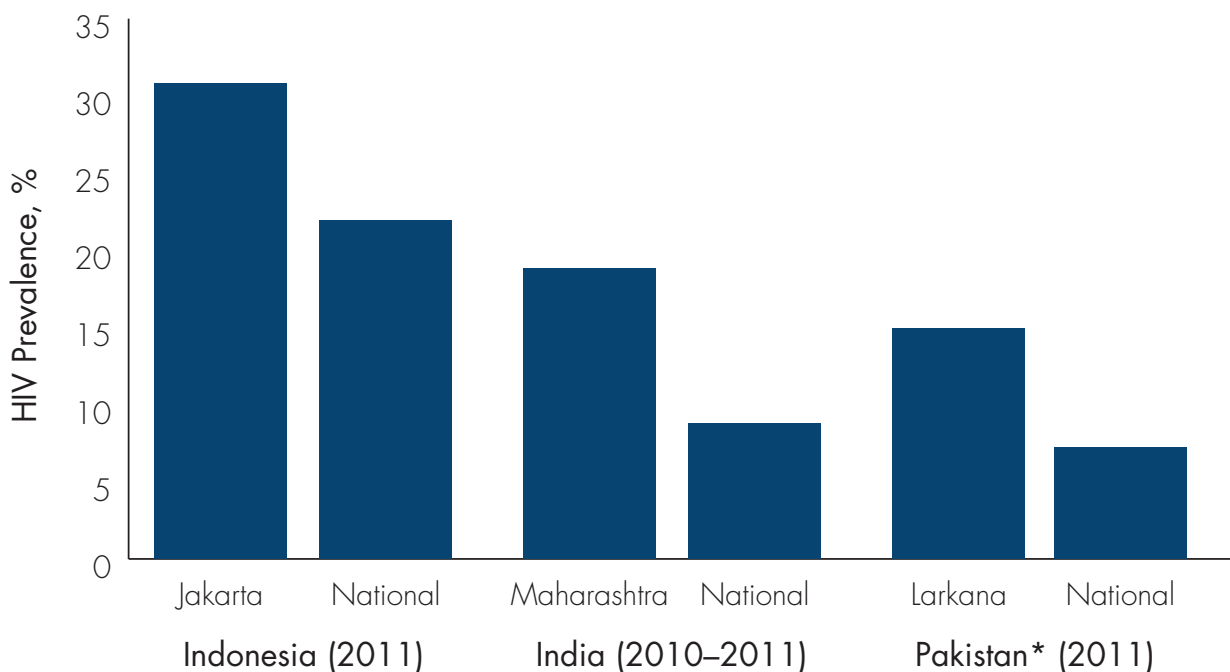
41. One notable difference is that published incarceration rates for the general population are much higher in the United States than for countries in Asia or the Pacific.

3.4.4.2 HIV prevalence for trans women in Asia

The Baral et al. meta-analysis included data from five countries in Asia: **India**, **Indonesia**, **Thailand**, **Viet Nam**, and **Pakistan**. In all five countries, trans women were more likely to be living with HIV than the general adult population. The disease burden was particularly high in India and Indonesia, with a prevalence of 43.7 percent and 26 percent, respectively. In these two countries, trans women were 200 and 180 times more likely to be HIV positive than the general adult population, respectively (Baral et al., 2013).

Other recent studies show that prevalence amongst trans women living in urban cities or states is even higher than national prevalence levels. As shown in Figure 2, data are available for Jakarta, **Indonesia**, Maharashtra, **India**, and amongst *hijra* sex workers in Larkana, **Pakistan**.⁴²

Figure 2: National versus city-specific HIV prevalence amongst trans women in Asia

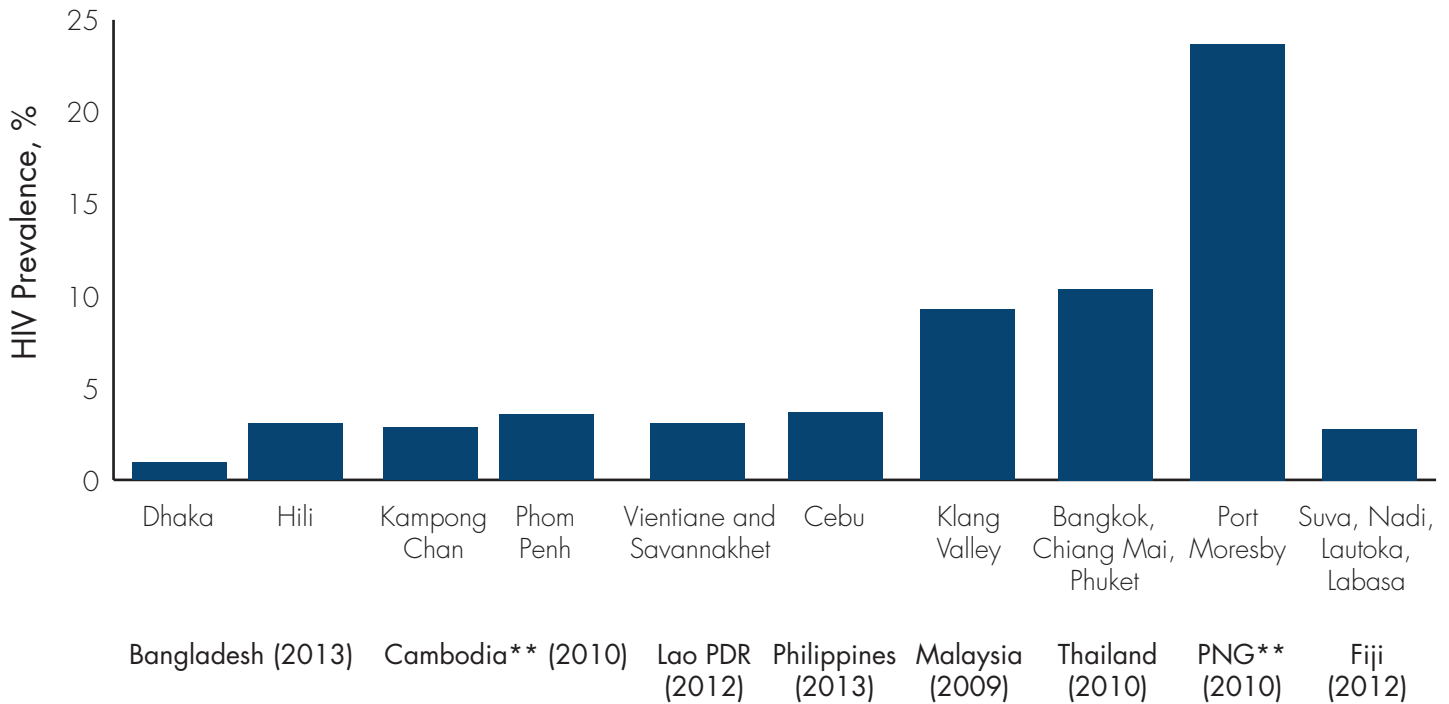


* *Hijra* sex workers only

42. Analysis by www.aidsdatahub.org, based on (1) Ministry of Health Republic of Indonesia. 2011. IBBS 2011—*Integrated Biological and Behavioral Survey*; (2) National AIDS Control Organisation, India. 2012. *HIV Sentinel Surveillance 2010–11: A Technical Brief*; and (3) National AIDS Control Program, Pakistan. 2011. *HIV Second Generation Surveillance in Pakistan—National Report Round IV, 2011*.

Other regional data collated by UNAIDS in 2012, as depicted in Figure 3, show an HIV prevalence of 10.4 percent across three cities in **Thailand** (2010) and 5.7 percent nationally in **Malaysia** (2012), with a higher prevalence in earlier 2009 data from Klang Valley. In the other four Asian countries where 2010–13 data are available, (**Bangladesh**, **Cambodia**, **Lao PDR**, and **the Philippines**) HIV prevalence ranges between 1 percent and 3.7 percent.

Figure 3: HIV prevalence for trans women in Asia and the Pacific



* TG sex workers

** Long-hair MSM

*** TG sex workers

Note: Long-hair MSM is a local term in Cambodia for males who exhibit and present feminine traits. They may identify as a woman, both man and woman, or as third gender. Available at: www.msngf.org/files/msngf/Publications/ippf_hivreportcards_msm_cambodia.pdf.

In addition, when comparable data are available, the HIV prevalence for trans women typically exceeds that for MSM. For example, in this region, this is the case in **Cambodia**, **Indonesia**, and **Pakistan**.⁴³

“In Japan, AIDS prevention strategies that specifically target trans people do not exist. Trans sex workers are in an environment where they are vulnerable to HIV or other sexually transmitted infections. But they have no access to preventive measures, testing, or knowledge and information about symptoms and treatment.”

—Lily Miyata, Kansai AIDS Council, **Japan**

Source: Email correspondence, April 2015

43. Based on 2011 Country Reviews from the HIV AIDS Asia Pacific Research Statistical Data Information Resources AIDS Data Hub, available at: www.aidsdatahub.org, and the 2014 Malaysia GARPR country narrative report. In Pakistan, the only available comparisons are between male sex workers and *hijra* sex workers

3.4.4.3 HIV prevalence for trans women in the Pacific

HIV prevalence data for trans women are available in two Pacific countries, focusing solely on trans sex workers. Almost a quarter (23.7%) of the 38 trans sex workers surveyed in Port Moresby, **Papua New Guinea** in 2010 were HIV positive.⁴⁴ This rate was higher than for other women who were sex workers (19%) or male sex workers (8.8%) (Kelly, 2011). This suggests that trans women's vulnerability to HIV infection cannot be attributed solely to their participation in sex work.

A 2012 IBBS survey in four towns and cities in **Fiji** found a HIV prevalence of 1.8 percent, compared to 0 percent for cisgender female sex workers. The estimated HIV prevalence for the general adult population is also extremely low, at 0.1 percent (UNAIDS, 2014).⁴⁵

The limited Pacific data about HIV prevalence for trans women is also mirrored in an absence of local HIV resources produced specifically for trans people.

“Even if UN agencies—UNAIDS or UNFPA or all these UN agencies or regional agencies talking about HIV—[are] making sure that we also prioritise key populations [including trans people], it's still not reflected in terms of awareness messaging and packaging. There is still no specific awareness information available, or material that's specific to our needs ... There are no television, newspaper, or printed materials on the specific needs of trans women and trans men and how they can protect themselves from HIV.”

—Transgender woman, 28, **Fiji** (WHO, 2014b)

3.4.4.4 HIV prevalence for trans men

There are no Asia or Pacific data on HIV prevalence for trans men.

In the United States, data on newly diagnosed cases of HIV amongst trans people in New York City show only a small proportion of trans men. Between 2006 and 2010, trans men constituted 11 (6%) of all newly diagnosed cases of HIV amongst trans people (New York City Department of Health and Mental Hygiene, 2012). Recent qualitative studies of trans MSM suggest a heightened vulnerability to HIV amongst this group of trans men (Schleifer, 2006; Rowniak and Chesla, 2013; Bocking et al., 2009; Reisner et al., 2014; Bauer et al., 2013).

Two false and linked assumptions underpin the invisibility of trans men's potential vulnerability to HIV infection. The first is assuming that trans men primarily engage in sex with cisgender women (often lesbians, who are assumed to be low risk) and the couple are assumed to use low-risk sexual practices. The second assumption is that, whatever their sexual orientation, the types of sex trans men have involve few risks. Yet trans men inhabit a wide range of sexual orientations and sexual behaviours, and may have cisgender or trans partners. They may also be linked to high-risk MSM sexual networks (Kenagy et al., 2005; Kenagy and Botswick, 2005; Bauer et al., 2013).

HIV risk for trans men is associated with condomless anal sex or, for those trans men who have retained a vagina and use it sexually, condomless vaginal sex practices. These are often referred to by trans men as “rear” and “frontal” sex, respectively.

43. Analysis by www.aidsdatahub.org, based on HIV Sentinel Surveys and Bio-Behavioural Surveys.

44. The HIV prevalence for transgender sex workers was later revised by the HIV and AIDS Data Hub to 2.8%. This was based on Global AIDS Progress Report (GARPR) data submitted in 2014, using the corrected denominator of all TGSW and not all SW. HIV and AIDS Data Hub Review in Slides: Transgender People (Male-to-Female). Available at: www.aidsdatahub.org/Key-Populations.

For trans men, there is often a lack of HIV information and services targeted to their specific bodies and needs. As a result, trans men may not have sufficient knowledge or power to negotiate safe sex (Sevelius, 2009). This has the potential to affect their risk of HIV infection, particularly for trans MSM. Trans men who enter a gay male community after transitioning often face new sexual negotiations. They may choose to compromise safety rather than risk rejection because of a strong desire to have their masculinity affirmed by a gay male partner (Rowniak et al., 2011). If testing facilities are not sensitive to the needs of trans men, this is likely to reduce the extent to which they are used by trans men, and perpetuate limited data about HIV prevalence for this population group.

“The fact that someone wants to have sex with us would mean that he doesn’t mind my genitals, he doesn’t mind my body, he doesn’t mind anything about me—and do I [therefore] have the right to ask for safer sex? ... It’s more about wanting a kind of belonging and not wanting to be rejected again.”

—Trans man, **Singapore** (WHO, 2014b)

3.4.4.5 Good practice examples of trans-led HIV services in Asia and the Pacific

The four case examples that follow describe good practice in HIV testing, counselling, and treatment for trans women in South and Southeast Asia and the Pacific. Projects and programmes such as these can also contribute to addressing current data gaps by adding to the body of available surveillance data. In addition, the Family Planning Association of India’s work with trans women and hijras, mentioned in Section 4.3.6 of the Blueprint, illustrates how a focus on sexual and reproductive health and HIV services also can be linked to gender-affirming health services.

Research in other regions shows that a high proportion of HIV-positive trans women are unaware of their status (Herbst et al., 2008). There is a dearth of information on trans men-led HIV services in the region. The following four case examples highlight trans-led initiatives in HIV services provision in **the Philippines, Thailand, Papua New Guinea, and Pakistan.**

CASE EXAMPLE: TRANS COMMUNITY-LED HIV TESTING AND COUNSELLING IN THE PHILIPPINES

COLORS is a community-based organisation led by trans women in Cebu, Philippines. Through their Trans Femina project, supported by WHO Regional Office for the Western Pacific, trans women run peer education trainings and provide HIV information and education materials, and HIV counselling and testing. Over a three-month period, COLORS reached out to 508 trans women and more than 60 percent (317) were tested for HIV. This is a very high response rate for peer education work in the Philippines. What appears to make the difference is that COLORS' trans peer educators include some nurses who are qualified as HIV counsellors.

COLORS works closely with a sustainable government health institution—the Cebu Social Hygiene Clinic. The clinic provides a space designated for COLORS volunteer staff members to conduct HIV testing and counselling for the community. Working with the clinic also makes it easier to provide direct referrals to other treatment, care, and support services. “After the test, you encourage them to get their results [and] refer them to support groups and the appropriate offices.”

This has been an important step towards recognising the partnership between trans community organisations and government health services. “With that desk, we have an office ... at the city government. [It] maybe officialises our initiatives and efforts.”

The trans-specific space within the government clinic provides more visibility, but there are many other trans women COLORS would like to reach.

“It’s a good thing that we are there. But most of our members go out at night and the desk may not be reaching everyone ... There is a need to open a community-driven center that can reach those at night.”

This COLORS-led initiative sets an example for replication through the Global Fund new funding model grant, 2015–2017, in the Philippines.

Source: COLORS, **the Philippines**.

CASE EXAMPLE: COMMUNITY-BASED ORGANISATIONS FOR TRANS WOMEN AND KHAWAJA SIRAS IN PAKISTAN

Naz Male Health Alliance (NMHA) is a community-based organisation in **Pakistan** addressing the health and psychosocial needs of trans women (typically referred to as *khawaja siras* or *hijras* in Pakistan) and young MSM.

As part of its ongoing work to empower these communities, NMHA has been working with them in five cities across Pakistan (Lahore, Karachi, Rawalpindi, Hyderabad, and Larkana) to establish six community-based organisations (CBOs). These CBO offices are strategically located close to the “hotspots” and in areas where there is a large concentration of *deras* (dwellings) for *hijras/khawaja siras*. This creates easy access and a secure and relaxing atmosphere for the economically deprived, low-income community members who primarily use NMHA's services.

The CBOs receive financial as well as technical support from NMHA. They deliver HIV voluntary counselling and testing, STI diagnoses and treatment, behaviour change communication, and condom and lubricant distribution. This is done via outreach, as well as through the drop-in-centre clinic. Each CBO is segregated into two areas. One area provides the community with a secure and comfortable drop-in centre. This part was prioritised as a way of strengthening the community. The second area is used to provide clinical services.

Service sites are separate for trans women and MSM to effectively address their specific needs and concerns. Each centre has a multidisciplinary staff of around 15 people, including physicians who are STI specialists, a psychologist, and peer educators. The centres are run entirely by the community they seek to serve.

The Government of Pakistan has publicly stated that NMHA has been responsible for a significant increase in newly registered HIV-positive trans women and MSM in its public HIV treatment centres. NMHA makes special efforts to create strong linkages and partnerships with groups such as the National AIDS Control Programme, Rahnuma-Family Planning Association, the Asia Pacific Transgender Network, the Asia-Pacific Coalition on Male Sexual Health, and Youth Voices Count, along with other stakeholders.

Source: Naz Male Health Alliance, **Pakistan**.

CASE EXAMPLE: COMMUNITY-BASED TESTING: PATTAYA, THAILAND

Sisters is a trans-led, community-based organisation in the beachfront tourist town of Pattaya. Its staff, peer educators and volunteers are all trans women—who often use local terms like *kathoeys* or *sao praphet song*. Over the last 10 years, Sisters has worked with almost 5,000 trans women across different communities, including sex workers, cabaret showgirls and youth.

Sisters' drop-in-center (DIC) is a safe and welcoming space that combines club activities such as sport and makeup and cooking classes with social services, screening for STIs and counselling. In partnership with a local public hospital, a trans nurse is available on site to provide HIV testing and counselling (HTC).

Sisters' outreach workers operate in trans bars, clubs, and parks, targeting areas where commercial sex is available. They promote awareness of Sisters' services, including the DIC, and distribute condoms and water-based lubricants. Peer educators are also available to visit trans women at home to provide counselling and information on hormone therapy and gender-affirming surgeries. Peer educators facilitate linkages to trans-friendly government health services and will accompany trans women to appointments for STI treatment, CD4 tests, and antiretroviral treatment.

A 2011 evaluation found that Sisters' HIV prevention programme targeted to trans women was effective in reaching a large proportion of this transient population and in addressing HIV-related risks. Key elements appeared to be making water-based lubricant accessible along with condoms in outreach activities and embedding rapid HIV testing within a community-based, trans-competent service (Pawa et al., 2013).

Sisters' work to reduce HIV risk amongst trans women continues to be based on community leadership and engagement, partnership with the government and its monitoring and evaluation strategy, adopted from Population Services International, Thailand. Sisters' most recent annual data show that, from October 2013–September 2014, 386 trans women and 69 partners of trans women used the service. Of the trans women, 47 percent of those reported being sex workers.

With discrimination and police harassment increasingly becoming major concerns, Sisters' director, Doy, has a vision for the organisation to extend beyond health services to provide more comprehensive social services for trans women.

Source: Sisters, **Thailand**.

CASE EXAMPLE: TRANS PEER-EDUCATORS IN PAPUA NEW GUINEA

The HIV prevalence for the general population in Papua New Guinea is 0.9 percent. For trans women/*palopa* in the capital city of Port Moresby, it is 23 percent. To address this high HIV prevalence, Save the Children established a sexual and reproductive health project catering to trans women, female sex workers, and MSM.

“When trans women get infected, their family rejects them and most of them can’t access ART [antiretroviral therapy] service due to stigma and discrimination. Most of them have died even though PNG [Papua New Guinea] has the policy of free ART dispensed in government clinics.”

The *Poru Sapot* clinic is open to each of its key populations once a week. Its clinical services include HIV and other STI counselling, testing, and treatment; tuberculosis testing; family planning; sexual and reproductive health; and gender-based violence screening, counselling, and referral. By providing this range of services in a welcoming space, the clinic aims to reduce the stigma and discrimination trans people face when moving between different health services.

Fifteen trans women lead the trans peer-outreach programme in the city. The project provides transport on the day trans women attend the clinic. Each regional peer educator has a project phone to coordinate the clients into one place and then fetch them in a bus so they can access services, including treatment. The clinic provides this additional support only to trans women because of the high incidence and severity of abuse they face in trying to reach the clinic.

Before treatment services were provided at the clinic, trans women were referred to the government clinics for enrolment in the HIV treatment programme. Stigma and discrimination were frequent and trans women were not being served, so the project developed a peer navigator programme. Trans women peer educators escort trans clients who have recently tested positive for HIV through the government system of HIV medication enrolment. In February 2015, the project supported 20 trans women on ART and plans to work with more.

Now the project sensitises all of the healthcare workers throughout the city and includes trans women in the health worker trainings.

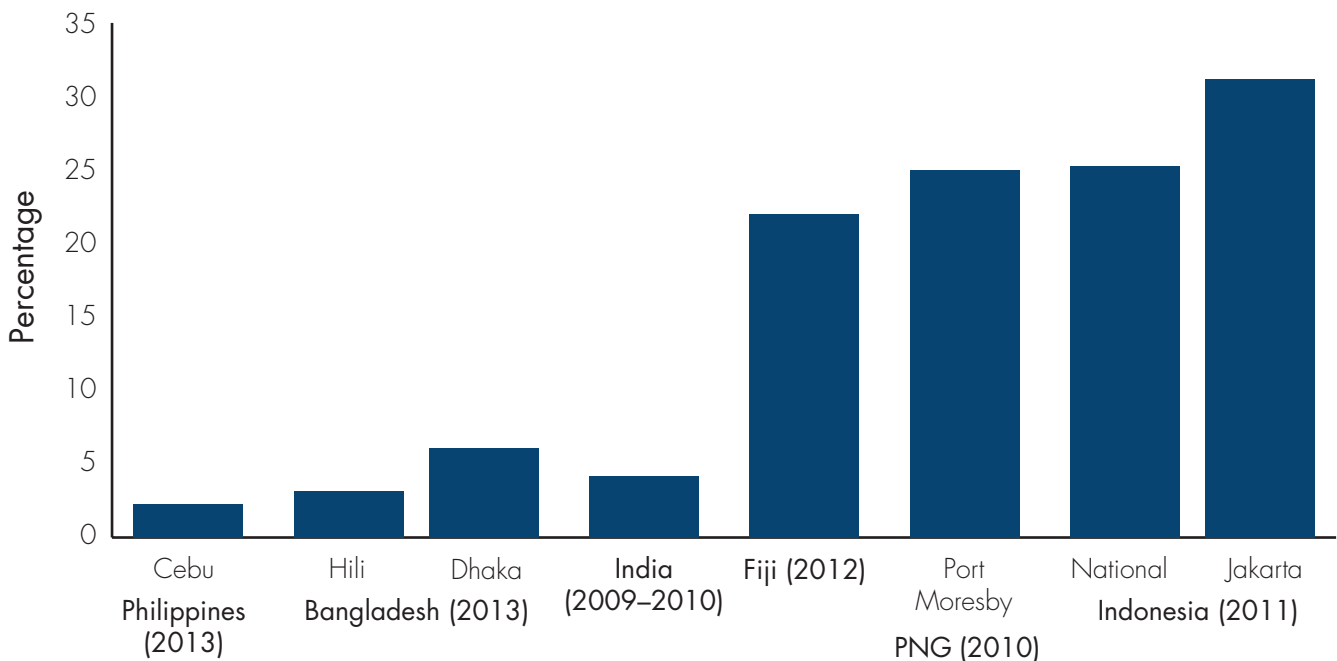
“Since the project came into place, there has been great changes among trans. Transgender feel their voices can be heard ... One day this will be phased off. Then what? Where will all the trans women get treatment?”

Source: Paro Sapot, **Papua New Guinea**.

3.4.5 Other sexually transmitted infections (STIs)

There are very limited data in this region on prevalence of STIs amongst trans women, and no information about trans men. Much of the data available, typically based upon small sample sizes, show higher rates of STIs for trans women in comparison with the general population. This is significant regarding ill-health outcomes associated with STIs themselves, and because STIs increase an individual's risk of infection with, and onward transmission of, HIV (Bonell et al., 2000; Freeman et al., 2006; Johnson et al., 2008). STIs may also alter the course of disease progression in HIV-positive individuals.

Figure 4: Syphilis prevalence amongst trans women, 2009–2013



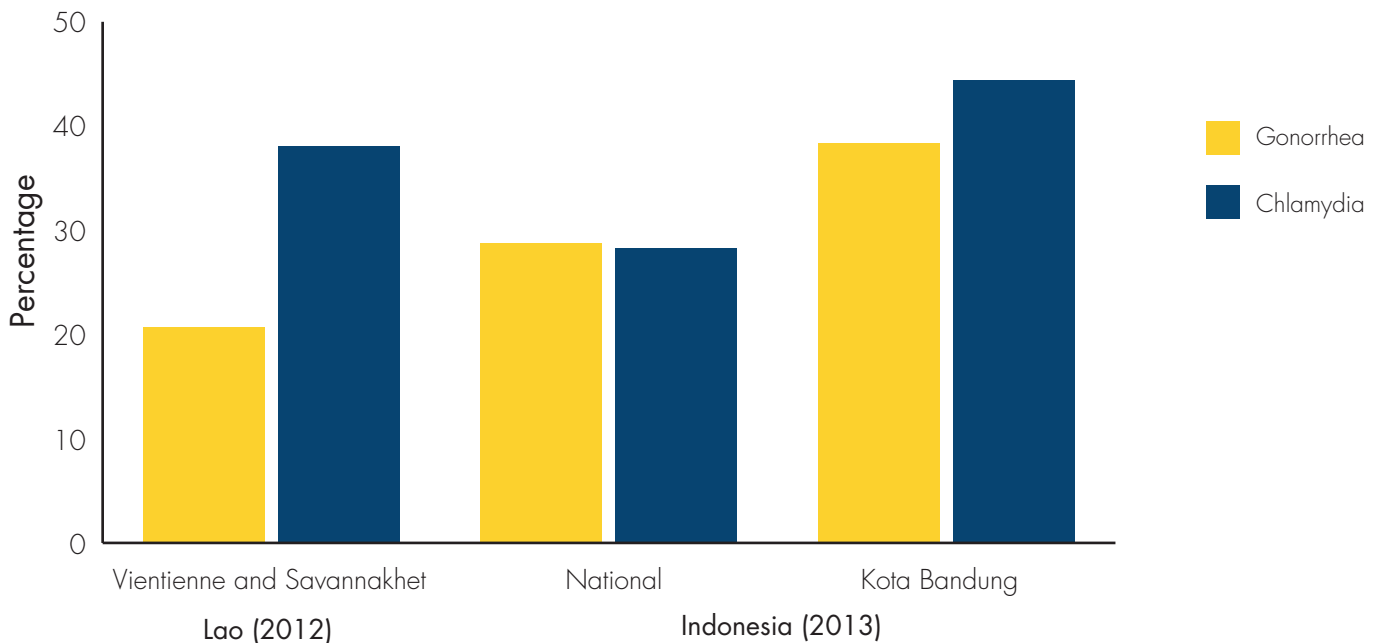
Source: HIV and AIDS Data Hub for Asia-Pacific. Review in slides: Transgender people (male-to-female) November 2014. Available at: <http://aidsdatahub.org/transgender-people-2014-slides>

Data from 2009–2013, as shown in Figure 4, show that syphilis prevalence is particularly high amongst trans women in **Fiji** (22%), Port Moresby in **Papua New Guinea** (25%), and **Indonesia** (25.3%), where there is an even higher rate in the city of Jakarta (31.2%).

In **India**, the limited disaggregated data show relatively high STI prevalence amongst hijras in some states and cities (Chakarapani, 2013). This includes a syphilis prevalence of between 10.3 percent and 13.6 percent (Brahmam et al., 2008; Gupte et al., 2011; Sahastrabuddhe et al., 2012).

Prevalence rates for gonorrhoea, shown in Figure 5, were high in Vientiane and Savannakhet, **Lao PDR** (20.7%), **Indonesia** as a whole (28.8%), and its third largest city Kota Bandung (38.4%). Prevalence of chlamydia was similar or higher (38.1%, 28.3%, and 44.4%, respectively).

Figure 5: Gonorrhoea and chlamydia prevalence amongst trans women, 2009–2012



In the Indian city of Pune, the genital ulcer disease prevalence was 15.3 percent; for genital warts, prevalence was 10.3 percent (Sahastrabudhe et al., 2012). Both of these have been described as high rates (Chakrapani, 2013).

3.4.6 Alcohol and other substance use

Like other marginalised minority groups, trans people may use alcohol and other substances to block out pain caused by social exclusion and stigma and discrimination, and may develop harmful substance use and dependence. Fear of being judged by health providers may discourage some trans people from seeking treatment for substance use disorders, including dependence. Substance use may also be a way of coping with body dysphoria. There is minimal research on these issues—particularly on whether access to gender-affirming health services can reduce over-reliance on drugs or alcohol.

In Asia and the Pacific, there are very limited quantitative data on alcohol and drug use amongst trans people. They tend to be collected in the context of HIV research, which also limits the focus to trans women. Anecdotal evidence suggests that drug use may be an emerging health issue for trans men in Asia.

HIV research frequently measures injecting drug issues because of the risk of HIV transmission through shared use of needles. In the five countries in Asia where data are available (**Bangladesh, Indonesia, Malaysia, Pakistan, and the Philippines**⁴⁶), between 0.2 percent and 3.4 percent of trans women reported injecting drug use.⁴⁷

46. A report from COLORS showed 10 percent of trans women reached uses drugs (1% are injecting drug users). The most commonly used drug is methamphetamine.

47. Sources: Prepared by www.aidsdatahub.org based on (1) National AIDS/STD Programme Bangladesh. 2008. *Behavioral Surveillance Survey 2006–07*; (2) Ministry of Health Republic of Indonesia. 2011. *IBBS 2011 – Integrated Biological and Behavioral Survey*; (3) Malaysia AIDS Council and Ministry of Health. 2010. *Integrated Biological and Behavioral Survey 2009*; (4) National AIDS Control Program, Pakistan. 2011. *HIV Second Generation Surveillance in Pakistan – National Report Round IV 2011*.

High or frequent alcohol or drug use, including opioids and stimulants, may impair judgements about safer sex. For this reason, research also has focused on the extent to which trans people, including sex workers, have used drugs or alcohol before sex. Pawa et al. found more than 50 percent of trans women in **Thailand** who were sex workers used alcohol or drugs before sex (Pawa et al., 2013). Amongst 280 trans women reached by an HIV prevention programme in **China**, 3.6 percent (14) had ever injected opioids and 6.8 percent (19) reported non-injection drug use before sex in the last three months (Avery et al., n.d.).

A 2011 Thai study reported 42.6 percent of trans women in **Thailand** had used drugs in the past three months, whereas in **Cambodia**, a baseline study of trans women in the sex industry in Phnom Penh noted high rates of amphetamine and alcohol use (Guadamuz et al., 2011; Davis et al., 2014). A 2010 report from **India** identified the need to address harmful alcohol and substance use amongst *hijras* and trans women.

“An unknown but significant proportion of hijras/trans communities consume alcohol possibly to forget stress and depression that they face in their daily life. Hijras provide several reasons justifying their alcohol consumption that range from the need to ‘forget worries’ (because there is no family support or no one cares about them) to managing rough clients in their sex work life” (UNDP, 2010).

Alcohol use was commonly found during outreach under the Family Planning Association of India’s (FPA) Shadows and Lights Project, described in Section 4.3.6.

Twenty *hijras* interviewed as part of a 2012 needs assessment in **India** listed a wide range of drugs taken to reduce social isolation or, in some cases, relieve pain associated with laser treatment or *nirvaani* (traditional castration). Some participants reported that consuming hashish helped people living with HIV by stimulating their appetite. This report cited a 2009 study of *hijras* in Lahore, **Pakistan** that found 3 percent had injected drugs; however, more than half had taken what were described as “hard drugs,” such as cocaine, heroin, morphine, or amphetamines (Rehan and Chaudhary, 2009, cited in Humsafar Trust, 2012).

A 2012 survey of sex workers in **Fiji** concluded that self-reported alcohol use was not high, though 55 percent reported using marijuana daily (Mossman et al., 2014).⁴⁸ Trans sex workers were significantly more likely than other female sex workers to report that they took up sex work because it was a good way to obtain money for drugs and alcohol. They were also significantly more likely than other female sex workers to have transactional sex for alcohol (31% compared to 13%, respectively) or for drugs (14% compared to 4%, respectively).

Other studies have looked at drug or alcohol use more generally. In the Pacific, a 2008 survey of trans women/*leiti* and MSM in **Tonga** found high rates of heavy drinking.⁴⁹ More than one-third of those who reported consuming alcohol in the previous 12 months had between 10 and 19 drinks on a normal drinking occasion, while another third consumed 20 or more drinks.⁵⁰

3.4.7 Mental health

Mental health is a key component in trans people’s right to health. This section summarises some of the mental health stresses that trans people may experience due to the stigma and discrimination attached to gender diversity. However, trans people are no different from other groups in seeking mental health services for a wide range of reasons, often unconnected to their gender identity. Mental health professionals should have familiarity with gender nonconformity, act with appropriate trans cultural competence, and exhibit sensitivity in providing such care (WPATH, 2012).

For information related to mental health approaches and practices for health providers, please see Section 4.5.

48. The combined figures for all sex workers showed that 8 percent reported drinking alcohol daily and 14 percent reported glue sniffing. Less than 2 percent reported using any other types of drugs in the last month. Eleven percent reported injecting drugs in the previous 12 months.

49. Although the data for *leiti* and MSM are combined, *leiti* made up more than two-thirds (68%) of the 100 survey participants. Thus, at least half of all *leiti* will have consumed 10 or more drinks on a normal drinking session. Consuming five or more drinks is generally considered binge drinking.

50. Second Generation Surveillance Survey of MSM in Tonga, 2008.

3.4.7.1 Regional data

With the exception of a recent Australian study, regional data on mental health experiences of trans people predominantly focus on children and youth.

A 2012 study found that LGBT youth in **Nepal** often suffer from depression, anxiety disorders, substance use disorders, and even suicide or suicidal ideation (Sharma, 2012). In **Japan**, statistical data collected by gender clinics in Okayama and Tokyo found that trans people were more likely to report school bullying, dropping out of school, and suicidal ideation/attempts.⁵¹

In **New Zealand**, 2012 data from a nationally representative survey found students who reported being trans had compromised health and well-being. They were more likely to report school bullying, suicide attempts and depressive symptoms, and less likely to perceive that at least one parent cared a lot for them (Clarke et al., 2014).

FIRST AUSTRALIAN NATIONAL TRANS MENTAL HEALTH STUDY

The First Australian National Trans Mental Health Study looked at mental health experiences of 946 trans and gender-diverse people ages 18 or over and found high levels of mental health distress.

- 43.7 percent were currently experiencing clinically relevant depressive symptoms
- 25 percent met the criteria for a current major depressive syndrome
- Respondents were 4 times more likely to have ever been diagnosed with depression than the general population and approximately 1.5 times more likely to have ever been diagnosed with an anxiety disorder ...
- 20.9 percent of respondents reported suicidal ideation or thoughts of self-harm on at least half of the days in the last 2 weeks

Trans people who were on hormones or had undergone some form of transition-related surgery had markedly lower levels of clinically relevant depressive symptoms than those unable to access these health interventions. The study called for improved access to healthcare, including gender-affirming health services, based on an informed consent model.

Source: Hyde et al., 2014.

3.4.7.2 Mental health pressures

Many trans people who wish to change their body to match their gender identity cannot do so for financial, political, medical, religious, cultural, or other reasons. This can cause significant personal distress, heightened by a fear that others will reject their bodily diversity.

A person's place within their family is a significant part of their identity. Family obligations can be particularly strong in many parts of Asia and the Pacific, and can place constraints on a person's decisions about transitioning. Loss of family support can negatively affect a trans person's well-being. Family and peer support, along with identity pride, have been shown to mediate the negative impact of stigma and discrimination on trans people's mental health (Bockting et al., 2011). Yet trans people have been shown to have the lowest levels of family and peer support compared to other segments of the LGBT population (Bockting et al., 2005). Rejection may mean that trans people lose many of their social networks and support systems when they transition (UNDP and USAID, 2014b). Peer support networks potentially can fill some of these gaps and reduce isolation. Many trans people also fear that they will never have an intimate, loving relationship. The cumulative impacts of such stress and isolation are reflected in high rates of depression, suicide rates, or other forms of mental illness (UNDP, 2010; UNDP and USAID, 2014b).

51. Personal communication with Prof. Yuko Higashi, President of the 17th Annual Conference of the Japanese Association for Gender Identity Disorder, and a member of WPATH. According to Prof. Higashi, Professor Mikiya Nakatsuka from the Graduate School of Health Science, Okayama University, undertook the Okayama study. Prof. Nakatsuka's research looked at suicidal attempts and self-injury amongst 1,167 people who sought support for gender identity disorder between 1999 and 2010.

Trans people may face the additional burden of mental health issues associated with HIV infection, and of marginalisation, discrimination, and stigma. Thus, routine screening and trans-sensitive management for mental health disorders (particularly depression and psychosocial stress) should be provided for trans people living with HIV. This is both to optimise health outcomes and improve adherence to ART. Management can range from counselling for HIV and depression to appropriate medical therapies (WHO, 2014, 2011).

Addressing the stigma attached to gender and bodily diversity is vital to improving the mental health and well-being of trans people. Typically, these specific mental health needs are invisible and neglected, despite WHO recommendations that national mental health plans should specify measures for vulnerable groups.

3.4.7.3 Access to trans-inclusive mental health services

Trans and gender-nonconforming people in Asia and the Pacific are part of a rich diversity of gender identities and expressions that exist in all parts of the world. This “common and culturally diverse human phenomenon should not be judged as inherently pathological or negative” (WPATH Board of Directors, 2010b).

Despite this clear advice from WPATH, as noted in the de-psychopathologisation discussion in Section 3.4.2, many trans people in this region report negative interactions with mental health professionals. Instead of being accepted for who they are, trans people commonly report that their gender identity was viewed as a “problem” to be remedied. This means that the level of attention that mental health professionals in this region normally give to assessments falls far short of that envisaged in the WPATH SOC7.

There are also different and positive experiences in this region. Two-thirds of youth in the 2014 Australian research had seen a health professional for their mental health in the last 12 months; 60 percent of them were satisfied with their experiences. They valued health professionals who were knowledgeable in gender diversity and trans healthcare. More than half of all participants had experienced at least one negative experience with a healthcare professional. A quarter of the research participants avoided medical services due to their gender presentation (Smith et al., 2014).

However, those working in mental health often are poorly trained and ill equipped to work with trans people from a diversity perspective rather than a pathological or curative perspective. These issues are compounded when trans people are reliant upon a letter of referral from a mental health professional to access gender-affirming health services.

In some cases, mental health professionals respond to pressure from family members to impose reparative therapies that attempt to change a trans person’s gender identity so they identify as cisgender. These therapies sometimes involve involuntary committal to a psychiatric hospital ward (UNDP and USAID, 2014b). Reportedly, counsellors in **Cambodia** commonly encourage trans and LGB youth to “try and change and follow your parents’ wishes” (UNDP and USAID, 2014a), despite the WPATH SOC7’s clear statement against reparative or conversion therapy.

Treatment aimed at trying to change a person’s gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success ... Such treatment is no longer considered ethical (Coleman et al., 2011, p. 16).

Trans people from **Indonesia**, **Malaysia**, and **Viet Nam** have described being forced to go to religious leaders to be healed by prayers. These examples included psychologists or psychiatrists in parts of Indonesia who were reluctant to see trans children or youth and recommended that parents consult a traditional healer or shaman instead. In the following Viet Nam example, a trans woman was both hospitalised and taken to a religious leader.

When “J,” a 26-year-old trans woman in Ho Chi Minh City [**Viet Nam**] first announced that she was female, she was involuntarily checked into the hospital by her family. She had to undergo a blood test and later was subjected to “curative” treatments by a shaman. She was psychologically harassed and physically assaulted in her own home.

Source: UNDP, 2014h.

3.4.8 Gender-affirming health services

3.4.8.1 Introduction

For many trans people, medically transitioning is a vital prerequisite for their overall health and well-being. The term “gender-affirming health services” encompasses all of the medical support needed by trans people from the point they begin to consider a medical transition. It includes, for example, access to counselling and peer support, hormone therapy, hair removal, chest or breast reconstruction surgeries, genital surgeries, and other body modification surgeries. Hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; WPATH, 2008; Coleman et al., 2011).

Recent research undertaken to inform the development of WHO’s *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations* (WHO, 2014) found that transition-related concerns were the major health priority amongst the trans people interviewed. They can also be an important entry point to other health services.

The overall lack of transition-related information and services in the public health system, with regard to both hormone treatment and gender-affirming surgery, were seen as the greatest challenges to transgender people in achieving their highest attainable state of health ... providing competent and non-discriminatory transition-related treatment and care services through the public health system is considered vital for improving physical and psychological health amongst transgender people (WHO, 2014b).

In Asia and the Pacific, most gender-affirming health services, including any medical oversight of hormonal therapy, are not available through public healthcare systems. The exceptions are **Hong Kong SAR, China** and targeted services through an increasing number of states in **India** (Ministry of Social Justice and Empowerment, 2014).⁵²

Yet there are many ways that primary healthcare providers in all countries can support trans-specific health needs, treating trans people with dignity, equality, and respect. This section looks specifically at the experiences of trans adults in this region when trying to access hormones and gender-affirming surgeries. The experiences of children and youth, including good practice guidance, are covered in Chapter 5. Good practice guidance on gender-affirming health services for adults can be found in Section 4.8 and “Appendix A” 1.

3.4.8.2 Lack of healthcare coverage

In this region, the costs of most gender-affirming health services are not covered by public health systems or private health insurance. As a result, trans people have to pay out of pocket to access counselling, a diagnosis, laboratory tests, hormone treatment, hair removal, surgeries, and/or other treatment. These services are often available only in private hospitals or clinics and thus are prohibitively expensive for most trans people. For those who have private health insurance, reimbursement requests are rejected more often than not. This means that trans people may be forced to seek out cheaper and less clinically sound options or have irregular or incomplete treatment, and are lost to follow-up.

Public sector hospitals or clinics have little or no capacity to provide trans healthcare, as these procedures are not reimbursable and thus are rarely performed, if at all. The lack of capacity and non-reimbursable procedures create a vicious circle in many situations in the region. The lack of coverage, absence of specialist expertise, few protocols for trans healthcare, and negative attitudes of many healthcare personnel drive trans people into the arms of unregulated and nonqualified healthcare providers.

In **Thailand**, in 2009, the Thai Medical Council adopted the WPATH SOC7 for trans people in the public healthcare system (Chokrungrvaranont et al., 2014). However, implementation of these SOC would require considerable and long-term investment in capacity building, training, and sensitisation; clinical and laboratory skills and infrastructure; and the reimbursement of related costs of care. As a result, these SOC are not followed by the National Health and Social

52. Even in high-income countries such as **Australia** and **New Zealand**, trans people and health professionals have criticised the very limited availability of gender-affirming health services through their public health systems (Hyde et al., 2014; Aotearoa/New Zealand’s SOGII UPR Coalition, 2014).

Security Offices, who together provide health coverage for more than 80 percent of all Thai people (Chokrungruanont et al., 2014).

3.4.8.3 Assessments by mental health professionals

Few psychiatrists and clinical psychologists in the region specialise in gender-related mental health and transition issues. The cost of consultations with these professionals will easily exceed the budget of the average trans person. The WPATH SOC7 recommend a mental health assessment before hormone therapy. As “Appendix A” 1 notes, this can be done by an appropriately trained primary care or mental health provider.

Health professionals working in Asia confirmed that endocrinologists and surgeons in the region generally follow the WPATH SOC7 and require referral letters before initiating hormone therapy or gender-affirming surgeries. However, a referral letter from any licenced psychiatrist will usually be sufficient, regardless of the person’s expertise or how many consultations took place over what time period. In practice, referral letters are often released after one visit or a consultation with a mental health professional or an assistant. There is seldom any arrangement in place for providing any mental healthcare related to supporting the person’s transition.

There is an ongoing need to identify ways that primary care and mental health providers in the region can work together to provide mental health assessments and ongoing mental healthcare.

3.4.8.4 Hormones

This section of the Blueprint focuses on trans people’s access to and use of hormones in the region. For the vast majority, this takes place outside of the formal medical sector, as described below. This unregulated and unmonitored access to hormones raises significant health risks, which are discussed in both of those sections. Regional examples of trans people’s access to hormones through the formal medical sector are contained in “Appendix A” 1 (for adults) and Chapter 5 (for children and youth).

Trans people’s decisions about what hormones to use are frequently driven by their cost and perceived effectiveness in bringing about desired masculinisation or feminisation in the fastest time. In these circumstances, overall health considerations are typically not prioritised. This brings additional health risks in countries where hormone treatment or contraception are unregulated. These risks are heightened in countries, particularly in Asia, where specific forms of hormones that are no longer recommended internationally for trans people are available for purchase. In some countries, purchase is from pharmacists, while in others, including **China**, trans people frequently buy hormones from unqualified local producers and vendors (UNDP and USAID, 2014b).

Decisions about the type and amount of hormones to use are typically based on advice from trans peers. This can be inaccurate or outdated.

“I started transitioning when I was 11 years old ... I self-medicate using estrogen and anti-androgen, knowing it from them [transgender peers] ... medications [were] available over the counter in pharmacies.”

—A trans woman, Manila, **the Philippines** (WHO, 2013b).

Such decisions are made without knowledge about safety, short- and long-term impacts, contraindications, and side effects. There are no initial blood tests or medical checks beforehand to measure baseline hormone levels, nor is there medical guidance or oversight to monitor side effects and adjust dosage levels. If hormones are injected, unskilled or unhygienic practices may lead to scarring and inflammation, and possibly the transmission of infectious diseases, including HIV.

Not surprisingly, throughout Asia and the Pacific, trans people have high levels of concern about the potentially long-lasting adverse effects from long-term use of cross-sex hormones. Many “manage” short-term side effects such as nausea, headaches, and weight gain by going on and off hormones, whereas the long-term effects remain largely unknown at this time. There is significant unmet demand for information about safe hormone use, particularly in accessible formats, including in local languages.

“ ... I found some article[s] in English. But it’s lucky for me that I can read, I can write English. But for the [other] people, especially for the transgender in Thailand, it’s just very difficult for them ... to understand the scientific term[s], the vocabulary and the term[s] they use.”

—Transgender woman, 29, **Thailand** (WHO, 2014b)

Many health providers are ill informed about trans health needs, and some actively discriminate against trans people. Others are reluctant to prescribe hormones, fearing that doing so for trans people may be illegal (Singh et al., 2014).

In this context, trans people look to each other to fill vital information gaps; they currently source most information from peers or online. In some cases, this advice is robust, based on scientific evidence and informed by community members’ experiences. In other instances, it may be factually incorrect and even dangerous. Senior members of a community may have no medical knowledge or have access only to outdated information. Their status within that community may make it difficult for others, particularly new members, to question this advice.

Whereas peer support has been identified as an important enabling factor, such information may not always be accurate or sufficient to meet an individual’s health needs. This is particularly the case when considering possible interactions between hormone use and other medications, including for trans people who are HIV positive or have other health conditions. A mental health professional consulted for the Blueprint noted that peer counselling, with supervision from health professionals, can be very effective in resource-poor or remote areas, and could help meet information gaps in the region.

Across most of the region, trans people typically have no access to private or publicly funded targeted primary care services, such as STI and HIV testing or cross-sex hormone therapy. The region also lacks specialists within the public health system who can provide guidance about hormone therapy. In many parts of Asia, no secondary or specialist care is available through the public healthcare system, and no standard or targeted policies or procedures exist that outline the support trans people should receive. Within the private healthcare system, certain skills and expertise are available in some locations but are unaffordable and thus inaccessible to the majority of trans people. Even in the private sector, certain key disciplines, such as psychiatry, mental health, and dependency treatment, are poorly populated or developed.

One response from health professionals to address the specific health needs of trans people is the planned Tangerine Clinic in Bangkok.

CASE EXAMPLE: TANGERINE CLINIC

The clinic is a joint initiative of the Thai Red Cross AIDS Research Center (TRCARC), working with Research Triangle International in Bangkok. Financial support has come from the USAID Regional Development Mission in Asia.

The clinic will provide health services to both trans men and trans women, so they can access responsible gender-affirming hormone treatment under the guidance of trained and supportive medical and other professionals. HIV and STI testing, treatment, and care, and trans-specific rectal, neo-vaginal, genital, cervical, uterine, and breast evaluation will be available.

All services will involve consent and be provided at cost, giving trans people a say and ownership of what they know and want to have done about their bodies and health. Mental health, dependency, and sexuality consultation and counselling will be added as soon as trans-specific curricula for providers and protocols are ready to help facilitate delivery of these services to trans people.

Source: Research Triangle Institute. Email correspondence, April 27, 2015.

Note: The Tangerine Clinic will act as a research venue and will conduct both a formative evaluation to refine service delivery models for transgender people and an evaluation of the clinic pilot.

Feminising hormones

Regulated exogenous hormones are easy to purchase over the counter in pharmacies in several countries in Asia.

"I cannot get any access from the medical practice, medical providers, so I just read [about] it [on] the Internet ... Most [transgender people] are doing self-medication too. It's really rare to find trans women who [deal] with the doctor for hormone replacement therapy. It's expensive and the doctor also has stigma and discrimination."

—Transgender woman, 22, **Indonesia** (WHO, 2014b)

A 2003/2004 survey of 147 trans women in **the Philippines** found that most started hormones without any medical support, and all continued to self-administer them with no medical supervision. Many participants reported taking several doses each day, "swallowing as many tablets as they could afford to accelerate body changes" (Winter et al., 2007). Similar practices are common across Asia, and have been documented, for example, in **Lao PDR, Thailand, Malaysia, China, and Nepal** (Winter, 2012; UNDP, 2014b, 2014e). In Nepal, concerns have been raised that some healthcare professionals administer hormones for financial gain without explaining the consequences to their clients (UNDP and USAID, 2014e).

In the Pacific, there is an even smaller pool of private health professionals with any level of specialisation around trans health needs. So self-administered hormones—with limited or no medical guidance—are the norm. Unlike many parts of Asia, in the **Pacific**, trans women have access to a very limited range of hormones. The most commonly available one is estrogen, often combined with progestin in the form of oral contraceptive pills.

"Trans women in Suva, a whole lot of them are coming up to me and asking about hormones. But the information I give them is from the Internet. Some are going on and off [hormones] because of the mood swings. They really need a specialist. In the whole of the Pacific, there is no specialist, no nothing."

—Trans woman, **Fiji**

Source: Interview, February 2015

In other parts of the **Pacific**, the only option is to obtain hormones overseas, which raises additional risks. If complications arise, there is typically no access to specialists knowledgeable about hormone therapy for trans people.

“If there were hormones in my country, I would have changed already... One of my trans sisters got hormone pills from a trans person in the Philippines. Then she started feeling the side effects coming up. She came to me and I was really scared and told her I don’t know anything about that, we need to go see a gynaecologist. She nearly died.”

—Trans woman, **Papua New Guinea**

Source: Interview, February 2015

Masculinising hormones

There are no published studies available about trans men’s use of hormones in Asia or the Pacific.

This short section draws on material supplied by trans men and health professionals during the Blueprint consultations. Section 4.2 provides more details about the significant gaps in information that trans men in this region are able to access related to hormone therapy and other medically necessary, gender-affirming health services.

Androgens, such as testosterone, used by trans men to masculinise their bodies can be obtained in many parts of Asia, particularly Southeast and East Asia, including online. In countries where testosterone is more regulated, such as **Singapore**, it is more expensive. This is partly because the required prescription is usually accessible only through private clinics.

There is no indication that testosterone is available for trans men in the Pacific, with or without a prescription.

Interviews with trans men indicate that sourcing and self-administering testosterone is also widespread in Asia.

“A group of us just decided ... we should just start experimenting on one another ... The first time was really quite exciting and we all learned something together ... We can control the amount of dose we want to take ... So if you are doing it yourself, you can try and see what works best for you.”

—Transgender man, 27, **Singapore** (WHO, 2014b)

Relatively easy access to testosterone poses risks in situations in which trans men have limited or no access to a health worker knowledgeable about hormones. This is particularly an issue if there is no visible trans men’s community that can provide information about safe dosage levels and injecting techniques.

3.4.8.5 Surgeries

The older term “sex reassignment surgery” is usually used to refer to surgeries that create female genitals for trans women and male genitals for trans men. However, as Section 4.8.4 outlines, there are other surgeries sought by trans people in order to physically transition, including breast augmentation for trans women and chest reconstruction for trans men. Not all trans people experience gender dysphoria, and those that do may seek to modify only some parts of their body. For others, all gender-affirming surgeries may be medically necessary.

Public funding for any gender-affirming surgeries is rare in this region, outside of **Hong Kong SAR, China** and the provision of surgeries for *hijra* and *aravani* in some states in **India** (Winter, 2012). Long waiting lists to access surgeries through the public health system are reportedly an issue in these countries.

A 2014 study documented the experiences of *hijras* trying to access gender-affirming health services in seven major cities in **India**. It found almost no access to free services in tertiary-level public hospitals and high costs for genital surgeries in private hospitals. This study concluded that these costs have indirectly led many *hijras* to undergo *Dai Nirvan* or seek unqualified medical practitioners for removal of male genitalia.

“Our findings suggest the need to provide safe and affordable or free gender transition services in public health care settings, to equip health care providers to provide technically and culturally competent gender transition services, and to ensure a supportive legal environment and policies to promote the health of transgender people in India” (Singh et al., 2014).

Some *hijras* from India who participated in the February 2015 Blueprint consultations said that two public hospitals in Chennai currently offer gender-affirming genital surgeries for free. In addition, public hospitals in Delhi, Kolkata, Mumbai, and Chennai are offering such health services at subsidised rates.

Other trans people in India emphasised that such health services remain unavailable or inaccessible to most trans people. General concerns were raised that hospitals do not promote the gender-affirming health services that they do offer. This means most are accessed through a personal contact, often surreptitiously. In addition, it is rare for a health professional to have had specialist training in the health needs of *hijras* or trans people. This has led to significant concerns about the quality of care provided by some public hospitals. In mid 2015, as the Blueprint was being finalised, anecdotal evidence suggests that only one public hospital in India, in Bangalore, provides any subsidised hormone therapy or gender-affirming surgeries to trans men. Trans men may be able to obtain a diagnosis of gender identity disorder or gender dysphoria through some other public hospitals, but would then need to pay to attend a private hospital for any treatment.⁵³

In parts of South Asia, traditional castration practices outside of the formal medical system are still the predominant surgery undertaken by *hijras*.

In some parts of the region—for example, in **Viet Nam**—it is illegal to perform gender-affirming surgeries. As a result, no counselling or support is available. Both trans women and trans men have to travel abroad for such interventions; those who find specialists or surgeons willing to perform operations do so at their own risk. Health professionals cannot be held accountable, regardless of the result, as it is not a legal service.

In **Malaysia**, gender-affirming surgeries on trans women were performed by a team of doctors and psychologists at the University of Malaya Hospital between 1980 and 1982. The team provided counselling support and successfully lobbied the National Registry Department so that their clients were able to amend the gender marker on their identity cards. When the National Fatwa Council heard of this decision, it issued a *fatwa* (a religious edict) against what it referred to as sex reassignment surgery, and the university closed its services to all trans women. The university hospital was unsuccessful in trying to outline the scientific rationale for providing such surgeries, and so closed these services.

Health advocates involved in the Blueprint consultations critiqued this undermining of the medical basis for gender-affirming health services, as it negated the existence of trans people. Technically, there is no legal barrier to such surgeries in Malaysia, as the 1982 *fatwa* was not gazetted by any state. However, very few hospitals have performed the surgeries since that time. None of the trans people interviewed by Human Rights Watch for its 2014 report on human rights abuses against trans people in Malaysia knew of any hospitals that currently would perform such surgeries (Human Rights Watch, 2014).

53. Personal communication with Satya Rai Nagpaul, in consultation with trans activists of the Sampoorna Network (a network of trans and intersex Indians) from the following cities: Bangalore, Chennai, Delhi and Kolkata. Consultation conducted 5-9 June 2015.

CASTRATION IN SOUTH ASIA: A MEDICAL AND COMMUNITY PERSPECTIVE

In some trans communities, vaginoplasties are not prevalent. For example, *hijras* in South Asia have a traditionally different practice for feminisation. While some *hijras* will have a vaginoplasty, the practice more widely prevalent in the *hijra* community is castration. It is an orchiectomy, a penectomy, or both. There are also *hijras* who do not have any form of surgery.

Castration is associated with indigenous rituals and is referred to as *nirvani*. A person who undergoes the procedure is given a certain status within the *hijra* culture. This is linked to the old tradition of castration that was done by kings on male servants who then became highly respected servants, as they had access to the queen's quarters, too. This procedure was also a means to become associated with intersex individuals, who were already respected by the Mughal elite and the religious orthodoxy in South Asia.

These castration practices are shrouded in mystery in the *hijra* culture, and typically community members are not allowed to discuss castration practices with "outsiders." This general case example is provided as information for health professionals who provide health services to *hijras*. It is an attempt to talk about *hijras'* health needs in a way that respects *hijra* identity and culture.

These procedures have usually been performed by a senior *hijra* herself (who is castrated), quacks, midwives, or traditional healers. Some *hijras* are now beginning to approach qualified surgeons for the procedure, in some cases because it is more affordable than other forms of genital surgery.

The traditional procedures involve the individual taking lots of alcohol or other drugs, such as marijuana or opium; then the scrotal sack is cut, along with the testicles and the penis. The bleeding traditionally is cauterized with heated pins, a silver pin inserted in the urethra to keep it patent, and the wound bandaged. In some areas, burnt cow-dung is placed on the raw wound before bandaging. These procedures have resulted in deaths or serious infirmities later—for example, stenosis of the urethra. Castration also results in emotional imbalances and extreme loss of libido—effects that many *hijras* had not anticipated.

In India, the *hijra* community is increasingly approaching health professionals, including midwives, to perform the *nirvani* surgery in private clinics. The introduction of transgender welfare boards in Tamil Nadu and Karnataka has meant some *nirvani* operations are now happening in public healthcare settings.

Source: Dr Muhammad Moiz, Naz Male Health Alliance, Pakistan and Abhina Aher, *hijra* activist, India. Interview and email correspondence, May-July 2015

In other countries, gender-affirming surgeries are strictly regulated in ways that limit trans people's privacy and control over their own lives. In **China**, a trans person cannot access gender-affirming surgeries without the explicit consent of their families and a certificate from a mental health professional. This certificate must confirm that the trans person has been diagnosed with transsexualism for at least five years, lived as that gender for two years, and that their sexual orientation after surgery will be heterosexual (Asia Catalyst, 2015). These requirements are prohibitive, discriminatory, and incompatible with WPATH SOC7. Further restrictions include the need to show proof of no criminal record.⁵⁴ This restriction excludes many trans women, who are frequently arrested for doing sex work (Winter, 2012; UNDP, 2014b).

As in other parts of the world, not all trans people in Asia and the Pacific seek gender-affirming surgeries. For those that do, the most significant barriers are either the unavailability of such surgeries or the financial cost of paying for assessments, surgeries, and after-care in a private clinic. Trans women in low-income countries have limited access to any types of gender-affirming surgeries, including breast augmentation and genital surgeries. Even in **Thailand**, where surgery is readily available, only 11 percent of trans women from three cities sampled had undergone genital surgery (Guadamuz et al., 2011, cited in Baral et al., 2013). The Thai universal healthcare coverage scheme introduced in 2002 does not cover gender-affirming health services.

54. Health Office of Medical Affairs No. 185. 2009. "Sex Change Operations and Technology Management Standards." Available in Chinese at: <http://baike.baidu.com/view/3140460.htm>.

There is no evidence that gender-affirming surgeries are available in any parts of the **Pacific**.

For trans men, gender-affirming surgeries potentially include chest reconstruction as well as a hysterectomy and genital reconstruction. For many, even the relatively lower cost of chest reconstruction is out of their reach, despite WPATH SOC7 suggesting that this surgery is often a vital early step in a trans man's medical transition (Coleman et al., 2011). Trans men unable to have chest surgery report breathing problems, rashes, and pain from continuous use of chest binders to create a flatter chest contour (UNDP and USAID, 2014a; Acevedo et al., 2015). Section 4.8.2 summarises results from the 2014 Binding Health project, including suggested ways to minimise health impacts.

"I had to take on a loan to get my surgery, because I just wanted to get it over and done with so I can quickly get on with my life. Because it was just not possible for me to get out and get a job with the kind of body that I had and I just wasn't comfortable at all."

—Transgender man, 29, **Singapore** (WHO, 2014b)

Research with young trans women in Asia found that, for many, the most important aspect of their future was being able to have surgeries so they could transition physically to live as a woman (Youth Voices Count, 2013).

For many trans people in Asia, accessing gender-affirming surgeries involves travel to another country, typically Thailand. This is not a financial option for the vast majority of trans people in this region. As a result, major psychological distress is reported by trans people who wish to undergo these surgeries but are unable to do so (WHO, 2014b).

The cost of surgeries varies considerably, depending on the surgeon and the type of procedure. A quick search of prices online in Thailand and the United States identified many chest reconstruction or breast augmentation surgeries, starting at \$US10,000. Genital surgeries frequently cost between \$US15,000 and \$US25,000 for trans women. Some genital surgeries for trans men start at equivalent prices. However a full phalloplasty or penis construction can cost up to three or four times more. In addition, there are travel and accommodation costs for those who live abroad and travel for surgeries. Further costs include taking time off work for surgeries, which may be significant. For example, for trans men, genital surgery may involve four separate procedures spaced six months apart. For trans women, follow-up or two-step reconstructive surgeries are also often necessary to create or adjust shape or replace or remove hard tissue or scarring.

Participants in the *Being LGBT in Asia* dialogue in **Mongolia** in 2014 advocated that coverage of Mongolia's national health insurance should be extended to include gender-affirming health services, such as counselling, hormone therapy, and surgeries. In addition, gaps in services currently available in the country could be met through adding trans health needs to the Ministry of Health's recommended list for funded medical treatments abroad (UNDP and USAID, 2014d).

"I have never received medical service and treatment as a woman. I really don't know where to go because there is no specialist in the country who knows the special health needs of transgender people. We cannot afford hormone therapy and associated surgeries because they are not covered by health insurance."

—Trans woman, **Mongolia** (UNDP and USAID, 2014d)

3.4.8.6 Silicone and other soft tissue fillers—negative effects

Some trans women use injections of medical- or industrial-grade silicone oil, lubricant oils, caulk sealants, baby oil, and a variety of other substances to create a more feminine appearance in their faces and bodies. These injections into trans women’s hips, buttocks, thighs, breasts, lips, or face may cause serious health problems (Agrawal et al., 2014; Hariri et al., 2012; Visnyei et al., 2014). The injected products may harden, cause pain, and migrate to other parts of the body, resulting in permanent disfiguring and unwanted body changes. Such injections can lead to infection or chronic or acute systemic inflammation, which is particularly problematic for people living with HIV. Many women have died from such injections or “pumping.” In addition, there is a potential risk of HIV transmission if non-sterile equipment is used for such injections.

In this region, most research on silicone use has focused on Southeast Asia and documents trans women injecting silicone into their breasts, hips, buttocks, or face. A 2009 study found that 44 percent of participants in **Thailand** and 34 percent from the **Philippines** used injected silicone (Winter and Doussantousse, 2009). This is often delivered by someone with no medical training and in uncertain hygiene conditions (Winter, 2012).

There is little formal monitoring of the effects of soft tissue fillers in Asia and the Pacific. However, research in **Cambodia** has noted the negative side effects for trans sex workers from self-injecting fillers to change their facial features (Davis et al., 2014). In Cambodia, this includes injecting plant oil products such as *prengchan*. In **Viet Nam**, there is anecdotal evidence of serious harm and deaths caused by injecting non-medically approved silicone and other petroleum products (UNDP and USAID, 2014h).

One of the factors behind the demand for silicone and other soft tissue fillers is the lack of access to hormones or surgeries that create a more feminine appearance.

“Beauty salons ... provide silicone injection for their nose, their breasts, their hips ... Those who [perform the injections] are not professional nurses or doctors. They just get it from the black market ... Especially [those transgender people] who have occupation as prostitutes, they use that to enhance their beauty, their sex appeal ... Illegal injections using silicone oil are quite prevalent here ... because of the general poverty of trans people in my country, because they cannot afford gender-affirming surgery in either public or private [sectors], they ... opt to get illegal injections from quacks.”

—Transgender woman, 22, **Indonesia** (WHO, 2014b)

If health workers are not aware of the importance of body modification for trans people, they may be unaware of the risks trans women may take to feminise their appearance. Trans women may feel there is no other option available to them if they want to permanently modify their bodies. The guidance in “Appendix A” 1 of this Blueprint suggests screening, counselling, and a harm reduction approach as ways that health professionals can manage the serious health risks associated with silicone and other soft tissue fillers. “Outreach workers always bring me to have [a] VCT/STI test, but they don’t understand about our real problems ... sometimes I have pain in my face because of silicone surgery” (Youth Voices Count, 2013).

3.4.8.7 Gender-affirming care for trans people in detention

Detention and incarceration, however temporary, must not undermine access to general health services or lead to delays or interruptions in treatment. This includes having access to appropriate and timely treatment and care for HIV as a fully integrated component of primary healthcare services provided in penal institutions. In other regions, incarcerated trans persons have been known to face alarming levels of vulnerability to contracting HIV (Varella et al., 1996). It is crucial that prevention measures not be hampered by incarceration (WHO, 2014a). Prison populations should have access to condoms as well as confidential testing and counselling services (WHO, 2014a).

WPATH included a statement in its 2011 SOC clarifying that all elements of assessment and treatment described in the SOC7 apply to people living in prison and other institutional environments. In line with international human rights standards, the SOC7 note that health care for trans people living in an institutional environment “should mirror that which would be available to them if they were living in a non-institutional setting within the same community” (Coleman et al., 2011). The SOC7 emphasise that gender-affirming health services are medically necessary treatments and should not be denied to trans people detained in prison or a long-term health facility. This may require that detention facilities consult with health professionals who are knowledgeable about this specialised area of healthcare.

People already on hormone therapy or who meet the criteria to start such therapy should have access to hormones and be monitored appropriately. Denial of such treatment when hormone therapy is medically necessary carries a high likelihood of negative outcomes, such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality (Brown, 2010).

In this region, trans people are likely to buy and use hormones with no medical supervision. While they are in prison there is an opportunity to monitor their hormone levels and adjust the type and dosage of medication to address related health concerns.

3.4.9 Trans-specific sexual health information

This section of the Blueprint looks at some very narrow sexual health issues specific to trans people. This material sits within the much wider context of sexual health and sexual rights. These are most recently summarised in the June 2015 WHO report, *Sexual Health, Human Rights and the Law* (WHO, 2015a).⁵⁵

DEFINING SEXUAL HEALTH

“Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled” (WHO, 2006).

Trans bodies and sex

The Centre of Excellence for Transgender Health has developed three sexual health resources—one for trans women, one for trans men, and a separate one on fertility issues for trans people.⁵⁶ These touch on some important practical issues and sexual health needs specific to trans women and men.

It is very difficult for trans men in Asia and the Pacific who identify as gay to find any local sexual health information about negotiating safer sex. A Canadian sexual health resource was developed by and for trans MSM. It provides information on identities, sexuality, sexual behaviours, and experiences of queer trans men as well as advice about safer sex.⁵⁷

55. Sexual rights are defined in a 2006 WHO report on a technical consultation on sexual health. They are also outlined in the World Association for Sexual Health’s 2014 *Declaration of Sexual Rights*. Available at: www.worldsexology.org/resources/declaration-of-sexual-rights/.

56. Links to the sexual health pamphlets can be found online. Available at: <http://transhealth.ucsf.edu/trans?page=lib-00-0>.

57. Available at: <http://librarypdf.catie.ca/PDF/ATI-20000s/24654.pdf>.

Advice for trans women who have a penis and use it for sex

"It's healthy and normal to use your penis for sex. You should know that to keep an erection, you need some testosterone (T) in your body. If you are taking female hormones, it may be harder to keep an erection. Ask your healthcare provider what hormone doses are right for you. Keep in mind [that] when you take a lower dose of female hormones, the changes you may want to see may take longer."

Advice for trans men who have a vagina and use it for penetrative sex

"Testosterone can also thin the walls of the vagina. You could use a low dose estrogen cream inside the vagina to keep it from thinning too much. This will help [to keep] the vagina from bleeding if you have vaginal sex, which lowers the chances of getting an STI, especially HIV."

Source: Centre of Excellence for Transgender Health's Transgender Health Learning Center.

Douching

During consultation for this Blueprint, trans women asked for trans-friendly and appropriate information about personal hygiene—specifically douching. A trans woman from the **Philippines** described many instances in which trans women were physically assaulted by a sexual partner after anal sex if any fecal material appeared on his condom or penis. Some trans women in Asia were buying vaginal douches over the counter and using these, even though they are not designed for anal douching and should not be used for this purpose because of the potential of damaging anal mucosa. A trans woman from the Pacific said that there is no information available in the **Pacific** about douching, either for trans people or MSM.

"For us in the Pacific, younger trans women learn about douching from older trans women, especially from those that have worked in the sex industry ... We don't use enemas or syringes, as this costs money. For most of us, it's just a piece of hose pipe with one end on the tap and the other which goes on the rectum. And it depends on the individual what amount of water you want to pump into your intestine. The other way is using a soft drink bottle. You fill the bottle with water right to the top and put the top of the bottle against your rectum ... And this is repeated until the individual feels that there is nothing there [left inside]."

—Trans woman, **Fiji**

Source: Email correspondence, March 17, 2015

Evidence-based advice on douching is limited. The following information is not an official protocol and is included as a harm-minimising resource. Some citations have been included where supporting evidence is available to support the comments made.

For Trans People—Is douching necessary for anal sex?

- No, the most important thing is to make sure your sexual partner wears a condom and uses a condom-compatible lubricant (lube). This lube is water or silicone based.
- If you are concerned about cleanliness, going to the toilet half an hour before anal sex and cleaning the area around the anus with a moist cloth is good enough.
- Only a small amount of feces are likely to get on the condom, although it may look like more because of the lube.
- Relax. Sex is messy. If you make a mess, wash it up with soapy water.
- Your sexual partner does not have the right to force you to do anything—this includes forcing you to douche.

If you choose to douche:

- This should be done at least an hour before anal sex.
- Only use water when douching; make sure it is warm, not hot.
- If tap water is not clean enough to drink, do not use it for douching. Instead use filtered water or a saline solution (Gluckman and Emirzian, 2013).
- Anything other than water can cause irritation to the lining of your rectum. This may make you more likely to get HIV or another STI.
- Never use a vaginal douche for anal douching.
- One option is to fill an ear syringe with warm water. Gently squeeze this water into your rectum. This small amount of water should not cause any damage and should remove any residue left inside your rectum.
- Do not use a shower head or other water jets to douche. It is difficult to control the amount of water from water jets. The pressure also causes small tears in the lining of your rectum.
- Make sure you can control the water pressure if you are using another water source to douche.
- Wash the ear syringe or any other douching equipment thoroughly before and after use. Wash them with a mild anti-bacterial soap and hot water.
- Never share this ear syringe or other douching equipment with anyone else.
- Frequent douching is not a good idea, because it irritates the delicate lining inside of your colon. This causes small tears and makes you more vulnerable to HIV and other infections (Schmelzer et al., 2004).
- If a condom breaks during anal sex, do not douche. This can cause the semen (cum) or broken condom to be pushed further up into your rectum.

3.4.10 Training health professionals

Addressing the discrimination that trans people experience in health facilities is as important as developing proper medical procedures (UNDP and USAID, 2014b). Considerations to take into account are any additional safety and privacy needs for trans people. Examples of these needs could include access to private shower facilities for in-patient care and ensuring trans people can participate in sex-segregated therapy sessions or support groups based on their gender identity.

In 2014, participants in a transgender roundtable in **China** agreed that health professionals in their country require training on trans health issues, including medical and surgical procedures and post-surgery care. However, while this information is very necessary, it is not sufficient on its own. Participants identified a parallel approach, in which greater medical knowledge would be effective only within the context of anti-discrimination training that dispelled health providers' myths and stereotypes about trans people. Their vision was a trans-health model that highlighted "a spectrum of bodies and genders, harm reduction and advocacy, informed consent, peer expertise, self-determination and non-disordered gender complexity" (UNDP and USAID, 2014b).

The following examples demonstrate some initial steps in this region to build the capacity of health professionals to address trans health issues. These are in addition to other examples, described earlier in the Blueprint, that focus on HIV prevention, diagnosis, treatment, and care for trans people.

"The Time Has Come" is a regional training package for health providers, designed to reduce stigma in healthcare settings and enhance HIV, STI, and other sexual health services for both trans people and MSM. It offers an interactive training programme designed by expert peer trainers, and was jointly developed by the UNDP Bangkok Regional Hub and WHO's SEARO and WPRO. The training materials are available freely at the website below.

Source: www.thetimehascome.info.

In **Mongolia**, the Ministry of Health adopted a new Code of Ethics in November 2013. It defined non-discrimination as also including gender identity and sexual orientation. The feedback from health professionals who attended a UNAIDS human rights trainings in 2014 was very positive. Many admitted that they had never before had an opportunity to access information on the human rights of trans and LGB people, and how that affects their expected behaviour as health professionals.

The Reproductive Health Association of Cambodia (RHAC) has started a three-year project on transgender health, with support from the Swedish Association for Sexuality Education. This project commenced with a rapid assessment and a baseline survey of RHAC service providers and clinics. It identified that the current systems for gathering information about people's gender identity, and thus the health needs of trans people, were inadequate and need to be revised. Previously, providers received little orientation or training on trans health, and several expressed unsupportive views and attitudes in the survey. RHAC considers this as a major opportunity to improve the capacity of its service providers through training and developing modules on trans health (Reproductive Health Association of Cambodia, 2014).

3.4.11 Health research needs

There is a paucity of regional information about almost every area of trans health and well-being discussed in this Blueprint.

Winter (2012) mapped out some priority areas for research to realise trans rights in the region. These focused on collaborative research projects developed in partnership with trans people and finding ways to disseminate vital health information, particularly to isolated areas, in local languages. Other research priorities included size estimations of trans populations and documenting risk factors and protective factors that build resilience, alongside human rights

obligations and violations. Finally, Winter emphasised the need to document examples of trans-positive, competent, comprehensive, and accessible healthcare.

A 2013 regional assessment of trans people’s HIV, STI, and other health needs identified a range of strategic information gaps, including regular surveillance for HIV and STI; long-term use of hormones and their known health risks; the health of trans men; issues for trans youth and the health needs of trans people as they age; and the social determinants of trans health (WHO, 2013b). These are echoed in a recent APTN report (APTN, 2015).

This need to better understand different subpopulations within trans communities is also matched by an imperative to research the particular experiences of trans people in the Pacific. At the same time, the level of acceptance of gender diversity within some parts of the Pacific may inform culturally appropriate care for the many Pacific trans people living in New Zealand and Australia.

Compared to other regions, the size and linguistic diversity of Asia and the Pacific is likely to mean there are fewer opportunities for networking amongst health professionals, academics, and trans health advocates interested in trans health research. Identifying a research agenda is beyond the scope of this Blueprint. Both a human rights approach and sound research practice would suggest that trans people need to be actively involved in identifying research priorities.

3.5 Legal gender recognition

3.5.1 Importance of legal gender recognition

The right to recognition before the law is set out in the UDHR and binding human rights treaties.⁵⁸ The Yogyakarta Principles summarise how these apply to the human rights issues related to gender identity.

YOGYAKARTA PRINCIPLES

Principle 3: The Right to Recognition before the Law

“Every person’s self-defined sexual orientation and gender identity is integral to their personality and is one of the most basic aspects of self-determination, dignity and freedom. No one should be forced to undergo medical procedures, including sex reassignment surgery, sterilisation or hormonal therapy, as a requirement for legal recognition of their gender identity. No status, such as marriage or parenthood, may be invoked as such to prevent the legal recognition of a person’s gender identity.”

Identification documents are required for most activities in daily life. Trans people face marginalisation when they are required to use a birth certificate, passport, or other identity verification document that does not match their gender identity or gender expression. This discrimination may involve threats to a trans person’s safety or exclusion from vital health services, housing, employment, school, or social assistance. Thus, legal gender recognition must be a public health priority.

When trans people are disowned by their families this can have a significant impact on their attempts to gain legal gender recognition, particularly if parental permission is required to change or obtain identity documents. Many trans people are forced to leave their own region or country to start a new life. This can mean losing access to important family identity documents. For example, trans people in Indonesia who move to larger cities may not have the Family Card, which is needed to obtain an individual ID card. Without such a card, they cannot access basic services.

58. UDHR, Article 6; ICCPR, Article 16; CEDAW, Article 15; and CRPD, Article 12. In addition, Article 8 of the Convention on the Rights of the Child requires states to “respect the right of the child to preserve his or her identity.”

3.5.2 Natural disasters and gender recognition

Often identification is required at particularly vulnerable points in people's lives, such as medical emergencies, natural disasters, or when people are crossing borders or are homeless. In these circumstances, trans people who do not have identity documents that match their gender identity or expression may be turned away from essential services. This has previously been the documented experience of trans people as a result of devastating floods in **Pakistan**, tsunami in **India**, and earthquakes in **Haiti** (UNDP, 2013).

Below are two recent examples from the earthquake disasters in **Japan** and **Nepal** in 2011 and 2015, respectively.

LEGAL GENDER RECOGNITION ISSUES IN NATURAL DISASTERS: JAPAN 2011 EARTHQUAKE

The Great East-Japan Disaster is a term used to describe the March 2011 earthquake off the Pacific Coast of Tōhoku and subsequent related earthquakes and tsunami. The Social Inclusion Support Center, a community-based organisation, set up a telephone support service in October 2011 in response to the ongoing needs of disaster survivors. This *Yoriso* Hotline became a nationwide service after receiving some government support in March 2012. Callers could select a specific option if they had difficulties related to sexual orientation, gender identity or gender expression issues. Of the 10,878,227 calls made to the *Yoriso* Hotline between 1 April 2012 and 31 March 2013, 3.6 percent dialed this option (Yamashita and Gomez, 2015). This is unlikely to represent the full extent of LGBT community needs, as some of the issues LGBT people faced would not be related to their SOGIE issues and many may not wish to disclose their SOGIE status.

Typically, trans people living in the areas affected by the disaster had not openly disclosed their gender identity prior to the disaster. Many were forced to do so because of the public nature of evacuation centres or in order to regain access to hormone treatment after medical clinics and hospitals were destroyed. They feared discrimination and most did not have access to the support of a trans or wider LGBT community in their area. Some avoided going to the toilet or washing because they did not know if they would be safe in sex-segregated washrooms or public baths. With little or no privacy, some did not change their clothes—including trans men scared of showing they were wearing chest binders. There were positive experiences too, such as a trans woman who was accepted as a woman at a refuge, given access to a women's dressing room and bathroom, and supported by other women when men harassed her for being trans (Yamashita and Gomez, 2015).

While the Great East-Japan Disaster disclosed the pressures faced by trans and LGB people in the Tōhoku region, it also improved understanding about these issues amongst some women's and civil society organisations. This has led to calls for the specific needs of trans and LGB people to be included in disaster risk reduction plans.

Source: Yamashita and Gomez, 2015.

LEGAL GENDER RECOGNITION ISSUES IN NATURAL DISASTERS: NEPAL 2015 EARTHQUAKE

“The quake cast many transgender people out into the streets, as their homes crumbled; 65 homes of transgender people and their families [were] fully destroyed, at last count. When relief camps were quickly set up, people without families were segregated into male and female camps. Where did that leave the third gender?”

The lack of government identification papers reflecting trans people’s gender identity often leads to exclusion from relief centres or government handouts. Also, basic facilities such as toilets and bathrooms in emergency shelters are typically divided into male and female venues. Having to share toilets, particularly at night, put trans people at risk of violence and rape.

In partnership with international organizations, the Blue Diamond Society organised 15 tents in Kathmandu for people from the LGBTIQ community; and 50 tents for trans people and their families in the other affected districts. Both trans women and trans men felt safer together in these communal tents.

“The transgender community is using the same courage, resilience and tenacity that won them legal recognition, to shape relief efforts in Nepal [and to] set an example for future emergencies around the world. Gender considerate disaster risk reduction is essential, and transgender people need to be included in preparation planning. Their voices must be heard and their issues must be addressed in the current post disaster risk assessment.”

Source: Adapted from a media release issued by Blue Diamond Society and Asia Pacific Transgender Network, 3 June 2015. Accessed 10 June 2015 at: www.weareaptn.org/news/5/6/2015/op-ed-in-quake-hit-nepal-transgender-people-turn-adversity-into-opportunity.

3.5.3 Access to gender recognition in this region

The vast majority of trans people in Asia and the Pacific cannot obtain official documents under their appropriate names and/or sex to match their gender identity.

In many countries, there are no laws or policies allowing a trans person’s gender marker to be changed. This is the situation in all **Pacific** countries, though a small number of countries, including **Niue, Guam, Fiji, and Tonga**, do allow someone to legally change their name.

There are also no laws or policies enabling gender recognition in **Thailand, the Philippines, Viet Nam, or Malaysia**.

There have been individual cases in **Malaysia, Indonesia, and the Philippines** in which a court has enabled a trans woman to change her gender marker after gender-affirmation surgery. However, as recently as 2012, the Prime Minister’s Office told Parliament that such changes are not permitted in Malaysia (Human Rights Watch, 2014). A 2007 Supreme Court decision in the Philippines removed the right previously held by trans people to apply to the Regional Trial Court for gender recognition (Winter, 2012; Open Society Foundations, 2015). As noted in Section 2.5, the Commission on Human Rights of the Philippines has stated it would be supportive of a case under the women’s equality law to clarify whether trans women are able to change sex details on their birth certificate.

In other countries, laws and policies limit gender recognition to a minority of trans people, with strict stipulations that violate other human rights. One of these is requiring trans people to undergo all gender-affirming medical surgeries—often discussed in laws as “full sex reassignment surgery.” This requirement has been heavily critiqued by UN agencies, human rights experts, and health professional bodies (WHO, 2014; Méndez, 2013; Global Commission on HIV and the Law, 2012; WPATH Board of Directors, 2015; International Commission of Jurists, 2007).

Although many trans people wish to medically transition, the steps involved mean it is often a long-term goal. For other trans people, it is never a possibility because of financial, medical, or personal reasons. This is particularly true for trans men, as creating male genitals involves multiple stages of surgery; frequent technical difficulties and post-operative complications mean only a small minority of trans men have such operations (Coleman et al., 2011). If legal gender recognition requires such medical steps, trans people can be forced to spend many years, or all of their lives, with no legal verification of their gender identity.

The Ardhanary Institute has documented 11 cases in **Indonesia** since 2011 in which trans people have been convicted for amending their gender markers without undergoing surgery. Typically, these trans people had tried to change their gender markers so they could marry their partners. In one 2011 case from Central Java, a 26-year-old trans man known as Rega was jailed for 18 months after the family of his 17 year-old bride “discovered” on the day of his wedding that he was “born a woman.” Rega was charged with fraud and with having sex with a minor (UNDP and USAID, 2014c).

In **Thailand**, it is mandatory for legal documents to have an honorific or title that matches a person’s sex at birth. This title cannot be changed, even if a trans person has had gender affirmation/sex reassignment surgeries. In 2008, the LGBT community unsuccessfully petitioned the courts to allow trans women to change their titles from Mr to Ms. Only intersex people can change their titles after surgery (UNDP and USAID, 2014g).

In some countries that have a medical threshold for changing sex or gender details, the type of medical interventions required are not always clearly stated. At the *Being LGBT in Asia* regional dialogue in February 2015, a member of parliament from **Mongolia** recommended that requirements for registering a change in legal sex there should be clarified. She noted “It is not satisfactory that officials can impose their own interpretations ... and exercise discretion in an unpredictable or capricious way” (UNDP, 2015).

Gender recognition laws in **Japan, Singapore, South Korea, Taiwan, Hong Kong SAR, China, and mainland China** all require gender reassignment surgeries and sterilisation.⁵⁹ In Singapore and Hong Kong SAR, China, even after undergoing these procedures, trans people can change the gender markers only on their National Registration Identity Cards, not their birth certificates. Since 2008, trans people in mainland China who have had these surgeries and met the other criteria detailed below have been able to change their household registration records (*Hu Kou*). However, it remains difficult to change education records retrospectively, which creates obstacles to employment and higher education (Balzer and Dutta, 2012; UNDP, 2014b; UNDP, 2014e).

Additional barriers to gender recognition in **South Korea** and **Japan** are requirements that a trans person be over the age of 20, unmarried (and required to divorce if already married), and have no children.⁶⁰ **China** also requires someone to inform direct relatives, divorce if married, live and work in their affirmed gender, and have no criminal record. Meeting all of these criteria is very difficult for trans people, especially given that sex work is both illegal and the main form of employment for many trans women in China.

No country in Asia enables trans children and young people to amend their sex details on legal documents, even with parental consent. This is possible in both **Australia** and **New Zealand**.

In the few countries in Asia and the **Pacific** where a trans person has the right to marry, it is permitted only after surgeries that result in sterilisation. These restrictions undermine trans people’s rights to recognition before the law and infringe on their rights to privacy, finding (or raising) a family, and non-discrimination (Open Society Foundations, 2015). As noted in Section 3.3.9., New Zealand’s Marriage Act was amended in 2013 to clarify that a marriage is between two people, regardless of their sex, gender identity, or sexual orientation.

Across Asia, trans people often do not know whether or how they can apply to change their gender markers. The absence of such information can add even further weight to family pressure that forbids someone to transition legally or socially (UNDP and USAID, 2014a).

59. A December 2013 media report indicated that Taiwan was considering removing any medical requirements (Yiu, 2013). Trans people in Taiwan have confirmed that it is yet to be enacted.

60. In Japan, the parenting restriction has been lessened slightly, stipulating that trans people are not eligible if their children are under the age of 20.

In only a few countries in Asia have activists started to take court cases or initiate campaigns about their right to gender recognition. As discussed later in this section, some are very aware of world-leading gender recognition laws in Argentina and Malta that focus on the right to self-determination.⁶¹

A similar emphasis on self-determination is reflected in the WPATH Board's January 2015 statement on identity recognition (WPATH Board, 2015). It "urges governments to eliminate unnecessary barriers, and to institute simple and accessible administrative procedures for transgender people to obtain legal recognition of gender, consonant with each individual's identity." The WPATH statement explicitly opposes any medical requirements or restrictions on married people or parents gaining legal gender recognition. Furthermore, it maintains that trans youth and trans people in prison or other institutions also require legal gender recognition.

In other parts of the region, trans activists have been fighting to simply gain the right to change their gender markers after undergoing gender-reassignment surgeries (UNDP and USAID, 2014h). In 2013, the **Hong Kong SAR, China** Court of Final Appeal, in *W v. Registrar of Marriages*, finally allowed a trans woman who had undergone "sex reassignment surgery" to marry her boyfriend. In the wake of that court decision, a campaign was launched in Hong Kong SAR, China for a Gender Recognition Ordinance.

In the Pacific, the 16th Attorney-General's conference in **Fiji**, in December 2014, included a session on gender identity and the law. A trans woman attending from the Amithi Fiji Project called for legal gender recognition without any requirement to undergo medical treatment or surgeries (Pratibha, 2014).

3.5.4 Third gender categories

As noted in the terminology section, in both Asia and the Pacific there are long-standing culturally specific terms for trans people. Many of these refer to someone assigned a male sex at birth who identifies as other than male or female, and often as a third gender. There are also other trans people in the region, including those who use culturally specific terms to describe their gender identity, who do not see themselves as a third gender.⁶²

Four South Asian countries have recognised the specific status of *hijras*, *metis*, *khawaja siras*, and other trans people who identify as a third gender. Supreme Court rulings in **India**, **Nepal**, and **Pakistan** have all legally recognised a third gender status. In Nepal and Pakistan, slow implementation and restrictions on eligibility mean that the vast majority of *metis*, *hijras*, *khawaja siras*, and other trans people still do not have legal gender recognition. **Bangladesh** introduced a third gender category for *hijras* in November 2013, along with priority access for education and other rights (Karim, 2013).

A third gender category was created in **Nepal** after the December 2007 Supreme Court decision (*Pant v. Nepal*). It has been used by some banks and in Nepal's 2011 census form, though administrative and logistical problems meant that the census largely failed to record those who identified as a third gender. A third gender category was only added to Nepal's Citizenship Certificate (*nagarikta*) in 2013. It is based on self-defined identity with no medical or other expert verification required. However, very few such Citizenship Certificates have been issued because local and district administrations still typically require some form of expert proof. In addition, these are restricted to new applicants, excluding *metis* or trans people who have already been issued a male or female Citizenship Certificate (Martinez, 2014; UNDP, 2014e). In August 2015, Nepal introduced a third category on passports, marked "O" for other.

A 2013 survey of 1,200 LGBT people in **Nepal** found that 44 percent identified as a third gender. Yet only 8 percent (82 people) had tried to change their gender on their citizenship documents.⁶³ Only five people were successful, including

61. Argentinian Gender Identity and Health Comprehensive Care for Transgender People Act (Decree No. 773/12, of Gender Identity Act No. 26.743); Malta's Gender Identity, Gender Expression and Sex Characteristics Act; available at: <http://tgeu.org/malta-adopts-ground-breaking-trans-intersex-law/>.

62. For some trans women and men this reflects their identity as female or male respectively, not as a third gender. Others have critiqued third gender options, arguing that consigning trans people to a third gender maintains a male / female binary as the norm (Open Society Foundations, 2014).

63. This is calculated as a percentage of those who answered this question.

one trans man. Possible reasons for such low uptake of these provisions include inefficiencies or government officials' prejudice or lack of awareness. Within the community, there also may be confusion about the meaning and legal status of an "other" category, and concerns by LGB people that they also are perceived to be a third gender. In addition, trans women and trans men may wish to identify as female and male, respectively, rather than as a third gender (UNDP/Williams Institute, 2014). Nepal participants at the Blueprint consultations also mentioned that, unlike India, their country currently offers no affirmative action policies that provide a financial incentive for them to register officially as a third gender.

In December 2009, the **Pakistan** Supreme Court required registration forms to have a third column for *khawaja siras*/eunuchs (*Khaki v. Rawalpindi*), whose identity would be confirmed through unspecified medical tests. The Election Authority and the Social Welfare Department also agreed to work together to ensure that all registered *khawaja siras*/eunuchs were entered into voter lists (International Commission of Jurists, 2011). An April 2012 report stated that nobody had yet been issued with an identification card recognising their third gender (Bochenek and Knight, 2012).

Tamil Nadu was the first state in **India** to recognise "transgender" as an option for trans women (*aravani*) on ration cards; in 2013, this third gender option was added to India's new *Aadhaar* ID numbering system.

Both **Australia** and **New Zealand** have an additional third gender option on passports for anyone, not just trans people. This is based solely on someone's self-defined gender identity (although Australia requires a supporting letter from a health professional). One territory in Australia applies this approach to birth certificates as well (Open Society Foundations, 2014). This means that any person is free to use an M, F, or X as their gender marker on these documents.

Similarly, the April 2014 decision from the **Indian** Supreme Court, *National Legal Services Authority v. Union of India*, recognises a third gender option (specifically for *hijra*) but also stipulates that all trans people have the "right to decide their self-identified gender ... such as male, female or a third gender." It directs central and state governments to legally recognise trans people's gender identities. The judgement cites the Yogyakarta Principles and Argentina's 2012 gender recognition law, and recognises trans people's constitutional rights to personal autonomy, self-determination, and freedom of expression.

This raises wider debates for the region as a whole about how to recognise the rights of those who identify as third gender, while also enabling trans women to identify as female and trans men to identify as male—and providing them with the same legal protections.

3.6 Next Steps

It is fitting that this first half of the Blueprint ends with a focus on **India**—where a Supreme Court decision and a proposed Rights of Transgender Persons Bill have placed many of the human rights priorities for this region on the legislative agenda. What is perhaps most relevant is that both the Supreme Court decision and the Bill emphasise the linkages between these human rights issues and trans people’s access to gender-affirming health services.

It is hoped that the material provided in this first half of the Blueprint contributes to these national and regional debates, primarily through examples of common challenges and emerging good practice.

In the second half of the Blueprint, attention turns to sharing examples of good clinical practice that will improve trans people’s access to both general health services and medically necessary, gender-affirming interventions required by those who medically transition.

Chapter 4 provides clinical advice about supporting trans adults’ health needs. Chapter 5 gives additional advice for health professionals working with trans and gender-nonconforming children and youth. Chapter 6 suggests policy considerations to improve trans people’s access to the right to health, freedom from discrimination and violence, and full gender recognition.

.....

**COMPREHENSIVE
CARE,
PREVENTION,
AND SUPPORT**

.....

Information in this section about prevention, diagnosis, and treatment of HIV, STI, alcohol and drug use, mental health, etc., is based on WHO guidelines. However, WHO does not have specific policies, recommendations, or guidelines on gender-affirming therapy, surgery or preventive care. Such guidance would need to be developed through standard WHO guidelines development processes. Information relevant to gender-affirming hormone therapy, surgeries, and preventative care (see Section 4.8) is therefore based on other sources and good practice examples, in particular the care protocols developed by the UCSF Center of Excellence for Transgender Health⁶⁴ and WPATH SOC7. These provide peer-reviewed guidance on gender-affirming hormone therapy, surgeries, and preventative care.

4.1 Introduction

In many countries, the first healthcare worker a trans person may disclose their identity to will be a general practitioner or a family (medicine) doctor. Chapter 4 is mainly for such primary care providers and is designed to increase their capacity for trans cultural competence (see Other Key Terms, pg xiii). Primary care providers' role is to understand and explore issues of gender identity, conduct initial assessments, make appropriate referrals if they are not experts, discuss the pros and cons of various medical and surgical interventions, manage both transition-related and routine health issues, and provide preventative care appropriate and tailored to the individual.

Trans people need access to primary care and trans-specific healthcare services. Within the region, and even within countries, trans people access care in different ways. This includes accessing hormones directly from pharmacists or over the internet. They seek gender-affirming care from private physicians, public clinics, specialist clinics, hospitals, sexual and reproductive health centres, NGO projects, or less commonly from specialised gender centres staffed by interdisciplinary care teams.

Coordination of care is critical, especially when trans people are likely to be reliant on care from a range of health professionals if they medically transition. A referral network or directory of trans-friendly and competent providers that goes beyond healthcare to include social care can further support trans health needs. Regular communication is essential. In addition, providers who see a critical mass of trans clients in a given area could be encouraged to hold regular meetings or establish online, secure forums to exchange information and discuss and resolve challenges they encounter in providing comprehensive care.

Health professionals throughout the world—even in areas with limited resources and training opportunities—can apply the many core principles that undergird the WPATH SOC7. These principles strongly inform the guidance in Chapter 4 of this Blueprint. They include the following:

- Exhibit respect for clients with nonconforming gender identities (do not pathologise differences in gender identity or expression)
- Provide care (or refer clients to knowledgeable colleagues) that affirms clients' gender identities and reduces the distress of gender dysphoria, when present
- Become knowledgeable about the healthcare needs of transsexual, transgender, and gender-nonconforming people, including the benefits and risks of treatment options for gender dysphoria
- Match the treatment approach to the specific needs of clients, particularly their goals for gender expression and need for relief from gender dysphoria
- Facilitate access to appropriate care
- Seek clients' informed consent before providing treatment
- Offer continuity of care
- Be prepared to support and advocate for clients within their families and communities (schools, workplaces, and other settings)

64. Available at: www.transhealth.ucsf.edu/protocols.

These examples of care protocols are designed for high-income countries. However, the general principles can be adapted and implemented in various settings, including those that are resource limited.

This chapter includes practical information that will assist health workers to support trans people. General considerations in trans-competent service provision include the following:

- Improving health interactions with trans people
- Understanding the importance of the first interaction a trans person has with the health service provider, including the client intake form, reception, waiting room, etc.
- Considering the types of approaches that make a difference for the health of trans clients
- Using or adapting a trans-competent primary care protocol that includes HIV and other STI testing, counselling, and treatment
- Providing sexual health information relevant to trans people
- Addressing mental health concerns, alcohol, and other substance use
- Promoting resilience amidst stigma, discrimination, and violence
- Addressing the consequences of physical violence
- Knowing specific gender-affirming healthcare related to body modifications
 - Facial and body hair removal
 - Non-medical body modifications (such as binding and tucking)
 - Hormone administration
 - Surgical and other medical procedures

Chapter 5 provides specific information for health professionals working with gender-diverse children or youth clients.

There are generally **two fundamental principles** that providers and other healthcare staff should adhere to when treating trans clients:

1. Honour the patient's preferred gender identity and use the name, pronouns, and terminology that the patient prefers.
2. Understand that gender identity and anatomy may not be congruent. Provide medical care that affirms the patient's gender identity even while addressing issues or providing treatments typically for persons of the other sex.

4.1.1 Tips for improving health interactions with trans people

At consultations in Nepal and Bangkok, more than 100 participants were asked to write short quotes that could be shared with health professionals via the Blueprint. These quotes focused on identifying the actions health professionals could take, or should avoid, in order to improve health services for trans people. The responses, from a very diverse range of trans people and some health professionals, produced these consistent themes.

THESE ARE FIVE POSITIVE THINGS HEALTH PROFESSIONALS COULD DO TO MAKE A DIFFERENCE:

1. Listen and support trans clients

"Healthcare providers should not make assumptions about what their clients need. We need to listen carefully to what clients tell us. Every trans person is a unique person, each with their own goals. There is no single journey that a trans person ... has to take. Listen to what they need."

2. Be professional and respectful

"Respect our body status, identity, preferred pronouns and privacy."

"Follow your (professional) ethics and provide the highest possible standard of healthcare for everyone."

"Stop being judgemental and do your job as a health worker ... Being judgemental never allows us to be open in front of you, and our issues are always unresolved."

3. Know and respect human rights

"Universal healthcare must not leave any human being behind, regardless of whether you are a transgender."

"Health is about well-being, no one decides for me except myself."

4. Learn about trans health needs

This included being aware of medical information about specific treatment options and knowing how to work with a diverse range of trans people having different needs.

"Understand the needs of trans people because good health facilities are the rights of everyone no matter if you are male, female and/or trans."

"You will treat trans clients over your career, so you need to start becoming educated about trans health needs."

"Do not assume that all trans people fit into the same mould and have the same health needs as each other."

5. Provide trans healthcare information, referrals, and services

The most frequent request was to provide counselling and support for accessing hormones, and follow-up care for both hormone therapy and surgeries.

"Give health services to trans people that we need or give us referrals to others."

"Everyone has the right to access to information from health professionals. It doesn't matter what's your identity."

THESE ARE THE FIVE THINGS HEALTH PROFESSIONALS SHOULD AVOID:

1. Discrimination

"Do not make fun of us and have other people laughing and gossiping while we are getting health services."

"We are afraid to visit the healthcare service next time."

"Stop raising your eyebrows when we walk through door, which means turning trans away."

"Stop making me feel worse and think twice about going for my next visit."

"Stop closing the door when you don't understand."

2. Moralising/judging trans people

"Stop trying to change our behaviour and our gender, or sexual orientation. People are different and my body is my right."

"Stop putting your personal religious belief in your work as a doctor or health professional."

3. Pathologising trans people

"I am not a disease, I'm a person."

4. Asking inappropriate questions or doing inappropriate examinations

"Can I check up my body without any harassment from the doctor?"

"Stop asking so many irrelevant questions when we just go to you for a check-up."

"Doing unnecessary physical check-ups on trans men and trans women," "trying to see our genitals."

"Stop using trans women as plastic surgery advertisements." (In separate sessions during the consultations, concerns were raised that trans women were pressured to consent to allow videos of their surgeries to be used in online advertisements for plastic surgery.)

5. Breaching confidentiality

"Stop violating your own protocols and ethics. It's your duty to serve any clients, including trans."

"Stop showing hijra to other doctors, nurses, staff. We are not specimens and need privacy."

4.2 Information Needs

Specific sessions were held in the two subregional consultations to identify the types of questions that trans people raise with health professionals and that should be covered in the Blueprint. What was striking in those discussions was how much information trans people are unable to access. Questions from trans women included the following:

- Long-term effects and safety of hormones, and whether there is any difference between birth control pills and other hormones
- Effects on libido and fertility
- Needing to be on hormones before having breast or genital surgery
- Safe anal douching (See 4.3.8, Trans-specific sexual health information)

Trans men had a much longer list of questions about virtually every way that hormones or surgeries might affect their bodies. This was particularly noticeable amongst trans men living in communities in which English is not widely spoken or read. They asked questions such as: "Can I take a pill to grow a penis?" and "Will I produce sperm so I can get my partner pregnant?" One trans man had been prescribed a cream to rub on his chest and told it would make his breast tissue disappear. During the consultation, a group of trans men from one South Asian country discovered what binders were and learnt how these could help flatten their chests.

These were sobering examples of the inaccessibility of accurate health information. One example of the very real difference such information can make in giving trans people greater control of their lives and their transition journey is the Thailadyboyz (TLB) Sexperts! Program in **Thailand**. It is a low-cost, trans-led community project in which predominantly trans women and *kathoey* provide online sexual health and legal information, and social support to their peers in the Thai language (Chaiyajit, 2014).

Like trans women, trans men are reliant on each other's advice to fill health information gaps. In some countries in this region, there is very little information to share and, in communities with few visible trans men, no one to ask. APTN has collated some of these questions and possible responses, and would like to see a short online resource created for trans men in Asia and the Pacific that can be translated into local languages.⁶⁵

Health providers can play a pivotal role in answering and anticipating health questions like these, and linking trans clients to national or regional peer networks, including APTN.

CASE EXAMPLE: FOR TRANS PEOPLE—MEETING THE INFORMATION NEEDS OF TRANS MEN IN INDONESIA

Indonesia's first ever Transmen Camp was held in August 2014 in Yogyakarta, attended by 11 people. The camp was the first opportunity for trans men to learn about SOGIE issues, human rights, trans bodies, and the history of the trans men's movement in Indonesia. "We also learnt from trans men in the Philippines through a Skype call." One of the strengths of the camp was participation and support by allies. "A doctor talked about medical treatment and strategies for communicating with physicians about your transition health needs."

After the Transmen Camp, two participants formed Transmen Ngehe, a support group in Jakarta, which meets twice a month. The first meeting each month is a closed group for men; the second meeting is open to anyone who wants to learn about trans men's issues. The open meeting is hosted by different non-trans community groups, and has become an important way to build allies and understanding, particularly within the LGBT community.

Four months before the Transmen Camp, the organiser had started daily diaries on his personal blog about his experiences as a trans man. In September 2014, he and two other trans men officially launched the blog as Transhition (<http://transhition.blogspot.com>). The name and logo are a reference to how hard it is to transition as a trans man in Indonesia. Roughly 20 trans men regularly respond to the blog, which receives about three emails per week. It has had about 6,000 visits in the first six months, between September 2014 and February 2015.

"There are many trans men in Indonesia. Before 2013, trans men closed themselves off from society and each other. They just met on international online forums. But only a few trans men can access Internet sites that use the English language."

The three founders of Transhition live in Yogyakarta and Jakarta. "We want to provide accurate but easily understood online information, in Indonesian and slang, for other trans men." Transhition's eventual aim is to develop a comprehensive website about being a trans man in Indonesia.

"For the first year, our main concern is giving information about self-acceptance and basic information about trans identity. This is a part of our strategy to show that trans issues are not merely about physical transition." Transhition plans to have information available about hormone therapy and gender reassignment by the end of 2015. However, it wants to avoid situations in which young trans men hurry through a physical transition process, ignoring the wider social, economic, psychological, and health impacts. "We learnt from the Philippines, where many young trans men take hormones without knowing the risks and procedures." They have heard that this hurry has resulted in some deaths amongst trans men in the Philippines.

Source: Interviews with Transmen Ngehe and Transhition.

65. There are English-language resources and online communities for trans men in this region, primarily in Australia and New Zealand. However, the information is not always relevant to the very different experiences of trans men in Asia or an emerging trans masculine community in the Pacific.

4.3 Client flow in a health facility

Clients interact with many different people when first accessing a facility, including security guards, janitors, receptionists, and other front-line staff, before they see a health professional. For this reason, all staff, both clinical and non-clinical, need to be trained to demonstrate respect and consideration towards everyone who accesses the premises. Staff who are encountered first are key players, since their attitudes will be considered a reflection of the overall attitudes and quality of the health service. If trans people perceive an attitude or behaviour as hostile or disrespectful, it may prevent them from utilising the service.

4.3.1 Reception, waiting room and restrooms/toilets

The receptionists are amongst the first staff who will interact with clients and have access to personal client information. Receptionists are the “face” of a service, and need to be included in any trans sensitivity trainings.

Additionally, waiting rooms need to be safe and non-discriminatory. Receptionists and other health facility staff can support the creation and enforcement of a trans-inclusive waiting room. This could include developing and posting trans-inclusive non-discrimination policies, enforcing these policies when violated, and engaging trans people and communities in ways to make the waiting room trans friendly.

When possible and feasible, clinics could include appropriate restroom/toilet facilities to accommodate clients with a variety of gender identities and expressions. This could include having a gender-neutral, unisex, or private restroom.

4.3.2 Clinical records, forms and charts

Trans individuals frequently prefer a name that is different from their legal name. Clinic forms and charts should allow for more than two genders, a preferred or nickname in addition to legal name, a preferred pronoun or title, and a space to indicate what name to use during telephone calls, correspondence, and when calling people from the waiting room.

For example, a trans man may use a male name when his legal name is female. His preferred male name might be confidential, and it may be unsafe for it to be used in correspondence with him. Forms and computer systems need to allow for noting this degree of detail about preferred names. Mechanisms should be in place to prevent misidentification of clients due to a discrepancy between preferred and legal name. These matters should be discussed openly and negotiated with the client. Laboratories and pharmacies are other places where legal names are often used on records, with the result that trans people may avoid testing or accessing medications.

Box 4.1 is an example of a trans intake form that can be adapted to local context, with the engagement and input of trans people.

BOX 4.1: EXAMPLE OF TRANS PATIENT INTAKE FORM

1. What is your current gender identity? (Check and/or circle ALL that apply)

- Male
- Female
- Transgender female/trans woman/MTF
- Transgender male/trans man/FTM
- Third gender
- Gendervariant/Genderdiverse
- Additional category (please specify): _____

2. What sex were you assigned at birth? (Check one)

- Male
- Female
- Additional category (please specify): _____

3. What is your legal name? _____

4.3.3 Clinical evaluation

The first clinical evaluation establishes a relationship between the provider and client. Some of the initial questions could include the following:

- Basic questions about gender identity and expression
- Preferred name, pronouns, gender and details of their social, medical, and surgical transition. For example, is the client:
 - Living full time in the preferred gender role? For how long?
 - Taking feminising or masculinising hormones? Source of the hormones (e.g., prescription, “street” dealers, sharing with others, Internet, etc.), frequency, duration, and any complications? Have they had any trans-related surgeries?
- Sexual behaviour e.g. whether a trans individual is sexually active with men, women, other trans individuals, all or none of the above.
 - Avoid assumptions about sexual orientation
 - Avoid assumptions about sexual positioning—e.g., many trans women and trans MSM are versatile and do not always take a receptive or “bottom” role during anal sex

Care should be taken to ask what is relevant and not lose track of the presenting concern.

A sexual health history should include the 5 Ps—information about partners, practices, protection (condom use and frequency), past history of STIs, and prevention of pregnancy (see Box 4.2). If time permits, it is also useful to gather information on the use of alcohol and other substances. Take a detailed family history, with special attention to cardiovascular disease, diabetes, and cancer—especially of the breast, prostate, or reproductive organs. Also assess whether the client has experienced violence, self-harm, or injuries at home.

Psychosocial issues that may be addressed in an initial examination are discussed in Section 4.3.5, General Prevention and Screening. Review healthcare maintenance, including immunisations, tuberculosis (TB) screening, HIV screening, STI screening, and safety; also provide safer sex counselling.

Box 4.2: Example of taking a sexual history

The 5 Ps of Taking a Sexual History

Partners	Are you having sex? Do you have sex with men, women, transgender men, transgender women, all or none? In recent months, with how many partners have you had sex?
Prevention of pregnancy	Are you currently trying to have a child? Do you need information on birth control?
Protection from STIs	What do you do to protect yourself against STIs or HIV?
Practices	To understand your STI/HIV risk, I need to understand the kind of sex you are having. Have you had or do you have vaginal sex? [Ideally, before asking a trans man this question, ask what term he uses for this part of his body]. Have you had or do you have anal sex? Have you had or do you have oral sex? Do you use condoms? If “sometimes,” in what situations or with whom do you use them? If not, why?
Past history of STIs	Have you ever had symptoms of STIs? Have you ever had an STI? When? How were you treated? Have you ever been tested for HIV? When? Would you mind sharing the result?
Other	What other concerns or questions do you have about your sexual health?

Adapted from “CDC: A Guide to Taking a Sexual History,” available at: www.cdc.gov/STD/treatment/SexualHistory.pdf.

4.3.4 Physical examination

Physical examinations may be difficult or even traumatic for trans clients, especially if they have had previous negative healthcare experiences or if they are uncomfortable with their body parts. Examinations may need to be deferred to a later visit and not done at the initial encounter. Medical providers should work to build trust and rapport with their clients through the use of appropriate language, including asking the client about their preferences in describing anatomy.

Providers should explain all components of the examination and procedures beforehand so the client can be fully informed and decide whether or not to consent to some or all of them. Providers may also wish to discuss the choice of language and medical terms with their trans clients; for example, many trans men prefer that providers refer to “chest” and not “breasts.”

A client-centred approach prioritises establishing trust and building health professionals’ knowledge about bodily diversity (Feldman and Goldberg, 2006). This diversity includes the impacts of non-surgical body modifications, such as chest binding by trans men or “tucking” of testicles by trans women.

4.3.5 General prevention and screening

Health is a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity. Trans people need access not only to gender transition-specific healthcare needs, but also to holistic and gender-affirming routine general health services and preventive care. The most important principle to apply in general prevention and screening is to provide care for the anatomy already present, regardless of the client's self-description or identification, presenting gender, or legal status. The protocol recommended below highlights areas in which trans-related medical treatments may have an impact on a client's well-being.

4.3.5.1 Diet and lifestyle

Like everyone else, trans people may not always engage in healthy lifestyles. However, the circumstances in which trans people live, including impacts of minority stress resulting from their gender identity, may make it much harder to maintain a healthy lifestyle.

Trans men who have not had top surgery may intentionally carry extra weight to obscure the appearance of breasts and hips; others may attempt to stay thin to de-emphasise curves and a feminine appearance. Some trans men with larger breasts avoid exercise due to physical discomfort. Others will be reluctant to wear tight-fitting sportswear or uniforms. Chest binders designed for trans men may make it easier for some to exercise, particularly for non-contact sports; however, binders that are too tight may restrict chest expansion and make exercise difficult. Conversely, some trans men on testosterone may have difficulty in gaining weight or muscle mass. Testosterone intake should be adjusted to appropriate male age and activity levels.

Trans women may have eating disorders, such as anorexia, or may intentionally take in fewer calories than necessary to maintain a slight build. Other trans women may prefer to gain weight to promote the growth of breasts and hips, which can lead to overweight and obesity. Some trans women may avoid exercise because it is perceived as a male trait or can result in increased muscle mass and a less feminine appearance. Providers should remind trans women of the importance of exercise to maintain a healthy cardiovascular system and optimal bone density.

4.3.5.2 Vaccinations

Assess whether vaccinations are up to date. Most recommended vaccinations are not sex specific and thus are the same as for any client. Both trans women and trans MSM may be at increased risk of Hepatitis A and B and human papillomavirus (HPV)-related disease. Appropriate vaccination needs should be discussed in line with a specific country's policy.

4.3.5.3 Mental health

See Section 4.5: Addressing mental health concerns.

4.3.5.4 Substance use

See Section 4.6: Alcohol and other substance use and dependence.

4.3.5.5 Soft tissue filler injections

Some trans women may seek or have sought injections of medical- or industrial-grade silicone oil, lubricant oils, caulk sealants, baby oil, and a variety of other substances into their hips, buttocks, thighs, breasts, lips, or face to feminise their appearance. For those without access to medical and surgical transition services, the use of soft tissue fillers may be the only permanent body modification tool available to them. Using soft tissue fillers can provide a rapid and welcomed transformation to their appearance. Unfortunately these fillers carry risks, including local and systemic infection, embolisation, painful granuloma formation, and a systemic inflammatory syndrome that can be fatal. In some countries, health workers have performed soft tissue filler injections, often unethically or illegally.

Additionally, some laypersons may hold "pumping parties," at which trans women are injected with these substances using insufficiently sterile techniques. Trans women should be screened for prior or risk of future use of soft tissue filler injections and counselled appropriately. Providers should employ a harm-reduction approach to trans women

who continue to inject soft tissue fillers. Clients should be advised against sharing needles or participating in pumping parties. In line with WHO guidance, consideration should be given to providing clean needles, gloves, and advice about sterile techniques to help reduce injection-site infections. Complications resulting from prior injections may require surgery to remove fillers or repair excessive damage.

4.3.5.6 Diabetes mellitus

Many countries do not have screening guidelines for diabetes. Some (e.g., **Australia, Philippines**) use a risk assessment tool and laboratory tests—for example, fasting blood glucose to assess diabetes risk. Trans people who have not used cross-sex hormones require the same screening criteria as persons of their natal sex, so national guidelines (if they exist) should be followed. There have not been any studies that indicate a higher risk of diabetes amongst trans people receiving cross-sex hormones.

- *Trans women currently taking estrogen:* There are no long-term studies that have demonstrated an elevated diabetes risk amongst trans women; however, feminising hormones may result in weight gain, which can contribute to glucose intolerance.
- *Trans men currently taking testosterone:* Screening and treatment should be the same as with non-trans clients. Consider screening (by client history) for polycystic ovarian syndrome (PCOS); diabetes screening should be considered if PCOS is present, since it is associated with a higher risk of diabetes (Mayer et al., 2015).

4.3.5.7 Cardiovascular disease

The most important intervention for prevention of cardiovascular disease is tobacco cessation. In many parts of the world, trans people have higher tobacco prevalence than the general population. It is therefore important to screen and treat for known cardiovascular risk factors. For more information on assessing cardiovascular health and hormone use, see “Appendix A” 1.

4.3.5.8 Pulmonary disease

Elicit any history of asthma, COPD, or TB; encourage smoking cessation. The presence of these conditions may preclude surgical interventions.

4.3.5.9 Cancer

When cancer-screening programmes are available, trans people who have not used cross-sex hormones or had gender-affirming surgery should be screened using the same criteria and risk parameters as persons of their natal sex.

Trans women, past or current hormone use:

- *Breast:* In the absence of trans-specific guidelines, some experts recommend that national breast-screening practices be applied to trans women (e.g., mammography). Despite a theoretical risk, no increase in breast cancer incidence has been found to date among trans women on hormones. Risk factors should be assessed on a case-to-case basis and according to current evidence-based algorithms.
- *Prostate:* Use a digital rectal examination to evaluate the prostate in trans women (follow national guidelines for natal men). In trans women who have had a vaginoplasty, the prostate can be palpated in the anterior neovaginal wall. Follow up-to-date algorithms on the use of Prostatic-Specific Antigen (PSA). Note that trans women who are on androgen blockers will have suppressed PSA levels.
- *Neovagina:* Pap smears in neovaginas are not indicated because the neovagina is lined with keratinised epithelium and cannot be evaluated with a Pap smear. It is therefore important to perform periodic visual inspection with a speculum, looking for genital warts, erosions, and other lesions.

Trans men, past or current hormone use:

- *Breast cancer:* Annual chest wall/axillary exam; follow breast cancer practices as for natal females (not needed following chest reconstruction, but consider if only a reduction was performed).
- *Cervical cancer:* For any trans man with a cervix, do a visual inspection with acetic acid (VIA) and/or and other screening procedures according to national standards (WHO, 2014d).

- *Uterine cancer:* Evaluate spontaneous vaginal bleeding in the absence of a mitigating factor (missed testosterone doses, excessive testosterone dosing leading to increased estrogen levels, weight changes, thyroid disorders, etc.), as for post-menopausal natal females. A hysterectomy could be considered if fertility is not an issue, the client is > 40 years of age, and the client's health will not be adversely affected by surgery.
- *Ovarian cancer:* There are no recommended ovarian cancer screening tests for trans men. If oophorectomy is performed, it is important that hormone therapy be maintained to reduce the likelihood of osteoporosis.

Follow standard national screening recommendations for other cancers, including anorectal, if possible.

4.3.5.10 Musculoskeletal health

Screening for osteoporosis is not part of the national health guidelines in most countries. Providers should be aware that after a gonadectomy, if a trans client stops hormones, there could be a risk of osteoporosis. Providers should encourage ongoing hormones in the setting of gonadectomy.

There is some early evidence that trans women may have lower bone density before initiation of cross-sex hormones, possibly due to lower involvement in physical exercise (avoidance of exercise to prevent muscle mass).

In countries where there are national guidelines for osteoporosis screening, providers should encourage trans clients to participate in such screening.

4.3.6 HIV, STI, and hepatitis screening/prevention and management

Across the Asia and the Pacific region, countries have different approaches to STI diagnosis, including whether STI screening is offered or whether only syndromic management occurs. Similarly, countries may provide routine HIV screening to everyone or only to those perceived to be at higher risk.

Providers should follow relevant national or WHO guidelines for STIs, HIV and Hepatitis B and C screening/management and recognise that trans persons may be at great risk, especially if there are ongoing risk behaviours for sexual or blood-borne transmission (e.g., unprotected penile-vaginal or penile-anal intercourse, history of prior STIs, or sharing needles for injection of hormones or illicit drugs) (WHO, 2013; WHO, 2011). Hepatitis A and B and HPV vaccination should be offered following country guidelines. HPV vaccines provide protection against infection and diseases caused by HPV. Some HPV strains cause genital warts; other types are responsible for cancers, including cancers of the cervix, vulva, vagina, and anus.

CASE EXAMPLE: INTEGRATING HIV AND GENDER-AFFIRMING HEALTH SERVICES IN INDIA

The Family Planning Association of India (FPAI) created the GIZ Shadows and Light Project to improve access to sexual reproductive health and HIV services for transgender and hijra communities. In several locations, including Mumbai, Chennai, Bangalore, and Hyderabad, clinics engaged healthcare providers who were sensitive to the needs of trans clients, and provided hormone care, information about gender transition, laser (hair removal) services, and referrals for gender-affirming surgeries. This successful project provided screening and treatment for STIs (including hepatitis and syphilis), and diagnosed and provided HIV services.

Source: Family Planning Association of India. Email correspondence, May 3, 2015.

Symptomatic STIs can be managed through syndromic approach. Syndromic approach is based on the identification of a consistent group of symptoms and easily recognised signs (syndromes) and provision of treatment that will deal with the majority of STIs responsible for producing syndromes. Syndromic management works well for urethral discharge and genital ulcer, but does not perform well with vaginal discharge and anorectal discharge (WHO, UNFPA et al., 2013).

Advantages include cost savings to laboratory testing and treatment of all main causes of identified syndromes, thus addressing co-infections that might otherwise go unidentified. It also reduces loss to follow-up because clients typically receive a diagnosis and treatment within a single visit.

Syndromic management does not, however, address asymptomatic infections. For example, cervical and anal infections may be asymptomatic. Thus, where resources allow, it is recommended that screening with laboratory testing and aetiological diagnosis be conducted for all sexually active clients. Specific guidance on syndromic management and aetiological diagnosis is beyond the scope of this document, but can be found in comprehensive regional guidelines (WHO, 2011; WHO – Regional Office for South-East Asia, 2011).

Contrary to earlier assumptions, a trans woman's neovagina is also susceptible to common STIs and inflammations seen in the vagina of natal women, such as bacterial vaginosis and infection with HPV (Meltzer et al., 2008; Yang et al., 2009). As of May 2015, only three case reports have appeared in the published literature of gonococcal infection of a neovagina (e.g., van der Sluis et al., 2014). HPV infection in the neovagina has been implicated in the aetiology of neovaginal cancer in trans women (Harder et al., 2002).

All trans people attending STI clinics should be screened for syphilis and also, if possible, for gonorrhoea and chlamydial infection and offered counselling and testing for HIV (WHO, 2013; WHO, 2011; WHO, 2014a).

4.3.7 Reproductive health

Discuss fertility issues with clients considering hormone therapy. Cross-sex hormone use may reduce fertility; this may be permanent even if hormones are discontinued. Estrogen may have the effect of reducing libido, erectile function, and ejaculation in trans women. Testosterone generally increases libido.

If required, an internal genital examination should be based on a client's past and recent sexual history and whether the person is comfortable with examination; a discussion of the risks and benefits of the procedure should precede any physical examination. Use a gloved finger and/or an appropriate-sized speculum.

Even though testosterone reduces fertility in clients, it is not a contraceptive substance; trans men having unprotected sex with non-trans men are at risk for pregnancy as well as STIs. Consideration should be given to offering trans MSM appropriate contraceptive options that do not lead to unwanted systemic feminisation. Options include depot medroxy progesterone acetate, condoms, and intrauterine devices (IUDs).

Special considerations for trans women: Neovaginal walls are usually skin, not mucosa; when it is mucosa, it is urethral or colon mucosa. Perform periodic visual inspections with a speculum to look for genital warts, erosions, and other lesions. There have been a few case reports of STIs and other infections involving the neovagina (e.g., gonorrhoea, bacterial vaginosis); however, the squamous epithelial tissue (penile inversion vaginoplasty) is not very susceptible to bacterial STIs. In some countries, anal cancer screening (anal Pap smears) may be recommended for HIV-infected MSM and transgender women. It is important to also check for the presence of urethral discharge and ano-genital discharge (using an anoscope) and genital ulcers.

4.4 HIV Testing, Counselling, and Treatment as Part of Comprehensive HIV and Sexual Health Services

As described in detail earlier in this document (see Section 3.4.4., on HIV), available data consistently show that trans women are disproportionately affected by HIV. No similar data exist for trans men in this region, and a few studies amongst trans men in the United States show generally low levels of infection (Herbst et al., 2008). However, a small number of studies have identified contextual and behavioural factors that may place some trans men at heightened risk for HIV infection and transmission (Kenagy et al., 2005; Kenagy and Botswick, 2005; Kenagy, 2005).

Despite these heightened risks, relatively few HIV programmes or services exist specifically for members of trans populations. Trans populations tend to be included under programming for MSM, which deprioritises trans people's unique needs.

HIV counselling and voluntary testing for HIV and other STIs should be offered routinely to trans people, both in community and clinical settings (WHO, 2014a and 2015c). This should be part of a comprehensive and integrated programme of services ensuring that trans people have early and sustained access to targeted HIV prevention, care, and treatment services. Such a comprehensive service provision model sometimes is referred to as a “cascade” of HIV services (Figure 4.1).

Figure 4.1: The HIV prevention, care and treatment cascade



Source: USAID-funded LINKAGES Project

The HIV services cascade is based on the assumption that successful HIV programming requires strong linkages between prevention, care, and treatment components. This means that transmission is interrupted and HIV-positive individuals are identified in the early stages of infection and successfully linked to long-term, sustainable ARV treatment. Research in recent years has documented the lack of interconnectedness between these various intervention components and the resulting losses to follow-up. These losses are greater across the cascade for trans people than amongst the general population. They are exacerbated amongst trans subpopulations, including trans sex workers, drug users, and youth.

An array of environmental, structural, and community- and individual-based interventions are required to ensure that trans people can access HIV services that do no harm and are sensitive to trans health and HIV needs. HIV programming for trans populations should, as a whole, identify specific gaps or “leaks,” propose strategies to improve linkages, and monitor programme performance across the cascade.

In some places that serve a larger trans community, there could be assistants who are trans persons themselves (e.g., peer navigators). These assistants may help in the collection of personal data, provide general information about the functioning of the service, and motivate users to take advantage of certain interventions (e.g., Hepatitis B vaccine, HIV testing, anal examinations, self-support groups, etc.), as well as provide peer education and support.

66. These would include the *WHO Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2015*; *WHO Consolidated guidelines for HIV testing service*; *the HIV cascade toolkit for key populations* developed under the USAID-funded LINKAGES project and the upcoming *WHO/UNFPA Implementing comprehensive HIV/STI programmes with transgender persons: practical approaches from collaborative interventions*.

It is beyond the scope of this document to prescribe programming approaches for each component of the HIV services cascade. At any rate, numerous resources exist for individuals or organisations requiring a more comprehensive overview of HIV prevention, care, and treatment for trans populations.⁶⁶ This Blueprint does, however, provide specific recommendations on HIV-related clinical services in the context of broader healthcare delivery for trans clients in the Asia and the Pacific Region.

The WPATH SOC7 specifically state that “It is unethical to deny availability or eligibility for sex reassignment surgeries or hormone therapy solely on the basis of blood seropositivity for blood-borne infections, such as HIV, or Hepatitis B or C, etc.” (Coleman et al., 2011, p. 35). Guidelines have been established for surgery for HIV-positive trans people (Kirk, 1999) and outcomes have been good (Wilson, 1999).

4.4.1 HIV testing and diagnosis

HIV testing for trans men and women will generally follow the algorithms and protocols recognised by the relevant national authorities. Some national AIDS control programmes recognise supplementary HIV diagnosis algorithms for members of key populations, which may or may not specifically include trans individuals (WHO, 2015c). In the 2015 *Consolidated Guidelines for HIV Testing Services*, WHO recommends the following for all key populations, which includes trans people:

- HIV testing services should be routinely offered to all key populations in the community, closed settings such as prisons, and clinical settings.
- Community-based HIV testing services for key populations, with linkage to prevention, treatment and care services, are recommended in addition to provider-initiated testing and counselling.
- Couples and partners should be offered HIV testing services with support for mutual disclosure. This applies also to couples and partners from key populations.

Trans persons should be strongly encouraged to receive regular HIV tests with appropriate counselling. Trans clients who are diagnosed as HIV positive should be proactively linked to care and treatment services according to national treatment protocols, with the minimum necessary delay to reduce loss to follow-up. In some settings, trans clients who screen HIV negative but report high levels of HIV risk may be eligible for HIV pre-exposure prophylaxis (PrEP) to block the acquisition of HIV. Current WHO guidelines endorse the use of daily oral PrEP (specifically the combination of emtricitabine/tenofovir disoproxil fumarate [TDF + FTC] for MSM and trans women (WHO, 2014a). Trans men are not addressed specifically in current guidelines but may be covered under recommendations for serodiscordant couples (WHO, 2014a). Given the fast-moving evidence, these recommendations may change in the future, and it is therefore important to check for the most recent, relevant WHO guidance on a regular basis.

HIV pre- and post-test counselling for trans clients should take into account trans-specific risk factors and cofactors. These may include the following:

- Anal/vaginal intercourse without a condom, including receptive anal/vaginal intercourse for trans men
- Insertive/receptive anal intercourse for trans women
- Receptive neovaginal intercourse amongst trans women who have had sex reassignment/gender-affirming surgery
- Sharing of injection paraphernalia during drug or hormone use, or for soft tissue filler injections

Counselling also should take into account that erratic hormone use can result in mood swings, masculinising hormones increase libido, and feminising hormones may impair erections and thus make condom use more difficult (Bockting et al., 1998).

Sex work may additionally contribute to heightened HIV risk, particularly when clients offer more money for unprotected sex. Trans women and men may feel at a disadvantage in negotiating sexual practices and prevention behaviours because they perceive a shortage of partners willing to enter into a committed relationship. The desire to conform to specific cultural beliefs and practices around gender roles may also contribute to heightened sexual risk. Like other at-risk populations, research has shown that for trans women, unprotected sex is most likely with non-commercial primary partners (Nemoto et al., 2012).

4.4.2 Care and treatment

Multiple factors limit access to HIV care and treatment services for trans clients. These include, but are not limited to the following:

- Lack of healthcare coverage
- Avoidance of medical care due to a lack of trans health-competent providers
- Misconceptions about HIV treatment interfering with trans-specific medical care (hormone therapy or gender-affirming surgeries)
- Lengthy delays between the HIV diagnosis and pre-ART staging processes that contribute to loss to follow-up

Encouraging HIV-positive trans persons to access treatment is critical not only to individual clinical outcomes but also in reducing the likelihood of onward HIV transmission. Programmes can plug the “leaks” in the HIV services cascade through the adoption of policies to reduce the gap between testing and treatment as much as possible. These might include the adoption of rapid HIV diagnostic algorithms, the introduction of point-of-care CD4 testing, clinic navigation services, and proactive case management to follow up clients who do drop out. Programmes may also provide trainings for healthcare providers and assist clients to access social support services, when available, that may cover treatment-related costs.

Once enrolled in a treatment programme, HIV-positive trans people may follow the approved ART national guidelines in the same way as other HIV-positive people.

There are no studies that investigate the pharmacokinetics and drug-drug interactions between the HIV ARVs and the estrogens used for medical transition. However, ethinyl estradiol, the form of estrogen commonly used in oral contraceptives, shows well-characterised drug interactions with some ART (Keller, 2009). Although the WPATH SOC7 discourage the use of ethinyl estradiol for medical transition, this is the only formulation of estrogen (usually in combination with a progestin as an oral contraceptive medication) available to many trans women in low- and middle-resource settings. The hormone therapy sections of this Blueprint include more detailed information from the *WHO HIV Consolidated Guidelines for Key Populations* (WHO, 2014a) and the *WHO Policy Brief on Transgender People and HIV* (WHO, 2015b).

Currently, there are no documented serious drug interactions between medications used in hormone therapy for trans people and first-line ARVs. Some ARVs, such as the boosted protease inhibitors (PIs) may result in a lowering of estrogen levels. Trans women should be monitored for symptoms of low estrogen—for example, hot flushes, mood swings, and irritability. Fosamprenavir, one of the ARVs, is not recommended for use with ethinyl estradiol due to a potential reduced level of fosamprenavir drug levels. This ARV should be avoided in combination with feminising regimens.

4.4.3 Strengthening adherence

A final, but crucial, gap in the HIV services cascade is when clients initiate ART but do not adhere to treatment by not taking their treatment at the time or dose prescribed. The rapid replication and mutation rate of HIV means that very high levels of adherence (e.g., $\geq 95\%$) are required to achieve durable suppression of viral load (Bangsberg et al., 2000; Montaner et al., 1998; Paterson et al., 2000). HIV-positive trans persons should be encouraged not just to access but also adhere to HIV and STI treatment. This could be facilitated through adherence counselling by providing regular treatment reminders (for instance, via SMS or a programmed mobile phone reminder) or combining ART with the desired hormone therapy—a priority for many trans persons.

Finally, social support, especially trans peer support, is essential—both to directly encourage and monitor treatment adherence, and to assist HIV-positive trans people in addressing medical or other challenges affecting treatment adherence specifically or their physical and mental well-being more generally. Whereas programmes in many settings provide support groups for people living with HIV, these are often segregated by gender or sub-population. They may not be welcoming to trans participants and may be ill suited to provide for the specific needs of trans men and women. Whenever possible, social support for trans people should be provided, either offline or online, by trans peers (Bockting et al., 1998).

4.5 Addressing Mental Health Concerns

Mental health is one of the main health concerns amongst the trans population (IOM, 2011). Anxiety and depression, including suicidal ideation and attempts, are prevalent and are associated with stigma and discrimination (Bockting et al., 2011). Evidence and data on mental health can be found in Chapter 3: Right to Health (Section 3.4.7, Mental health).

A mental health assessment is crucial, with particular emphasis on how the trans client has coped with the social stigma attached to gender variance. Anxiety and depression should be distinguished from gender dysphoria—that is, distress that the trans person might be reporting that associated with a conflict between their sex assigned at birth and their gender identity.

It is essential that healthcare providers are alert to manifestations of suicidal ideation. The American Association of Suicidology provides a list of signs that a provider can use to assess risk for suicide.⁶⁷ Those signs can be remembered with the mnemonic: IS PATH WARM?: Ideation, Substance Use, Purposelessness, Anxiety, Trapped, Hopelessness, Withdrawal, Anger, Recklessness, and Mood Changes. Signs of acute suicide risk include talk about or threats of killing oneself, looking for ways to commit the deed (e.g., purchasing pills, a pistol, or poison), and talking or writing about dying or killing oneself. In the presence of such signs, clients should immediately be referred to a mental health service; support from a suicide prevention task force or service should be sought.

As with all clients, the primary care provider should screen for psychiatric illness. Two questions based on ICD-10 that examine mood and loss of interest in the past two weeks would have sensitivity of more than 98 percent in the general public. Depression is common, so providers should ask about persistent depressed mood, anhedonia, and suicidal ideation, and treat or refer those with clinical depression.

Trans people may have suffered harassment or physical trauma. Clients who have experienced trauma should be asked about symptoms of post-traumatic stress disorder as well as other anxiety disorders. Substance use may occur as a means of avoidance coping in clients with gender dysphoria and/or in stressful environments. Referrals for psychiatric management should be made to mental healthcare providers who have an understanding of trans issues.

Screening for and addressing co-existing mental health concerns can greatly facilitate a person's transition, ability to make informed decisions about medical steps, and their overall quality of life. Further discussion about assessing, diagnosing and treating coexisting mental health concerns can be found in Section VII of the WPATH SOC7.

Evidence and data on mental health in the region can be found in Section 3.4.7.1, Mental health, Regional data.

67. Available at: www.suicidology.org/resources/warning-signs.

4.6 Alcohol and Other Substance Use and Dependence

It is important to ask people attending a healthcare service about patterns of alcohol, tobacco, and other substance use via a standardised questionnaire. Questions should address frequency of use, types of substances, doses, route of administration, conditions in which the use is more likely to occur (e.g., smoking when nervous), and related mental or behavioural experiences (e.g., acting out, brawling, fighting, or having “blackouts”).

If responses suggest zero to low risk of substance use, service providers should follow up by inquiring about intentions of future use and strategies to deal with peer pressure or external stressors. For persons with moderate to high risk, psychosocial, educational and biomedical interventions are recommended as described in WHO’s Mental Health Gap Action Programme (mhGAP) and related guidelines. Brief interventions show effects in reducing harmful use; motivational counselling could also be effectively provided by peers. In the case of injecting drug use, referral should be made to harm-reduction services as described by WHO (2007, 2014a), in particular, provision of sterile injecting equipment through needle and syringe programmes and opioid dependence should be treated with opioid substitution therapy (WHO, 2009). According to the UN Office on Drugs and Crime (2010), drug dependency services should be as follows:

- Available and accessible
- Individualised and responsive to multiple needs
- Evidence informed and within a human rights and dignity framework
- Culturally and socially relevant
- Coordinated between health and justice systems
- Involving of the client and community (with the client’s consent)
- Soundly managed with strategic planning of systems

The availability of spaces that allow for socialising with peers independent of alcohol consumption can play an important role in substance use prevention and rehabilitation, especially for young trans persons.

Evidence and data on alcohol and substance use and dependence in the region can be found in Section 3.4.6, Alcohol and Other Substance Use.

4.7 Addressing Stigma, Discrimination and Violence and Promoting Resilience

Stigma, discrimination and violence can severely impede the health and rights of trans people, as outlined in Sections 3.2 and 3.3. Anti-stigma and anti-discrimination policies and codes of conduct are essential both inside and outside of the health sector (WHO, 2014a). In order to ensure standards are met, implemented, and maintained, monitoring and oversight are crucial. Reporting mechanisms are needed to report incidences of discrimination before, during or after obtaining health services (WHO, 2014a).

Law enforcement representatives are key stakeholders, yet can impede trans people’s access to services. Health service providers need to ensure that law enforcement activities do not interfere with services (WHO, 2014a).

With trans clients, a provider can assess how the trans person has coped with stigma and discrimination encountered during their transition. This includes both an assessment of felt and enacted stigma (Bockting et al., 2011). The healthcare provider should pay particular attention to whether or not the client was gender-nonconforming in childhood and what stigma management strategies were employed. If indicated, the health provider can assist the client in identifying or adopting effective stigma management strategies. This may include providing information about complaints procedures, anti-discrimination bodies or peer support networks. The negative effects of abuse and violence need to be assessed, and referrals to counselling provided as needed.

4.7.1 Addressing consequences of physical violence

In comparison to many other groups and populations, trans persons face disproportionately high levels of violence. The base of this violence is transphobia—individual and group attitudes of rejection, scorn, and disdain and violent behaviours towards persons who are trans and perceived as transgressing gender norms. Transphobia takes many forms, including physical violence.

As a result of physical attacks, for some trans people the points of entry to the health system are the emergency rooms of clinics and hospitals. Providers should be aware that there are four kinds of needs that deserve attention:

1. Immediate emotional/psychological health needs
2. Immediate physical health needs
3. Ongoing safety needs
4. Ongoing support and mental health needs (WHO et al., 2014)

Additional considerations include the following:

- Providing first-line support
- Providing emergency contraception as soon as possible, which can be taken up to five days after condomless sex
- Administering post-exposure prophylaxis for HIV no later than 72 hours after exposure
- Offering STI prevention and treatment
- Offering Hepatitis B immunisation
- Testing for HIV and pregnancy
- Assessing mental health and offering care as needed (WHO et al., 2014)

4.8 Specific Gender-affirming Healthcare Related to Body Modifications

WHO has no specific policies, recommendations or guidance on gender-affirming health care related to body modification. Recent WHO-related HIV guidance has stated that access to these services is crucial for the survival and well-being of trans individuals and for addressing other health issues such as HIV prevention, diagnosis, treatment and care (WHO, 2014a; WHO 2014b; WHO 2015b).

However, access to specific healthcare, such as specialised counselling, hormone therapy, and/or surgery, is severely limited in this region.

The information about gender-affirming healthcare provided here is based on other sources and good practice examples from the care protocols developed by UCSF, and draws heavily on Version 7 of the WPATH SOC (Coleman et al., 2011).

4.8.1 Facial and body hair removal

Body hair distribution is strongly affected by androgens, which are more abundant in natal males and lead to a more extensive distribution of hair. Body hair grows during and after puberty and may cover any surface of the body except the lips, palms of hands, soles of feet and the back of ears.

For trans men, administration of androgens usually stimulates growth of body hair, including facial hair, if the person has inherited a predisposition for hirsutism (i.e., hairiness). Thus, body hair issues for trans men are more likely to be about adapting to body hair growth (particularly on the chest area if they are on hormone therapy without having chest surgery) or to male pattern baldness.

For trans women, in contrast, the administration of female hormones does not eliminate body or facial hair if it has developed during puberty. For this reason, many trans women have to deal with the discomfort of a male-type hair distribution, including a moustache and beard that needs to be shaved or epilated and covered with makeup on a daily basis.

BOX 4.3: FOR HEALTH PROVIDERS—EXAMPLES OF CLINICAL MANAGEMENT OF HAIR REMOVAL PROCEDURES FOR TRANS WOMEN

Prevention Measure

- Medical supervision is advised for hair removal in immunosuppressed individuals
- Laser removal in “aesthetic clinics” is not advised if there is no medical supervision
- Peer education on safety of hair removal procedures is strongly advised
- Special care should be taken with people who have pre-existing skin conditions

Potential Complications

- Shaving—razor bumps and burns, folliculitis
- Waxing—burning, infectious folliculitis (including boils)
- Chemical depilation—burning, infectious folliculitis
- Electrolysis—burning, folliculitis, and cellulites
- Laser hair removal—burning

Clinical Management

- Assess, provide guidance, develop treatment plan, evaluate use of medication, and support alternative procedures

Source: Adapted from *Blueprint for the Provision of Comprehensive Care for Trans Persons and their Communities in the Caribbean and other Anglophone Countries*.

For many trans women, a more permanent solution is highly desirable. In some countries, laser hair removal may be a solution if administered by qualified professionals, but it carries increasing risks with increasingly darker skin. Different laser techniques pose different levels of risk when used with darker skin (Elman et al., 2000). Dark-skinned clients (or even olive/light-brown-skinned clients) should do careful research to ensure that their laser providers have the necessary skill level and equipment to work on their type of skin.

Electrolysis is another option to solve the problem of body and facial hair, but it is expensive, lengthy, and uncomfortable. Electrolysis should be performed by a qualified professional who is knowledgeable about the procedure and the necessary aftercare. This includes avoiding either exposure to sunlight or the use of makeup. Any alternative hair removal procedures should be discussed openly with the primary healthcare provider to ensure that they are safe and result in satisfactory results. Box 4.3 describes examples of prevention, potential complications, and management of hair removal procedures for trans women.

Traditional methods of hair removal exist in some cultures; for example, in **India**, traditional tweezers (“chimta”) are used by trans women (Singh et al., 2014).

4.8.2 Non-medical body modifications

Trans people might use binders, padding, prosthetics, or other accessories to modify their bodies. For trans women, this may include wearing a padded bra, tucking genitals to hide them, and wearing wigs or hair extensions. “Tucking” involves gently pushing the testicles up inside the body and then pulling the penis back in between the legs. This is all held in place with tight-fitting underwear or surgical tape.

It is important that trans women use surgical tape only, as other types of tape could peel off skin when removed. Cutting the hair very short in the groin area also makes it easier to remove the tape. Tucking for too long can cause health problems; it is wise to spend some time each day without tucking. Tucking can cause chafing and sores. It can also lower sperm count, which will be important to consider if a trans woman wants to have a child.

It is common for trans men who have not had chest surgery to flatten their chests using a binder. The results from the Binding Health project (see box) suggest ways to minimise any negative health impacts of binding.⁶⁸

Trans men may also wear a packer or prosthesis to create a bulge in their genital areas. Some prosthetics can also be used as an aid for urinating while standing and to penetrate a partner during sex. These prosthetics are available in a limited number of countries in Asia.

FOR TRANS PEOPLE—HEALTH IMPACTS OF CHEST BINDING FOR TRANS MEN

The Binding Health Project is a 2014 study on the self-reported health effects of chest binding amongst a sample of 1,800 people worldwide who bind, including trans men from this region. Respondents were asked a variety of qualitative and quantitative questions on binding practices, physical and mental health outcomes attributed to binding, patient-provider interactions, and use of trans-specialty care. People reported a range of negative health problems, ranging from rib fracture (3%) to back pain (54%).

When looking at the intensity (hours per day), frequency (days per week), and duration (months with any binding), the measure of frequency was the one most associated with a variety of negative health outcomes. This suggests that reducing the number of days per week spent binding and taking an “off” day when possible may reduce the risk of negative health outcomes.

Larger chest size was not associated with pain outcomes or musculoskeletal concerns, but was associated with several skin and soft tissue problems, such as scarring, swelling, and other skin changes. Those people who bind and have larger chest sizes may want to be particularly aware of these risks. Supporting existing community recommendations by using items such as Ace bandages, saran wrap, and duct tape were associated with negative health problems and should be avoided.

Importantly, the proportion of participants reporting a “very positive” or “positive” mood went from 7.5 percent when not binding to 69.9 percent after binding, demonstrating the strong mental health benefits of binding for some trans men. People also reported an increased ability to go out in public and an improved sense of safety when binding.

People should weigh the potential physical risks to daily functioning and safety against the mental, emotional, and other benefits when considering whether and how much to bind. Physical risks of binding may be mitigated by incorporating “off” days from binding and selecting safer binding methods. Longitudinal and/or randomised studies should be conducted to strengthen the evidence base behind these suggestions (Acevedo et al., 2015).

4.8.3 Hormone initiation, administration, and monitoring

Without normative and established global guidance, it is beyond the scope of this document to provide guidelines on the administration and monitoring of hormones among trans people. There are promising practices and protocols developed by countries and organisations in higher-income settings. This information will be provided as examples in *Appendix A: Hormone Administration, Monitoring and Use*. It should not be construed as recommendations but as demonstrations based on experiences in Asia and the Pacific and other settings.

FOR POLICYMAKERS—HORMONAL THERAPY TO IMPROVE ENGAGEMENT AND RETENTION IN CARE

Many trans people use feminising or masculinising hormones to align their physical appearance with their gender identity. Respondents to a recent qualitative study confirmed the community knowledge and information obtained through the Blueprint consultations—trans people prioritise access to and use of hormone therapy over HIV care and treatment (WHO, 2014a; WHO, 2014b). This creates opportunities for hormone therapy to be an important entry point into HIV care and treatment for trans people.

“I really want to see a specialist. The [trans] sex worker community, we are selling sex. We have to deliver the product ... They want to look feminine. All I can tell them is the tablet I am buying from the chemist. I think the Fijian government should consider this is a serious health need for trans people. If you give doctors comprehensive training, people will flock to the clinics and they will get the numbers they are looking for.”

—Trans sex worker, **Fiji**

4.8.4 Surgical and other medical procedures

This section provides background information on the surgical procedures clients may be considering or have already undergone. These procedures generally should be conducted subsequent to an assessment of a client’s individual preparedness for the intervention in question, like any other clinical intervention. The WPATH SOC7 include a list of recommended criteria for such assessments (Coleman et al., 2011, Appendix C). In addition, countries may have their own guidelines.

Gender-affirming surgeries such as vaginoplasty and phalloplasty may not be available in all countries, especially those that are resource limited. Most countries, however, will have access to surgeries such as hysterectomy, orchiectomy, and mastectomy, as these are routinely available for non-transgender people. Where these surgeries are available, they should not be denied to trans people.

Primary care physicians should be able to discuss the pros and cons and different medical and surgical interventions that may be recommended for a client’s overall health and well-being, and assist clients in understanding surgical options. These might include a hysterectomy/oophorectomy for a female-to-male client or urological consults for a male-to-female client. Primary care physicians need to know about the effects of body modifications.

Age alone is not a factor preventing someone from medically transitioning. However, surgical procedures for gender affirmation may not always be feasible for older trans people due to physical wellness requirements. Older trans people desiring surgical procedures should discuss specific procedures, physical requirements and recovery periods with the surgeon to ensure safety and efficacy.

Primary care physicians may provide post-operative care for clients who have had surgery in another country. They also may be called upon to advocate with insurance carriers or other specialists for a client’s medical needs.

a) Male-to-female surgeries

Orchiectomy

Orchiectomy is the removal of the testes. Some trans women will have this procedure without a vaginoplasty or penectomy. Estrogen therapy in progress may need to be adjusted post-orchiectomy; orchiectomy may permit lower doses of estrogen therapy and eliminates the need for testosterone blockers.

Vaginoplasty

Vaginoplasty is the construction of a vagina to enable female sexual function using penile tissue or a colon graft. The use of penile tissue is a complex procedure intended to utilise analogous tissue as well as maintain nerve function to preserve sexual responsiveness. The procedure usually involves clitoro-labioplasty to create an erogenously sensitive clitoris and labia minora and majora from surrounding tissues and/or skin grafts, as well as a clitoral hood. Colon grafts do not require dilation and are self-lubricating; however, the lubrication is present at all times and may become bothersome to some. Additionally, colon grafts must be visually inspected for evidence of colon cancer following cancer-screening guidelines and should be monitored if the client develops inflammatory bowel disease.

Penectomy

Penectomy is the removal of the penis. This procedure is not commonly done on its own except in parts of South Asia where castration is still common in some communities (see Section 3.4.8.5 for a case example from both a medical and community perspective). Instead, generally penis removal is done in concert with vaginoplasty. In some surgical techniques, the penile skin is used to form the vagina; thus, this is not a straightforward amputation, but rather a potentially complex procedure intended to utilise analogous tissue as well as maintain nerve function to preserve sexual responsiveness.

Augmentation mammoplasty (breast augmentation)

If breast growth stimulated by estrogen is insufficient (progressing only to the “young adolescent” stage of breast development), augmentation mammoplasty may be medically necessary to ensure that the client is able to function socially as a woman.

Reduction thyroidchondroplasty

Reduction thyroidchondroplasty reduces prominent thyroid cartilage.

Voice surgery

Voice surgery is intended to raise the pitch of the speaking voice. Speech therapy is recommended before seeking a surgical solution.

Facial feminisation

Facial feminisation includes a variety of aesthetic plastic surgery procedures that modify the proportions of the face to facilitate social functioning.

b) Female-to-male surgeries

Chest reconstruction/bilateral mastectomy

Chest reconstruction/bilateral mastectomy is the procedure most frequently required by trans men. A variety of techniques may be used, depending on the amount of the client’s breast tissue. Scarring may result and nipples may be either large or small and grafted, depending on the surgeon’s technique.

Hysterectomy/oophorectomy

Hysterectomy/oophorectomy may be necessary in the event of fibroid growth, endometrial conditions, or as a prophylactic procedure in clients with a family history of cancer. Hysterectomy may be a part of a phalloplasty/vaginectomy procedure when the vaginal tissue is used to construct the urethral canal.

Metoidioplasty

Metoidioplasty is the construction of male-appearing genitalia by employing the testosterone-enlarged clitoris as the erectile phallus. The phallus generally will be small and has the appearance of an adolescent penis, but erectile tissue and sensation are preserved. This procedure releases the clitoral hood and sometimes the suspension ligaments to increase organ length, may involve raising the position of the organ a centimeter or so towards the anterior, and may include scrotoplasty and (less frequently) urethroplasty. Closure of the vaginal opening may be full or partial, or the vaginal opening may not be impacted at all, depending on the surgeon's technique. This procedure is much less invasive than a phalloplasty procedure (see below), and emphasises preservation of erotic sensation. Performing an urethroplasty allows the individual to urinate standing up. If this procedure is not performed, the individual may wish to use a stand-to-pee (STP) device.⁶⁹

Phalloplasty

Phalloplasty is the construction of a phallus that more closely approximates the size of an erect male organ, using tissue from another part of the client's body. Size and appearance are prioritised over erectile capacity, and in some cases over erotic sensation. Skin flaps used in this procedure include abdominal flap (no erotic sensation), radial forearm flap, deltoid flap, and calf flap (all of which contain nerves that may be grafted to the pudendal nerve to provide erotic sensation). Erectile capacity is provided via implanted semi-rigid or inflatable penile prostheses.

Scrotoplasty

Scrotoplasty is the construction of a scrotum, usually using labia majora tissue and saline or silicone testicular implants. Some surgeons will use tissue expanders and place the implants after the tissue has been stretched sufficiently to accommodate the implants. This procedure is rarely done separately, but is usually performed in conjunction with either a metoidioplasty or a phalloplasty procedure. With some phalloplasty/urethral extension techniques, it may be necessary to perform the scrotoplasty as a later stage, after urethral healing.

Urethroplasty

Urethroplasty is the creation of the urethral canal through the neophallus to facilitate standing urination. This is usually, but not always, done in conjunction with genital reconstruction.

Vaginectomy

Vaginectomy (the removal of the vagina) may be done with an ablative technique or surgical techniques. It is required if the vaginal opening is to be closed.

c) Post-surgical follow-up

Trans women: Trans women should be examined for difficulties in healing. After pedicled penile flap technique vaginoplasty, the client must dilate three to four times daily, per the surgeon's recommendations, using progressively larger dilators. After the initial six- to 12-month period, if the client is having regular sexual intercourse, no further dilation is required. Otherwise, continue routine dilation once or twice per week. Lubrication will be necessary for intercourse.

Post-operative complications may include bleeding, infection, or impaired wound healing. Possible late complications may include stenosis of the new urethral meatus. Refer to a surgeon with expertise.

Pap smears in neovaginas are not indicated; the neovagina is lined with keratinised epithelium and cannot be evaluated with a Pap smear. The provider should perform periodic visual inspection with a speculum, looking for genital warts, erosions, and other lesions. If an STI is suspected, do appropriate testing. Neovaginal walls are usually skin, not mucosa; when they are mucosa, they will be urethral or colon mucosa.

69. See www.ftm essentials.com.

Trans men: trans men should be examined for difficulties in healing. Complications in chest reconstruction may include hematoma, partial or total nipple necrosis, and abscess formation. Drains and compression bandages do not always prevent these complications. Keloid scarring may occur, particularly amongst Asian people within this region. In some instances, scarring may be lessened by ensuring that incisions are not stretched prematurely during healing. Complications of genital reconstruction include implant extrusion, urethral fistulas and strictures, loss of sensation, and tissue necrosis in the neophallus created by phalloplasty. This is not generally a problem with metoidioplasty.

In conclusion, primary care providers can play a significant role in improving health outcomes for trans people. For example, general practitioners and family doctors may be providing information or preventative care, conducting initial assessments, managing transition-related and general health issues, or making appropriate referrals. The protocols in this chapter have been designed to support primary care providers as they do this work.

The next chapter discusses examples of specific protocols for health professionals who work with gender-diverse children and youth.

WORKING WITH GENDER-DIVERSE CHILDREN AND YOUTH

WHO support for the Blueprint should not be interpreted as WHO endorsement of the guidance provided in this chapter. Any WHO guidance would need to be developed through a standard WHO guidelines development process.

5.1 Introduction

Across this region, there is a huge diversity in the experiences of children and youth whose gender expression or gender identity is different from their sex assigned at birth. There is also a range of terms that trans children and youth use to describe themselves. Alongside those who identify as trans, others embrace the concept of gender nonconformity or may seek spaces where they are free to be gender questioning and can explore their gender identity.

The rights set out in the United Nations Convention on the Rights of the Child apply to every person under the age of 18 unless, under relevant laws, the child is no longer considered a minor. In order to clarify age-specific health needs, for this chapter, the term “children” is used more narrowly to refer to people under the age of 10. The terms “adolescents” and “young people” are used when referring to those ages 10 or older. Adolescents are defined as those ages 10–19 years, and young people as those ages 10–24 years (Interagency Youth Working Group, 2010). For the purposes of this document, more general information (covering anyone under the age of 25) uses the phrase “children and youth.” These definitions are based on the practices of the following UN agencies:

TERM	AGE	SOURCE
Children	Below 18 (or less if the age of majority is lower)	UN (based on the Convention on the Rights of the Child)
Adolescents	10–19	UNICEF/WHO/UNFPA
Young people	10–24	UNICEF/WHO/UNFPA
Youth	15–24	UNICEF/WHO/UNFPA

In some cultural communities, including parts of **Polynesia** in the Pacific, gender diversity is widely accepted. However, many other trans and gender-nonconforming children and youth face significant barriers in trying to find safe and supportive places where they can be themselves.

Gender-nonconforming and trans children and youth are frequently discriminated against and bullied because of their gender identity or expression.⁷⁰ As already noted in Section 3.4.7, Mental health, research in this region has highlighted the impact of such bullying on trans people’s mental health outcomes. The Education section (Section 3.3.4) also outlines positive initiatives within Asia and the Pacific to make schools more inclusive for trans and gender-diverse children and youth and their families.

WHO has no specific policies, recommendations or guidance on gender-affirming health care related to body modification for young and adolescent transgender people. The protocols and information in this chapter are based on the UCSF Center of Excellence for Transgender Health and informed by the 2015 Technical Brief: *HIV and young transgender people* (WHO, 2015d).⁷¹ This chapter is further supported through reviews and feedback from young trans health medical providers in Asia and the Pacific (see Acknowledgements for more information).

70. UNESCO’s work on homophobic and transphobic bullying, available at: www.unesco.org/new/en/education/themes/leading-the-international-agenda/health-education/homophobic-bullying/.

71. The care protocols are available at: www.transhealth.ucsf.edu/protocols. The WHO Technical Brief is available at: http://apps.who.int/iris/bitstream/10665/179866/1/WHO_HIV_2015.9_eng.pdf.

5.2 Gender-variant Behaviour or Expression Compared to Gender-variant Identity

All children and youth are influenced to some extent by societal expectations based on their sex assigned at birth. In this region, very strict distinctions often are maintained between accepted behaviour and appearance for girls and boys. A young person's gender expression is described as gender variant or gender nonconforming when their behaviour, appearance, or personality differs from these societal expectations.

As with adults, a child or adolescent's gender expression is distinct from their gender identity and sexual orientation. Some children whose gender expression is different from their sex assigned at birth grow up and identify as trans, whereas others do not. Some children with a nonconforming gender expression identify as being lesbian, gay, bisexual, or queer as adolescents, whereas others will identify as heterosexual. Clear, age-appropriate information about the spectrum of gender expressions, gender identities, and sexual orientations is valuable for adolescents as they consolidate their sense of identity.

During adolescence, young people go through a rapid and dramatic developmental process. This is a time of significant physical, psychological, sexual, emotional, and social change. It may not always be easy to disentangle or reconcile feelings about one's body from social expectations placed on boys and girls, and sexual attraction to others.

Across Asia and the Pacific, trans women and culturally specific identities, such as *hijra*, *meti*, *waria*, *katoey*, *fa'afafine*, and *leiti*, are the most visible gender or sexual minorities. It is helpful if gender and sexuality education encompasses less visible identities as well, including trans boys/men and lesbians. Such information, particularly if it is supported by school counselling services, enables young people to learn about their health needs, healthy relationships, and safer sex practices, whatever their gender identity or sexual orientation.

For children who have a gender-variant identity, the degree to which it is reflected in their external gender expression can have a profound impact on how they might cope with any attached social stigma (Bockting and Coleman, 2007). Those more outwardly gender-role nonconforming tend to be visible earlier in life and face enacted stigma. Those outwardly conforming are more likely to isolate themselves and keep their gender identity hidden. This can contribute to felt stigma. Both types of stigma have been shown to be negatively associated with mental health (Bockting et al., 2011).

Assessing a child's gender expression and gender identity enables a health professional to suggest appropriate interventions. Information for families and schools, including about how to address bullying, can be a useful form of support. When the issues a child or youth raises are about gender identity, the option of early medical interventions could also be considered, along with initial assessments of gender identity development and emotional and psychosocial support.

5.3 Differences between Children and Adolescents

Gender dysphoria refers to the distress caused by the incongruity between a person's gender identity and their physical characteristics. Providers need to be aware that gender dysphoria can have a strong negative impact on the health and well-being of trans people, including children and youth. It includes the distress felt if a young person is not able to express their gender identity. Gender dysphoria is felt by some trans and gender-nonconforming people at some points in their lives.

It is not possible to predict the gender identity of a child with gender-variant behaviour. Research indicates that the level of fluidity and variability in outcomes is greatest for prepubertal children (Coleman et al., 2011). Social transition, in and of itself (without any medical intervention) is possible, and may alleviate dysphoria, at least until puberty. Bearing in mind gender fluidity in childhood, if a child socially transitions before adolescence, it is important that they feel able to talk about how their gender identity or expression evolves over time.

Compared to younger children, gender dysphoria appears more likely to persist or present amongst adolescents, who then are much more likely to medically transition than younger gender-nonconforming children. There are no formal

prospective studies; however, in a Netherlands follow-up study of 70 adolescents diagnosed with gender dysphoria and given puberty-suppressing hormones, all continued with gender reassignment, beginning with feminising/masculinising hormone therapy (de Vries et al., 2010). Subsequent follow-up with 55 of these adolescents after gender-affirming surgeries found that in young adulthood, their gender dysphoria had resolved, psychological functioning had steadily improved, and their well-being was comparable to same-age peers (de Vries et al., 2014).

5.4 First Clinical Evaluation with a Gender-variant Child or Youth and their Family

In countries where such services are available and accessible for prepubertal children, the primary focus is on providing parental support and education. This focus is so that a safe environment is developed for the child, and the parents and child know about treatment options once puberty begins.

Generally, it is best for the provider to meet first with the child and family to identify what concerns either might have. A nonjudgemental stance is critical. The child's gender identity and their gender expression should each be assessed separately.

It is important at a first visit to assess where the young person and family are in their journey. It may be that the child and family are at very different places, so care needs to be taken as to how much information is provided initially. Discussing medical treatment may not be appropriate for a family that is just realising what is happening with their child, and may need to be done at a follow-up visit. The first visit may involve taking a medical history, answering questions, and doing some baseline laboratory tests, when appropriate. Any physical exam should be deferred to a second or later visit, as per the child or young person's wishes, but is required before prescribing any medication.

“One of our most important roles is to explain to families that this is no one's fault. Many parents often have feelings of guilt, believing they have somehow caused this in their child. We reinforce that nothing anyone has done has made this happen. This is not a choice. This is simply allowing the child to be the person they were always intended to be. It is also OK to grieve for the child they thought they had. But it is so important that they embrace the child they now have. It is their love and support that can make their child's journey so much easier.”

—Rachel Johnson, adolescent health specialist,
Counties Manukau Centre for Youth Health, **New Zealand**

Source: Email correspondence, May 14, 2015

A first visit is usually about establishing engagement with the young person and family. An adolescent may attend without their family for first visits, though family support is actively encouraged. Providing an introduction to the service and discussing consent and confidentiality is important. A detailed psychosocial history should be taken to identify risks and resilience, including the impact of gender variance. The HEEADSSS assessment format is one commonly used for psychosocial interviews (Goldenring et al., 2004). This assessment allows any urgent physical or mental health concerns or significant risk-taking behaviours to be addressed. Further psychological support is often required for families around this process.

If possible, youth under the age of 18 are strongly advised to see a mental health professional experienced in trans issues before beginning cross-sex hormone treatment. This is to ensure readiness to transition and assists the youth in exploring the ramifications of gender transition and any potential complications. It is desirable for young people to have the support of mental health professionals, provided this support does not become a barrier to ensuring access to hormone treatment.

If a youth has not completed puberty and development of primary and secondary sex characteristics (i.e., to Tanner Stage V), strong consideration should be given to consulting (provider to provider) with an expert in trans medicine who is experienced in working with trans young people.

5.5 Trans-positive Interventions

5.5.1 Environment

Interventions for children should focus both on facilitating gender identity development (irrespective of the nature of gender identity, i.e., boy, girl, third gender, or gender-nonconforming) and the prevention of any problems in psychosocial adjustment that involve the child and their environment (e.g., family, friends, or others at school).

Other approaches focus mainly or exclusively on the environment, so as to foster comprehensive community acceptance of the child's gender identity. These approaches recognise that a child's distress is often due to external factors and reactions. Health professionals can play an important role by educating school boards, principals, teachers, and counsellors about gender nonconformity, and advocating on behalf of their clients. They may be well placed to encourage schools to respect a child or youth's gender identity. This encouragement might include supporting a decision to change a child or youth's name and/or gender marker on school records. Other positive outcomes might include a school enabling trans students to wear the appropriate school uniform; participate in school and sporting activities and use facilities, such as toilets and changing rooms based on their gender identity (Counties Manukau District Health Board, 2011).

Providers should assist the child and family to balance a non-judgemental attitude towards exploration of gender identity and expression with steps designed to prevent negative reactions from the child's social environment. Rather than initiating or resisting a gender role transition, parents require support to cope with uncertainty regarding their child's evolving gender identity and expression. Opportunities for support from other families with a trans child may be available, either face to face or online. Health professionals may be aware of counselling services that have experience in supporting trans and gender-nonconforming children, youth, and/or their families.

5.5.2 Early and fully reversible medical interventions

As early as the first stages of pubertal development (Tanner Stage II) medical interventions are available in the form of puberty-suppressing hormones, gonadotropin releasing hormone (GnRH) analogues. This is a fully reversible treatment associated with a reduction in psychological distress (Hembree et al., 2009; Coleman et al., 2011). Puberty-suppressing hormones alleviate the distress associated with developing secondary sex characteristics and temporarily prevent undesired, permanent changes to the body. These changes include breast development, beard growth, and changes in the pitch of the voice.

In addition, puberty-suppressing hormones, usually GnRH analogues, provide additional time for the adolescent and the family to evaluate the option of cross-sex hormone therapy. This may also delay decisions until a young person has the capacity to make their own choice about irreversible medical interventions. GnRH analogues have been shown to be safe (de Vries et al., 2013). Once they are stopped, puberty can resume as usual or a decision can be made to start cross-sex hormone therapy.

FOR HEALTH PROVIDERS—MINIMUM CRITERIA FOR PUBERTY-SUPPRESSING HORMONES

The WPATH SOC7 set out the following minimum criteria before an adolescent is able to receive puberty-suppressing hormones:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed).
2. Gender dysphoria emerged or worsened with the onset of puberty.
3. Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, so the adolescent's situation and functioning are stable enough to start treatment.
4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

Source: Coleman et al., 2011, p. 19.

5.5.3 Partially or fully irreversible medical interventions

Other medical interventions are described as partially irreversible or irreversible (Hembree et al., 2009; Coleman et al., 2011).

Partially reversible treatment consists of feminising or masculinising hormone therapy that, in regulated contexts, is available as early as age 16. This therapy is usually administered with parental or guardian consent, and after a reasonable period of psychotherapy with a specialised mental health professional.

In the lower- and middle-income countries of this region, such expertise is usually not available or affordable for most trans youth. In many parts of Asia, young trans women and men start hormone therapy on their own, or with peers, as early as 11 to 12 years of age, with no supervision by health professionals. Where hormones are available over the counter at low cost, most adolescents already will have initiated hormone treatment without any psychotherapy. If health professionals stipulate that psychotherapy is essential, it may discourage young people from seeking assistance and advice about their transition.

Harm-reduction strategies may be an effective means to reduce the negative consequences of such early and unregulated hormone use. These might include the following:

- Building trust with trans adolescents so they disclose their hormone usage (type, dosage, and frequency)
- Educating about correct hormone use, including adjusting dosage to account for body size, as an important step in building trust
- Educating about the negative health impacts of unregulated hormone use, mindful that this strategy on its own may deter youth from seeking assistance
- Partnering with older trans peers and role models, who often provide advice to trans and gender-nonconforming youth who are considering hormone use
- Educating about the dangers of sharing or reusing needles for injecting hormones
- Encouraging physician monitoring rather than risky practices, including by providing a pathway to medical transition in stages appropriate to the adolescent's age and development
- Assessing for other risk behaviours and addressing accordingly

In **Thailand**, initial attempts have been made to develop partnerships between pharmacists and physicians in the vicinity of larger hospitals in Bangkok to ensure that quality, affordable hormones are available to young people, based on harm-reduction principles.

Irreversible treatment consists of surgery. Genital reconstructive surgery is available as early as age 18 after living one to two years full time in the desired gender role. Female-to-male chest surgery may be available before that. Surgery needs to be recommended by specialised mental health professionals.⁷²

5.6 Confidentiality and Consent

It is important to explain consent, confidentiality, and any limitations to the child or youth and their family.

Confidentiality concerns may be even greater for trans youth and children than for trans adults. Children and youth are reliant on parents for housing and financial support, including covering their education costs. Even trans adolescents who have grown up with a strong sense that their gender identity differs from their sex assigned at birth may not feel it is safe to disclose this information to family or peers. Others may be seeking support from health professionals to explore their feelings, including guilt about not meeting family expectations, and to discuss options.

72. The Center of Excellence for Transgender Health's website also includes answers to frequently asked questions about trans and gender-diverse youth. Responses are provided by physicians at the Children's Hospital Los Angeles, focusing primarily on the use of puberty-suppressing hormones (GnRH treatment). Available at: <http://transhealth.ucsf.edu/trans?page=protocol-youth>.

Assessment of the competence of a trans adolescent to give consent is the same as other medical consents and requires that the adolescent comprehends the issues and treatment options (Counties Manukau District Health Board, 2011). Confidentiality is an ethical and legal right for adolescent clients sufficiently competent to make their own medical decisions (Joint Adolescent Health Committee of the Royal Australasian College of Physicians, 2008).

Gaining consent from both the young person and parent(s)/legal guardian(s) is strongly recommended before starting either puberty-suppressing or cross-sex hormones. The aim is to obtain family support and consent for medical treatment; however, there may be occasional instances when this is not possible, as it may put a young person's safety at risk. A second mental health opinion may be required in complex cases, including if a young person's ability to consent is possibly impaired. However, it is important that young people in that situation are not excluded from accessing medical supports.

Article 12 of the United Nations Convention on the Rights of the Child recognises a child's right to express their views and for those views to be "given due weight in accordance with the age and maturity of the child." Article 3 also requires that the best interests of the child shall be a primary consideration in all actions concerning children. Asking a child's opinion and whether they assent (agree) to a decision is also important. While this carries no legal weight, it informs the decisions of others who are required to make decisions in the child's best interests.

The age at which a young person can make their own medical decisions without parental consent varies across this region. The concept of "Gillick competency" has been well established in case law and been applied to decisions about trans adolescents in this region. In *Re Isaac*, a 17-year-old trans male applied to the Family Court of Australia asking for a declaration that he was "Gillick competent" to consent to starting hormone treatment. Under Australian law, such treatment requires parental consent. In the December 2014 decision, Justice Cronin stated "as I consider Isaac is quite capable of making medical decisions, it is in his best interests to have the responsibility ... I am satisfied that Isaac is competent to make all decisions about any treatment in relation to gender dysphoria."⁷³

73. Available at: [www.austlii.edu.au/cgi-bin/disp.pl/au/cases/cth/FamCA/2014/1134.html?stem=0&synonyms=0&query=title\(Isaac\)](http://www.austlii.edu.au/cgi-bin/disp.pl/au/cases/cth/FamCA/2014/1134.html?stem=0&synonyms=0&query=title(Isaac)).

CASE EXAMPLE: FOR HEALTH PROVIDERS—GENDER VARIATION CLINIC AT RAMATHIBODI HOSPITAL, BANGKOK, THAILAND

The Gender Variation (Gen-V) Clinic at Ramathibodi Hospital in Bangkok is the first clinic in Thailand for gender-diverse children and adolescents. It was officially established in September 2014 by Dr Jiraporn Arunakul, an adolescent medicine specialist.

Despite the clinic's title, its focus is not solely on trans young people. The clinic provides medical care and counselling for any LGBT adolescents, ages 10–24 years, and also offers counselling to the parents of LGBT and gender-nonconforming children.

The clinic provides specific hormonal therapy to trans adolescents, prescribing masculinising and feminising hormones as well as hormones that suppress puberty.

Those with higher risks are transgenders, both kathoey and trans men, who take hormone pills to try to alter and develop their physical gender into another. Some of them take a larger dose than the prescribed amount and there is no one to help them regulate their intake or tell them how to use the pills safely. At our clinic, we have a specialist on the endocrine system to advise as to the safe intake of hormone pills.

—Dr Jiraporn Arunakul (cited in Mahavongtrakul, 2014)

In addition to Dr Jiraporn Arunakul, the Gen-V Clinic's staff members include a child and adolescent psychiatrist, psychologists, and a nurse practitioner. The clinic also works with an endocrinologist from Ramathibodi Hospital who monitors and follows up with trans adolescents receiving hormonal therapy. Hormonal therapy in Thailand is mentioned briefly in a 2009 Medical Council regulation (Medical Council of Thailand, 2009) and follows the Endocrine Society's 2009 clinical practice guidance (Hembree et al., 2009).

The Gen-V Clinic runs annual diversity training for its staff and colleagues from other wards and clinics at Ramathibodi Hospital. As it is the only clinic that operates on Friday afternoons, the Gen-V Clinic can ensure that the space is private and confidential for its clients.

The clinic is still relatively new. Over time, it hopes to develop knowledge and information that improve access to healthcare for gender-diverse children and adolescents while promoting understanding of LGBT people generally within Thai society.

It should be one of the roles of a medical practitioner to stand up and tell society what is or isn't wrong, what is not abnormal, or which group of people need specific care or help ... Looking at the reality, we already have these children in our society. They are not a mystery or an invisible crowd that we can't find. It would be better if they have a place that they can rely on to find answers about how to take care of themselves and understand who they are.

—Dr Jiraporn Arunakul (cited in Mahavongtrakul, 2014)

The following case example shows how culturally focused practice can improve health outcomes for Pacific trans youth in **New Zealand**. It comes from New Zealand's largest city, Auckland, which has a significant Pacific youth population.⁷⁴

CASE EXAMPLE: FOR HEALTH PROVIDERS—GENDER VARIATION CLINIC AT RAMATHIBODI HOSPITAL, BANGKOK, THAILAND

Paulo is a 16-year-old New Zealand-born Samoan trans female who presented to our clinic with three of her peers from an all-boys high school. All were looking for support to access feminising medical treatment.

Paulo lives at home with her traditional island-born parents, grandparents and six siblings. Paulo has always identified as female and until she turned 12 was supported in this role by her wider family. At the onset of puberty she was instructed by her father to leave “all girly stuff” behind and to start “manning up.” She was no longer able to present femininely and at times was beaten or banned from leaving the house because she continued to attempt to present as female.

Paulo sensed she was bringing deep shame to her family and was confused by the change in their attitude. She was struggling with depression and had withdrawn from most family events. Paulo was clear that she wanted to start puberty blockers and cross-sex hormones as soon as possible—and was keen for her family not to be involved in any of her decision making.

Safety and family connection are integral to youth-friendly approaches to clinic practice. Our Youth Worker provided a conduit to Paulo's family. She is a New Zealand-born Samoan, fluent in the Samoan language, with knowledge and skills about cultural perspectives of gender identity. Initial plans included identifying advocates inside Paulo's family—those adults who were sympathetic to her needs. These advocates were able to bridge the gap between clinical services and family. As the family's engagement grew, wider family meetings were called so that concerns and accurate information could be shared.

All meetings were opened with prayer. Information was shared in the family's first language, Samoan, using words familiar to the elders in order to improve understanding across generations. A family-centred approach allowed us to weave together this fragmented family.

Having a partnership with Paulo and her family meant that we could integrate the family into decision making about her transition. Sensitive subjects such as impacts of treatment on future fertility—and therefore the preservation of family lines—were able to be discussed at a family level. This meant Paulo was supported to make the best decision for herself in the context of her family—a difficult task for a concrete-thinking 16 year old.

Paulo's parents were reassured that Paulo's gender identity was not their fault and could not be disciplined out of her. With wider community acceptance, they have also come to understand that in order to keep their young person safe they have to embrace her for who she is, not for what they expected her to be. Paulo remains connected to her family. Her overall safety has improved and she continues to use the wisdom and love of the people closest to her to assist her with decisions relating to her transition and wider identity development.

Source: Mo Harte (Nurse Practitioner) and Neli Alo (Youth Worker), Youth Health Hub, Health West, Auckland, **New Zealand**.

74. More than one in every seven people in the Auckland region (14.6%, or 194,958) identifies as Pacific. This represents 14.6 percent of Auckland's population and, for example, is similar to the total population of Samoa. Almost half (46%) of the Pacific population in New Zealand is under the age of 20 (Statistics NZ, 2014).

POLICY CONSIDERATIONS

As mentioned in the initial background section, this document, and its predecessors in Latin America and the Caribbean, was developed collaboratively by representatives from multiple sectors. These include academia, the health sector, multilateral and bilateral agencies, governmental organisations and NGOs, trans communities, donors, and other stakeholders. The multidisciplinary and intersectoral perspectives offered by the various authors of the Blueprint have allowed a comprehensive view of the health needs and demands of trans people. The consultations held in the Asia and the Pacific region have grounded this document in the realities of what it means to be a trans or gender-diverse person trying to access health services, or a health professional or agency trying to deliver those services. The policy considerations below are based on the human rights framework and priorities that underpin this Blueprint.

Participation of Trans People in Research, Advocacy and Policy

Ensure greater participation of trans people in decisions that affect their lives

ACTION	BY WHOM
Audit current laws and policies to determine how they currently apply to or impact the health rights and social protection of trans people; identify how the laws could be repealed, reformed, and/or improved, in collaboration with trans people	UN agencies, governments/NHRIs, legal professionals, trans and other civil society groups, policymakers and decision-makers
Involve (including formal hiring of) trans people in research activities to ensure that these are appropriate, acceptable and relevant from the community's perspective	Governments, trans organisations, research institutions, health academics, policymakers and decision-makers
Engage trans organisations in global, national, and subnational health and gender committees and councils; include in governance	Governments, donors, research institutions, health academics, policymakers and decision-makers

Undertake research, in collaboration with trans people, to address significant data gaps

ACTION	BY WHOM
Undertake research on under-represented groups, including trans men, indigenous groups, and elderly people across the region and trans people in the Pacific	Academics, governments
Collect gender identity data about trans people to monitor and address the effectiveness of policies in meeting their needs, particularly in relation to indicators for social determinants of health	National statistical offices, academics, government agencies, service providers
Disaggregate data about trans people from studies involving MSM or LGB people, and ensure adequate attention to gender identity, gender expression, and trans-specific topics such as legal gender recognition and unique health concerns	Academics, governments

Increase public awareness about trans people and their human rights issues

ACTION	BY WHOM
Promote and support national dialogues on how human rights obligations apply to trans people, including through endorsing efforts targeting transphobia and all forms of verbal and physical abuse, hatred, exclusion, and intolerance	Governments, NHRIs, bilateral and multilateral organisations, and the media
Reduce stigma against trans people, including through public awareness that gender nonconformity is not a disease, condition, or disorder	Health professional bodies and health academics, policymakers and decision-makers, bilateral and multilateral organisations, trans and other civil society groups, and the media
Research, monitor, and report on human rights issues faced by trans people, including those in places of detention, asylum seekers and migrating trans people, using existing domestic and international human rights reporting mechanisms	NHRIs, trans and other civil society groups
Develop a trans focal point or trans desk within government agencies (including law enforcement) and NHRIs	Governments, NHRIs
Promote dialogue with faith-based organisations on the universality of human rights, including the relationship between freedom from discrimination and freedom of religion and belief	NHRIs, faith-based and trans groups

Health Services and Public Health for Trans People

Address discrimination and improve responsiveness of health services to trans people

ACTION	BY WHOM
Build the capacity of all staff to deal sensitively and competently with trans people and create a welcoming, non-judgemental, non-discriminatory environment (including by using trans-inclusive intake forms and posters, preferred names and pronouns, and by publicising non-discrimination policies)	Ministries/departments of health, health providers and personnel
Develop the technical skills and cultural competency necessary to provide adequate health promotion, prevention, treatment, monitoring, and support for trans people; work with trans organisations and/or hire trans staff to build capability and capacity to do this work well	Ministries/departments of health, health providers, health personnel
Sensitise healthcare professionals to their professional obligation and ethical mandate to provide non-judgemental care and on ways to work with trans people based on a human rights approach	Governments/ministries of health, WPATH, health professional bodies, health providers
Monitor and publicly critique the practice of “conversion” or “reparative” therapies (that try to change a person’s gender identity or expression or sexual orientation), highlighting that such treatment is no longer considered ethical	Health policymakers and decision-makers, health professional bodies, faith-based organisations

Address significant information gaps about trans people's health

ACTION	BY WHOM
Support peer-led trans health information initiatives in local languages, including through collaboration with health personnel skilled in working alongside trans health advocates	Governments, health personnel, trans people
Promote collaborative research involving trans people to identify and address trans health needs, risks, and protective factors that build resilience	Academics, policymakers and decision-makers, and professional bodies
Close gaps in biomedical research, such as the use of hormones concurrently with ART; the side effects of hormones and soft tissue fillers used in this region; and long-term use of hormones, including interactions with known health risks	Academics and biomedical professional organisations
Extend current HIV research to look at potential risk factors amongst trans men, including resistance to current prevention methods, drug use, and sex work	Academics, donors
Promote networks of trans health excellence across Asia and the Pacific	WPATH, regional and national trans health professional associations, health academics and trans health advocates
Document examples of trans-positive, competent, comprehensive, and accessible healthcare based on an informed consent model, including programmes and interventions offered by trans-led organisations or targeting under-researched or marginalised trans populations	Governments, academics, policymakers and decision-makers, and health personnel and service providers

Ensure trans people's equal access to general health services

ACTION	BY WHOM
Ensure that public health systems provide comprehensive quality services that are acceptable and accessible to trans people and address their specific health needs	Governments, policymakers
Develop and test trans HIV bio-behavioural interventions rather than simply adapting them from MSM interventions	Health researchers, policymakers and decision-makers
Develop or adapt trans-affirming algorithms for the provision of care to trans people, reflecting universal human rights standards and in response to the needs of specific trans populations	Health researchers, policymakers and decision-makers
Establish networks and referral systems with other appropriate clinical services to minimise navigation difficulties and improve coordination amongst services	Health personnel and providers

ACTION	BY WHOM
Ensure the safety, accessibility, and quality of healthcare for trans people in detention, asylum, in emergencies and disasters, and that they are housed in a facility according to their expressed gender identity	Governments, including justice and corrections officials, health personnel
Incorporate trans health as part of multidisciplinary health curricula, including (but not limited to) medicine, nursing, social work, and psychology	Health academics, health policymakers and decision-makers
Develop mental health research and promotion interventions (including suicide prevention) targeting trans people, in consultation with trans people, including youth	Governments, health academics, policymakers and decision-makers

Improve trans people's access to gender-affirming health services

ACTION	BY WHOM
Build awareness about the efficacy and legality of gender-affirming health services to reduce health professionals' reluctance to provide or facilitate access to medically necessary health services	Governments, health professional bodies, health policymakers and decision-makers
Assess current demand for and capacity to provide regulated access to hormone therapy, including puberty-suppressing hormones	Governments, health providers, including sexual health clinics
Support collaboration between health providers, health academics, and trans organisations to undertake needs assessments and baseline surveys on trans health needs, with a commitment to addressing identified needs	Governments, health academics and providers
Develop clear referral pathways and protocols for trans people so they and their doctors know the options and steps to follow; where there are gaps, identify potential opportunities for these to be filled through existing or additional health services, including medical schools and teaching hospitals	Governments, health policymakers and decision-makers
Build awareness amongst services focused on HIV and other STIs about how they can support trans people's access to gender-affirming health services	Health policymakers and decision-makers, health personnel

Improve the quality of gender-affirming healthcare for trans people

ACTION	BY WHOM
Provide accurate information to trans people about hormone therapy and other gender-affirming health services, and undertake continuing education to remain up to date on trans health	Health personnel
Certify that biomedical interventions for body modifications (e.g., hormone therapy) are managed and performed by properly trained and qualified professionals	Health policymakers and decision-makers, health personnel
Adapt/develop national clinical guidelines for gender-affirming health services for local contexts, building on international guidance from WPATH and WHO, and regional guidance, such as this Blueprint	Health policymakers and decision-makers, health personnel
Share knowledge and experience on provision of care to trans people, regardless of their health condition or HIV serostatus, including to trans and gender-nonconforming children and youth	Health personnel

End Violence against Trans People

Take comprehensive measures to tackle violence against trans people

ACTION	BY WHOM
Build the capacity of trans organisations to recognise and professionally monitor and report human rights violations, including violence against trans and gender-diverse people	Bilateral and multilateral organisations, NHRIs, regional networks
Undertake research on impacts of gender-based violence on trans people (including trans men and gender-nonconforming people who were assigned female at birth), and interventions required to reduce such violence and support those affected by it	Academic researchers in partnership with trans communities, government agencies
Undertake human rights training for judges, lawyers, police, prison personnel, asylum officers, security officials, and others in a position to perpetrate or prevent violence against trans people	Governments, NHRIs and law enforcement agencies, with trans people
Effectively investigate, prosecute, and punish all forms of violence based on someone's gender identity or gender expression (as well as sexual orientation), ensuring that victims are provided with appropriate support, remedies and redress	Governments and law enforcement agencies
Address violence against trans sex workers through repealing laws that prohibit commercial sex work; taking legal measures to ensure safe working conditions and stopping police harassment, abuse and violence against trans sex workers	Governments and law enforcement agencies

Move from Discriminatory to Protective Laws and Policies for Trans People

Ensure that trans people have legal protection from discrimination and are not criminalised

ACTION	BY WHOM
Ensure that trans people are protected under anti-discrimination provisions and audit other existing or proposed laws to ensure they protect trans people regardless of their gender identity, gender expression, or sex	Governments and NHRIs
Review or repeal laws that discriminate against trans people based on their gender identity or gender expression (or sexual orientation), or that are used to criminalise trans people	Governments
Repeal or revise laws, including offences such as “public nuisance,” “public morality” or “vagrancy,” that are used to harass and criminalise trans people, particularly sex workers	Governments
Undertake public education to prevent and reduce stigma, discrimination, and violence against trans people, including by developing media guidelines on the portrayal of trans people	Governments, NHRIs, media
Build the capacity of all staff to deal sensitively and competently with trans people and create a welcoming, non-judgemental, nondiscriminatory environment	Governments and law enforcement agencies Government and private sector agencies, employers

Ensure trans students’ right to education and safety at school

ACTION	BY WHOM
Document the vulnerability of trans and gender-nonconforming children and youth to bullying, explicitly address their rights and schools’ obligations regarding anti-bullying policies, and ensure that effective internal and external complaints mechanisms and support exist	Education officials, school boards, principals and staff
Audit school policies to ensure they protect students of all gender identities, gender expressions, and sexes, and enable trans and gender-nonconforming students to participate fully in all school activities	Education officials, school boards, principals and staff
Promote human rights education in schools and explicit inclusion of materials about gender identity and expression in school curricula	Health policymakers and decision-makers, health personnel
Support both mainstream and targeted initiatives in schools, developed in collaboration with trans and gender-nonconforming students, to make schools safe and supportive learning environments	Education officials, school boards, principals and staff
When sexual and reproductive health education is provided in schools, ensure that it incorporates material on gender identity and gender expression (as well as sexual orientation)	Education officials, school boards, principals and staff

Protect and fulfil trans people's right to decent work

ACTION	BY WHOM
Explicitly include trans people in all equal employment opportunity laws and policies, including special measures to address high levels of under-employment, unemployment, and precarious work	Governments, business, employers' and workers' organisations
Audit human resource policies to ensure they protect trans people from discrimination based on gender identity or expression, with specific attention to their right to privacy	Employers, business, employers' and workers' organisations
Develop resources on trans people's rights at work, including in pre-employment situations and when transitioning at work and covering the rights of migrant workers	Governments, business, employers' and workers' organisations

Promoting Legal Gender Recognition

Ensure that trans people are legally recognised and protected under their self-defined gender identities

ACTION	BY WHOM
Take all necessary legislative, administrative, and other measures to fully recognise each person's self-defined gender identity, with no medical requirements or discrimination on any grounds	Governments; public, private and community-sector agencies, employers
Review or repeal laws or policies that deny trans people the right to have their affirmed gender recognised in identification documents	Governments
Ensure that gender recognition procedures are accessible, fair, and nondiscriminatory, and respect trans people's dignity and privacy; and that changes to identity documents will be recognised in all legal and administrative contexts	Governments
Recognise trans people's choice as to whether their legal identity is male, female, other or a third option (including terms that reflect the cultural diversity of this region)	Governments; public, private and community-sector agencies, employers
Given current barriers to legal gender recognition, implement measures to ensure respect for the use of a social or preferred name, which may be different from that used in a person's civil or legal documentation; enable use of gender-specific facilities in accordance with that expressed gender identity	Governments; public, private and community-sector agencies, employers
Promote awareness about the importance of social and legal gender recognition and its links to the realisation of other human rights	NHRIs

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APPENDICES

Appendix A: Hormone Administration, Monitoring and Use

WHO support for the Blueprint should not be interpreted as WHO endorsement of the guidance provided in this “Appendix A”. Any WHO guidance would need to be developed through a standard WHO guidelines development process.

Due to differences in health systems and the availability of hormones, the provision of cross-sex hormones differs considerably across the Asia-Pacific region. In both Asia and the Pacific there is high use of oral contraceptives as the primary or sole source of estrogen. As stated in the *WHO Policy brief on transgender people and HIV*, it is important to counsel trans women who use oral contraceptive pills for feminisation about the higher risk of thrombotic events with ethinyl estradiol compared to 17-beta estradiol (WHO, 2015b).

In some countries, like **Australia**, centralised gender clinics are well established, whereas in other countries, hormones are frequently obtained over the internet without medical oversight. Guidelines for the use of hormones for medical transition are available in several high-income countries (for example, the United States, the Netherlands, the United Kingdom, and Australia). However, these need to be adapted for use in other country settings. Most guidelines and gender centres have different protocols for adolescents due to the specific endocrinological, biopsychosocial, and legal concerns of younger clients. For information on care for transgender children and adolescents, see Chapter 5.

It is important for the provider to know that not all trans clients will want to take cross-sex hormones. If a trans client does need to consistently express a gender different from their assigned sex at birth, cross-sex hormones are the most common means for body modification they can access for self-actualisation. These hormones bring the endocrine and psychological systems into balance. In the case of trans women, hormones enable feminisation without requiring clients to turn to unsupervised soft tissue filler injections.

In general, feminising hormones consist of estrogens and androgen blockers. Masculinising hormones consist of testosterone. It is essential that providers understand the correct dosing, risks, and benefits associated with the most commonly prescribed regimens (WHO, 2014a).

Cross-sex hormone administration has not been studied in prospective, randomised controlled trials. However, more than 50 years of clinical experience have shown that this practice could be effective in treating gender dysphoria (Hembree et al., 2009; Gooren et al., 2008). It is important that the ability to understand and monitor this treatment becomes a part of primary care practice.

Initiation of hormones

The WPATH SOC7 recommend that initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional (Coleman et al., 2011). For example, this could be an appropriately trained primary care or mental health provider.

The client presenting for initiation of cross-sex hormonal therapy for gender transition may require particular attention from a primary care provider. Although transition itself often provides great relief from gender dysphoria, it may be a time of heightened environmental stress, presenting challenges with regard to the client’s family, partner, school, and/or place of employment. Referral to a psychotherapist experienced in working with trans people is helpful for many.

The primary care provider should assess every client who is initiating cross-sex hormonal therapy for their ability to understand the risks and benefits of treatment, discuss these with the client, and consider obtaining a signed consent regarding this understanding. (See Appendix E for sample consent forms.)

Some clients may already have been using cross-sex hormones; they may have had them prescribed by a provider or may have obtained hormones over the counter, through acquaintances, or through any other means without any evaluation by a provider. In this latter instance, the WPATH SOC7 include provisions for providers to continue the medical treatment of clients who have independently initiated cross-sex hormone therapy, regardless of the client’s ability or desire to receive gender-related psychiatric/psychological evaluation. The provider should review the current

regimen in combination with a thorough assessment of the client's general health to determine whether to recommend changes in dosage or preparation. When clients are determined to continue using medication(s) in the absence of physician oversight, it is usually advisable to assume their medical care and prescribe appropriate hormones. Denying them care is likely to result in their continued independent treatment, possibly to their detriment.

Readiness for hormones

The WPATH SOC7 include a list of recommended general criteria for the assessments of a client's individual preparedness for hormone treatment (Coleman et al., 2011). Informed consent requires a detailed discussion with the client that covers the risks and benefits of treatment. For information about hormone therapy for trans and gender-diverse children or youth, please refer to Chapter 5. Appendix E provides some sample consent forms.

Medical assessment

The only absolute medical contraindication to initiating or maintaining estrogen or testosterone therapy is an estrogen- or testosterone-sensitive cancer. Other conditions, such as obesity, cardiovascular disease, dyslipidemias, or other conditions, should not preclude treatment in the setting of informed consent. Whereas in the past, a history of venous thromboembolism was a contraindication to estrogen hormone replacement, recent data show that safer estrogen preparations, such as transdermal, do not preclude hormone replacement.⁷⁵

Baseline laboratory tests

Baseline laboratory tests will allow the provider to assess for concurrent medical issues. They may also assist the provider in the choice of transition regimens.

The standard of testing of liver function in trans women is based on older studies with methodological flaws; using formulations no longer prescribed (ethinyl estradiol); and not controlling for conditions that cause elevated liver function, including alcohol and Hepatitis B. Transient elevations with no clinical significance were included in the evidence that estrogen causes liver abnormalities. There is no current clinical evidence of the need to check liver function in trans women using estrogen. Current publications make no mention of liver function abnormalities in relation to estrogen use. However, it may be useful to check transaminases if the client is taking oral estrogen.

Concerns to address before initiation of hormones

A more detailed list of concerns may be obtained from the WPATH SOC7 (Coleman et al., 2011), the United Kingdom Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria (Royal College of Psychiatrists, 2013), the Endocrine Society Clinical Practice Guideline (Hembree et al., 2009), and the International Medical Advisory Panel statement on hormone therapy for transgender people (IPPF, in press). The concerns discussed below are formulated from these documents, which are informed by promising practices.

Trans women on estrogens and androgen blockers

Feminising regimens are generally safe; however, attention should be paid to early diagnosis of any untoward effects of estrogens, androgen blockers, or both. Estrogens may cause deep vein thrombosis (DVT), pulmonary embolism, and cerebrovascular accident (CVA). Estrogen may have the effect of reducing libido, erectile function, and ejaculation. Prolactinoma is rare. Spironolactone may cause hyperkalemia. Cyproterone has been associated with meningiomas and depression as well as liver function abnormalities. Cross-sex hormone use may reduce fertility; this reduction may be permanent even if hormones are discontinued.⁷⁶

75. Available at: <http://transhealth.ucsf.edu/trans?page=protocol-hormone-ready>.

76. Available at: <http://transhealth.ucsf.edu/tcoe?page=protocol-fertility>.

Trans men on testosterone

Side effects of testosterone are usually minimal (see Table A1). Testosterone may cause polycythemia, headaches, weight gain, acne, androgenic hair loss, changes in lipid profile, increased libido, liver tumors, breast cancer, and mood changes. Cross-sex hormone use may reduce fertility; this reduction may be permanent even if hormones are discontinued.

Each country should consider which medications and formulations are feasible and available.

Table A1: Risks associated with cross-sex hormone therapy

RISK LEVEL	FEMINISING HORMONES	MASCULANISING HORMONES
Likely increased risk	<ul style="list-style-type: none"> ▪ Venous thromboembolic disease^a ▪ Gallstones ▪ Elevated liver enzymes ▪ Weight gain ▪ Hypertriglyceridemia 	<ul style="list-style-type: none"> ▪ Polycythemia ▪ Weight gain ▪ Acne ▪ Androgenic alopecia (balding) ▪ Sleep apnoea
Likely increased risk with presence of additional risk factors ^b	<ul style="list-style-type: none"> ▪ Cardiovascular disease 	
Possible increased risk	<ul style="list-style-type: none"> ▪ Hypertension ▪ Hyperprolactinemia or prolactinoma 	<ul style="list-style-type: none"> ▪ Elevated liver enzymes ▪ Hyperlipidemia
Possible increased risk with presence of additional risk factors ^b	<ul style="list-style-type: none"> ▪ Type 2 diabetes^a 	<ul style="list-style-type: none"> ▪ Destabilisation of certain psychiatric disorders^c ▪ Cardiovascular disease ▪ Hypertension ▪ Type 2 diabetes
No increased risk or inconclusive	<ul style="list-style-type: none"> ▪ Breast cancer 	<ul style="list-style-type: none"> ▪ Loss of bone density ▪ Cancer of breast, cervix, ovary, and uterus

Source: This table is reproduced, with permission, from IPPF (in press) and is adapted from WPATH SOC7.

Note: Bolded conditions are clinically significant.

a. Risk is greater with oral estrogen than with transdermal estrogen administration.

b. Additional risk factors include age.

c. Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

Hormone administration for feminisation

Hormonal therapy for trans women may include anti-androgen therapy as well as estrogen therapy. Available estrogens and anti-androgens used in different countries are shown in Tables A2 and A3.

Estrogens:

Estrogen comes in many forms, including ethinyl estradiol and 17- β estradiol. Ethinyl estradiol, the form of estrogen commonly used in oral contraceptives, has well-characterised adverse effects, such as venous thromboembolism. While WPATH SOC7 discourage the use of ethinyl estradiol for medical transition, this is the only formulation of estrogen available to many trans women, including those in this region. For example, a popular combination oral contraceptive used in this region for transitioning combines cyproterone acetate and ethinyl estradiol.

Non-oral estrogens, including sublingual, transdermal, and injectable hormones, are preferable. These have the advantage of bypassing the liver. Side effects associated with estrogens can be found in Table A1.

Oral estrogens confer an increased risk of thromboembolic disease for smokers over the age of 35.

After gonadectomy, lower doses are recommended. Titrate to effect, considering client tolerance.

Progesterone:

The risks and benefits of progesterone are not well characterised. Although some providers anecdotally have found it to have positive effects on the nipple areola and libido, it is usually not recommended. Mood effects may be positive or negative. There is a risk of significant weight gain and depression in some individuals. As per other studies using oral progesterone in post-menopausal women,⁷⁷ the oral use of medroxyprogesterone may increase the risk of coronary vascular disease, whereas intramuscular injections (e.g., Depo-Provera) may minimise this additional risk.

Anti-androgens:

Initial administration of anti-androgens (e.g., spironolactone or cyproterone) should be done in a single or divided dose, with weekly titration. Occasional clients—especially those who are larger or younger—require higher doses. Progesterone may have some anti-androgenic activity and may be an alternative if spironolactone is contraindicated.

If clients have significant hair loss issues, finasteride may be added as an adjunct (even initially). Hair implants may also be considered, where available.

BOX A1: FOR HEALTH PROVIDERS—CARDIOVASCULAR ASSESSMENT FOR TRANS PEOPLE

Trans women currently taking estrogen:

- *CAD/cerebrovascular disease:* Closely monitor for cardiac events or symptoms, especially during the first one to two years of hormone therapy; in clients at high risk (including pre-existing CAD), use transdermal estrogen, reduce estrogen dose, and omit progestin from the regimen.
- *Hypertension:* Monitor blood pressure every one to three months; consider using spironolactone as part of antihypertensive regimen.
- *Lipids:* Follow national guidelines for monitoring and treatment.

Trans men not currently taking testosterone:

- Screen and treat hyperlipidemia as with non-trans clients.

Trans men currently taking testosterone:

- Annual fasting lipid profile; if hyperlipidemia is detected, avoid supraphysiologic testosterone levels
- *Lipids:* Follow national guidelines for monitoring and treatment.

77. For example, the Women's Health Initiative Study. Available at: <http://www.nhlbi.nih.gov/whi/>.

Table A2: Examples of estrogens, routes and dosing

HORMONE	ROUTE	STARTING DOSE	AVERAGE DOSE	MAXIMUM DOSE
Estradiol/estradiol valerate	Oral or sublingual	2mg daily	4mg daily	8mg daily
Estradiol valerate	Intramuscular	20mg every 2 weeks	20mg every 2 weeks	40mg every 2 weeks
Estradiol cypionate	Intramuscular	2mg every week or 5mg every 2 weeks	2mg every week or 5mg every 2 weeks	2mg every week or 5mg every 2 weeks
Estradiol gel	Topical	0.75mg twice daily	0.75mg three times daily	150 mcg tds
Estradiol patch transdermal (preferred for over age 40, smoker). Patches may be formulated to be applied weekly or 2x weekly	Transdermal	25–50 mcg	100–200 mcg	400 mcg
Conjugated estrogen (Premarin®)	Oral	1.25–2.5mg daily	5mg daily	10mg daily
Ethinylestradiol (not recommended)	Oral			

Sources: Adapted from Royal College of Psychiatrists, 2013 and Hembree et al., 2009.

Table A3: Examples of anti-androgens and dosing

ANTI-ANDROGEN	STARTING DOSE	AVERAGE DOSE	MAXIMUM DOSE
Spirolactone	50mg daily	150mg daily	400mg daily
Finasteride	2.5mg daily	2.5mg daily	5mg daily
Cyproterone acetate	50mg daily	150mg daily	150mg daily
Goserelin	3.6mg/month	3.6mg/month	3.6mg/month
Leuprolide acetate	3.75mg/month	3.75mg/month 11.25mg/3 months	3.75mg/month 22.5mg/12 weeks 11.25mg/10 weeks

Sources: Adapted from Royal College of Psychiatrists, 2013 and Hembree et al., 2009, with additional input from medical providers in the region.

In Asia, there is also easy access to injectable long-acting estrogen compounds (liquid estradiol cypionate and valerate and powdered estradiol conjugate). The estrogen compound in oral contraceptives (OCs) is usually ethinyl estradiol, which in concert with its liquid and powdered family members has been found associated with a variety of long-term negative health outcomes in women, including trans women (Magnusson et al., 1999; Asscheman et al., 2011).

The progestin taken in combination with ethinyl estradiol seems to balance this risk, but the progestin itself has been implicated in a number of health problems (Magnusson et al., 1999; Asscheman et al., 2011). Since progestin has no role in feminisation other than reducing or stopping body hair growth, it has been argued that this drug is usually not necessary for East Asian trans women (Gooren, 2014). An East Asian trans woman who has gone through a male puberty usually has little or no body hair growth. If this hair is mechanically removed, progestins may not be required. For these reasons, hormone therapy for East Asian trans women may only require estrogen (in an oral form or as a self-administered transdermal patch or gel).

Hormone administration for masculinisation

Hormonal therapy for trans men may include testosterone therapy. Examples of available testosterone preparations used in different countries are shown in Table A4.

Table A4: Examples of available testosterone preparations

HORMONE	STARTING DOSE	AVERAGE DOSE	MAXIMUM DOSE
Testosterone (cypionate or enanthate) (intramuscular)	100mg every 2 weeks	200–250mg every 2–3 weeks	200–250mg every 2–3 weeks
Transdermal testosterone 1%	2.5g daily	5–10g daily	10g daily
Testosterone patch	2.5mg daily	5mg daily	5mg twice daily
Testosterone undecanoate (oral)	40–80mg once daily	160–240mg daily	150 mcg tds
Buccal testosterone	30mg once daily	30mg twice daily	
Testosterone undecanoate (intramuscular)		750–1000mg every 10–14 weeks	
Sustanon 250 testosterone (propionate/phenylpropionate/isocaproate/decanoate)	1 ml every 4 weeks	1 ml im every 2–3 weeks	1 ml im every 2 weeks
10% dihydrotestosterone cream	20mg 3 times daily (clitoral)	Used 3 months before metoidioplasty	

Sources: Adapted from Royal College of Psychiatrists, 2013 and Hembree et al., 2009, with additional input from medical providers in the region.

Some clients using testosterone esters do well on lower doses and weekly injections, especially those with a history of trauma (avoiding excessive peaks and troughs, which may set off emotional reactions). Excessive testosterone can convert to estrogen and impede desired effects. Testosterone therapy is not withheld for hyperlipidemia.

Clients who use intramuscular testosterone (not undecanoate, due to risk of pulmonary oil microembolism) should be taught to self-inject, including how to keep equipment sterile. A family member or friend may be taught to perform the injection for the client. Clients who develop polycythemia may respond well to transdermal gel preparations.

BOX A2: FOR TRANS PEOPLE—DEVELOPMENT OF A GENDER-CONGRUENT SPEAKING VOICE

After puberty, a person's speaking voice pitch adopts a permanent pattern, depending on biological sex characteristics. Lower pitches are usually associated with larger larynxes that result from androgenic stimulation, as well as from the development of resonating cavities and vibrating structures that endow most male voices.

Most female speaking voices tend to have higher overtones. The anti-androgens and estrogens used by trans women have no effect on voice properties. Amongst trans men, the use of testosterone can help lower the pitch of the voice and increase chest resonance and volume. These effects, however, vary on cross-sex hormones and for those not taking androgens.

Voice and communication therapy may be of great value for trans people who wish to re-educate their voices to sit at a lower or higher pitch without strain. Voice and communication therapists can provide techniques on how to use different resonators and more or less volume, and adopt different intonation patterns while speaking.

Other professionals, such as vocal coaches, theatre professionals, singing teachers, and movement experts, also may play a valuable adjunct role. Singing lessons in higher or lower ranges can make the voice more flexible. The successes of these approaches will depend to a significant extent on the accepting and respectful attitudes of the specialists, therapists, or instructors working with a trans person.

Allergy Alert: In some countries, testosterone cypionate is suspended in cottonseed oil and testosterone enanthate is suspended in sesame oil. Testosterone esters may also be suspended in arachis oil and should be avoided if a peanut allergy exists, and possibly also for a soy allergy. Prescribers should be aware of potential allergic reactions and investigate oil suspensions used in their countries.

Use of transdermal preparations may be recommended if slower progress is desired, or for ongoing maintenance after desired virilisation has been accomplished with intramuscular injection. Some clients experience skin reactions to the adhesive in a transdermal patch.

On rare occasions a progestin can be used to stop periods if the client wants only a low dose of testosterone or is having difficulty in stopping menses.

Other medications sometimes prescribed for trans men include the following:

- For male pattern baldness (MPB), prescribe finasteride or minoxidil. Caution clients that finasteride will likely slow or decrease secondary hair growth and may slow or decrease clitoromegaly.
- For clients with concerns about too-heavy secondary hair growth (e.g., male relatives are excessively hirsute), prescribe finasteride, dutasteride.

Laboratory monitoring for cross-sex hormones

Several guidelines exist for laboratory monitoring of trans persons who receive cross-sex hormones; where country guidelines exist, they should be followed. International guidelines that can be adapted for countries without their own guidelines include WPATH SOC7 and the UCSF Center of Excellence transgender protocols.

The specific tests obtained depend on the regimens chosen—for example, different androgen blockers for trans women require specific and targeted monitoring. A general guide is that after initiating hormones, lab tests should be monitored every three months for the first year, then once or twice a year thereafter (see Table A5). Frequency of monitoring should be increased if there are untoward effects, changes in doses, or initiation of other medications with potential drug-drug interactions.

Table A4: Examples of available testosterone preparations

	EVERY 3 MONTHS FOR THE FIRST YEAR	EVERY 6 TO 12 MONTHS
Feminising Regimens	Potassium (if on spironolactone) Liver function tests (if on cyproterone, flutamide) If available: testosterone, estradiol levels	Prolactin Lipids (triglycerides) Potassium (if on spironolactone) Liver function tests (cyproterone, flutamide) If available: testosterone, estradiol levels
Masculinising Regimens	Lipid levels Liver function tests Hematocrit If available: testosterone level	Lipid levels Liver function tests Hematocrit If available: testosterone level

Sources: Hembree et al., 2009; National Health Service, England, 2013.

Hormone use and risk for HIV infection

In trans people, the currently known risk for HIV infection is mostly behavioural, although other factors possibly increasing the risk, such as hormone use, cannot be excluded. Although injectable contraceptives (progesterone) have been shown to increase HIV risk in natal females (Hel et al., 2010; Wira et al., 2010), this is mostly mediated through endocrine-regulated cyclic fertility processes in the lower female reproductive tract. However, a small increase in HIV risk may result directly from progesterone use, independent of biological sex or gender. In some small experimental studies, progesterone has been found to be associated with an increase in circulating chemokine co-receptors, which HIV needs to enter the cell and cause infection (Giltay et al., 2000). Theoretically, this may increase HIV infection risk, given exposure. However, these results need confirmation in larger observational and controlled studies before more definite conclusions can be drawn.

The use of testosterone by trans men has not been implicated in HIV infection risk; however, a theoretical risk exists, as many trans men will develop atrophic vaginitis while on testosterone. This vaginal dryness may increase trauma during sex and thus increase the possibility of enhanced HIV transmission. Some studies suggest the opposite effect, in which testosterone was found associated with increased presence and circulation of adaptive immune cells (Giltay et al., 2000).

Concurrent use of cross-sex hormones and antiretroviral drugs for HIV prevention and treatment

Data on drug interactions between 17-β estradiol (the form most commonly used for hormone replacement therapy) and ARVs are lacking.

It is likely that many trans women in this region will be using oral contraceptives, either because 17-β estradiol is not available or they cannot afford it. This is despite ethinyl estradiol no longer being recommended for use by trans women (Gooren et al., 2015). Limited data suggest that contraceptive hormones may interact with two classes of ARV drugs, some non-nucleoside reverse transcriptase inhibitors (NNRTIs) and ritonavir (RTV)-boosted protease inhibitors (PIs). Theoretically these interactions have the potential to alter the safety and effectiveness of either drug.

However, no evidence exists that cross-sex hormone therapy significantly alters the working of most ARV drugs (Gooren et al., 2015). Therefore, current WHO contraception guidelines conclude that no drug interactions between hormonal contraceptives and currently recommended ART or PrEP are significant enough to prevent their use together (WHO, 2015b).

Most interactions between oral contraceptives and boosted protease inhibitors decrease the blood levels of estradiol but not of ART. Starting, stopping, or changing ART regimens may lead to hormonal fluctuations for trans women taking feminising hormones, so close monitoring is recommended (Keller, 2009). There are limited data on the interactions between ARVs and other drugs used in feminising hormone therapy for trans women, particularly with anti-androgens (e.g., cyproterone acetate, flutamide) (WHO, 2015b).

There are limited data on interactions between ARVs and androgens commonly used by trans men. Testosterone, the primary and single compound in cross-sex hormone therapy for trans men, has been prescribed in combination with ARV drugs for more than a decade to treat hypogonadism and the effects of symptomatic HIV infection in males. It is well tolerated, and no significant medical or immunologic adverse effects or negative interactions with ARV drugs have been reported (Rabkin et al., 1999; Dube et al., 2007). While negative effects in either direction of concurrent testosterone and prophylactic/therapeutic ARV use in trans men may be unlikely, more research is needed (WHO, 2015b).

A better understanding is needed about how hormones used for transition may affect HIV risk amongst trans people. Medical controversy remains over whether and how hormonal contraceptives impact HIV acquisition and transmission for natal women. Trans people take supraphysiological doses as part of their medical transition process—higher than levels normally present in the body (Keller, 2009).

Aging issues: Special considerations

There is no set upper age limit for hormonal therapy. Trans male clients beginning hormones after age 40 generally will progress more slowly in exhibiting the desired results.

Osteoporosis has been reported in both older trans men and trans women, and is frequently associated with poor compliance with the hormone regimen, especially after gonadectomy.

Some clients prefer to stop hormonal therapy; for post-gonadectomy clients under age 50, this is not recommended due to bone loss and potential symptoms similar to menopause in both trans women and trans men. Trans men stopping testosterone will experience loss of libido, hot flashes, loss of body hair and muscle tone, and weight redistribution in a female pattern.

Upper age limits that might preclude surgical interventions should be considered. There is currently no information about outcomes for older clients, and some surgeons impose upper age limits for specific procedures. Older trans people considering surgery should consult with surgeons to determine what physical readiness requirements might be advisable to be medically eligible. In addition, anticipated recovery times may be longer.

Appendix B: List of participants—Initial consultation meeting

Furama Silom Hotel, Bangkok, Thailand, 23–24 October 2014

Although people's organisations and designations are listed, trans people attending this meeting were invited to attend in a personal capacity and were selected because of their knowledge and experience, rather than to represent a specific organisation.

COUNTRY	NAME	DESIGNATION AND ORGANISATION
Australia	Aram Hosie	International Reference Group on Trans* and Gender Variant and HIV/AIDS issues (IRGT)
Australia	Felicity Young	Senior Director, HPP
Australia/Tonga	Resitara Apa	Pacific Sexual Diversity Network
Geneva	Annette Verster	WHO
Hong Kong SAR	Kaspar Wan	Activist
India	Abhina Aher	India HIV/AIDS Alliance
India	Amitava Sarkar	IRGT
India	Vivek Divan	Consultant, UNDP
Indonesia	Pritz Rianzi	Chair, Transmen Ngehe Support Group
Malaysia	Khartini Slamah	ISEAN HIVOS Program, Transgender Program Manager, PT Foundation
Nepal	Manisha Dhakal	Acting Executive Director, Blue Diamond Society (BDS)
New Zealand	Jack Byrne	Consultant, HPP
Philippines	Kate Montecarlo Cordova	Association of Transgender People in the Philippines (ATP)
Thailand	Aaron Schubert	USAID\RDMA
Thailand	Edmund Settle	Policy Advisor, UNDP APRC
Thailand	Emilie Pradichit	UNDP
Thailand	Fritz van Griensven	Thai Red Cross
Thailand	Kevin Hamlin	Programme Assistant, Asia Pacific Transgender Network (APTN)

B

COUNTRY	NAME	DESIGNATION AND ORGANISATION
Thailand	Matt Avery	FHI 360/USAID-funded LINKAGES Project
Thailand	Mike Burkly	USAID\RDMA
Thailand	Natt Kraipet	Network Coordinator, APTN
Thailand	Panisara (Poy) Skulpichairat	Founding member and working group member, Thai Transgender Alliance
Thailand	Steve Mills	FHI 360/USAID-funded LINKAGES Project
Thailand/Singapore	Joe Wong	Programme Manager, APTN
USA	Cameron Wolf	Senior Technical Advisor, Key Populations, USAID
USA	Clifton Cortez	Deputy Director, HIV, Health and Development Group, UNDP
USA	Darrin Adams	Senior Technical Advisor, HIV, HPP
USA	Diego Solares	HPP
USA	James Baer	Consultant
USA	Nachale (Hua) Boonyapisomparn	Consultant, HPP
USA	Tonia Poteat	Johns Hopkins University

Appendix C: List of participants—First consultation workshop

South Asia subregional consultation

Radison Hotel, Kathmandu, Nepal

5 February 2015

COUNTRY	NAME	DESIGNATION AND ORGANISATION
Australia	Sam Winter	Professor, Curtin University
Australia/Tonga	Resitara Apa	Pacific Sexual Diversity Network
Bangladesh	Anonnya Banik	Liaison Officer, Bandu Social Welfare Society (BSWS)
Bangladesh	Kamrun Nahar	Intern, BSWS
Bhutan	Chencho Dem	Programme Manager, Lhak-Sam Bhutan Network of Positive People (BNP+)
Bhutan	Dechen Seldon	
Bhutan	Sonam Yoezor	
Bhutan	UgyenTshering-Yangchen	
Fiji	Rani Ravudi	TG Project Coordinator, SANFiji
India	Ernest Noronha	Programme Officer, HIV, Health, and Development Group, UNDP
India	K. Sheethal	SCOHD Society
India	Laxmi Narayan Tripathi	Founder Trustee & Chairperson, Astitva Organization for Support & Development of Sexual Minorities
India	Mira Kinnar	Treasurer, SAKHA
India	Sonal More	Consultant, Personnel Selections
India	Shreya Reddy	Programme Manager, KinnerMaaEkSamajikSanstha Trust
India	Nadika	Sampoorna Network
India	Olga B. Aaron	Founder Trustee, Bringing Adequate Values of Humanity (BRAVOH)
India	Rudrani Chettri	

COUNTRY	NAME	DESIGNATION AND ORGANISATION
India	Simran Shaikh	India HIV/AIDS Alliance
India	Sita Bharadwaj	President, KINNAR BHARATI
India	Vidya	Mitwa India
Indonesia	Pritz Rianzi	Chair, Transmen Ngehe Support Group
Japan	Yuko Higashi	Professor, Osaka Prefecture University
Malaysia	Nisha Ayub	TG Programme Manager of Seed Foundation & Advocacy Manager of Justice for Sisters
Nepal	Aakanshya Timilsina	Outreach Office and Human Rights Officer, Sahra Nepal
Nepal	Aniee Lama	BDS
Nepal	Apekshu Duhul	BDS
Nepal	Basanta Singh	BDS
Nepal	Bharat Man Shrestha	LGBT Human Rights, HIV and Law Officer, UNDP
Nepal	Bhumika Shrestha	Event coordinator, BDS
Nepal	Binod BK	Pahichan Media Reporter, Mono Support Maple Group (MSMG)
Nepal	Durga Thapa	Member, Ekata Nepal
Nepal	Kiran Malla	Member, Naulo Srijana Nepal
Nepal	Manisha Dhakal	Acting Executive Director, Blue Diamond Society (BDS)
Nepal	Pinky Gurung	President, BDS
Nepal	Prem Thepa	BDS
Nepal	Samrat Chaudhari	President, Sahra Nepal
Nepal	Sanjay Tanang	BDS
Nepal	Sayal Shrestha	Freelance consultant
Nepal	Sumi Devkota	Freelance consultant
Nepal	Surendra Shah	

COUNTRY	NAME	DESIGNATION AND ORGANISATION
Nepal	Sushila Lama	Advocacy and Training Officer, BDS
New Zealand	Jack Byrne	Consultant, HPP
Pakistan	Malik Rizwan Mehmood (aka Bubbi)	Board Member, Naz Male Health Alliance (NMHA)
Pakistan	Mehrin Abdul Qadir (aka. Mani)	Monitoring and Evaluation Officer, NMHA
Pakistan	Dr. Muhammad Moiz	Technical Support Manager, NMHA
Pakistan	Zohaib Ali Soomro (aka Zehrish)	Monitoring and Evaluation Officer, Khawaja Sira Society
Sri Lanka	D. Thenu Lakal Ranketh Perera	Field Officer, Equal Ground
Sri Lanka	Sathya Bashana Ramanayake (Satya Baashi)	SSR—Field Supervisor under the GF National grant/ UNYAP
Thailand	Anna Chernyshova	Programme Manager, UNDP
Thailand	Emilie Pradichit	UNDP
Thailand	Joe Wong	Programme Manager, APTN
Thailand	Kevin Hamlin	Programme Assistant, Asia Pacific Transgender Network (APTN)
Thailand	Matt Avery	FHI 360/USAID-funded LINKAGES Project
Thailand	Thitiyanun Nakpor	Director, Sisters
USA	Darrin Adams	Senior Technical Advisor, HIV, HPP
USA	Nachale (Hua) Boonyapisompan	Consultant, HPP
	Lou	Freelancer
	Pradip Khadka	Press
	Ritik	

D

Appendix D: List of participants—Second consultation workshop

South East Asia, East Asia, and Pacific subregional consultation,

Narai Hotel, Bangkok

28 February and 1 March 2015

COUNTRY	NAME	DESIGNATION AND ORGANISATION
Australia	Felicity Young	Senior Director, HPP
Brunei	Serena Al	Pacific Sexual Diversity Network
Cambodia	Ngo Menghourng (Meng)	
China	Emma Hoo	APTN Board
China	Karen Liao	National UNV LGBT Human Rights Office, Poverty, Equity, and Governance, UNDP China
Fiji	Audrey Seru	Diverse Voices and Action for Equality
Fiji	Sesenieli Naitala (Bui)	SanFiji
Fiji	Sulique Waqa	Haus of Khameleon (Fiji)
Hong Kong SAR	Joanne Leung	Transgender Resource Center
Hong Kong SAR	Kaspar Wan	Activist
Indonesia	Alvi	
Indonesia	Eman Memay Harundja	
Indonesia	Rasulika Septila (Eqqy)	Learning Together LBT
Mongolia	Ayamdorj Anaraa	LGBT Centre Mongolia
Mongolia	Bilguun Batsukh (Soko)	LGBT Centre Mongolia volunteer
Mongolia	Chinzorig Gochoo (Sarnai)	Programme Manager, Youth For Health
New Zealand	Jack Byrne	Contractor, HPP
Papua New Guinea	Obert Samba (Elizabeth Taylor)	Clinic Coordinator, Save the Children
Philippines	Ar Arcon	Founder of Pinoy FTM (Fil Trans Men)
Philippines	Elyon Divina	Pinoy FTM

COUNTRY	NAME	DESIGNATION AND ORGANISATION
Philippines	Isagani Semacio-Bacasmás Jr. (Ysang)	
Philippines	Krizia Consolacion	Association of Transgender People in the Philippines
Philippines	Magdalena Robinson	Transgender COLORS, Inc.
Singapore/ Geneva	Zhan Chiam	International LGBTI Association (ILGA)
Sri Lanka	Chanaka Thilina Yatiwawala	Equal Ground
Sri Lanka	Thenu Ranketh	Field Officer, Equal Ground
Thailand	Dr Mukta Sharma	WHO
Thailand	Joe Wong	Programme Manager, APTN
Thailand	Kevin Halim	Programme Assistant, APTN
Thailand	Matt Avery	FHI 360/USAID-funded LINKAGES Project
Thailand	Natt Kraipet	Network Coordinator, APTN
Thailand	Thanapoom Amatyakul (Omo)	Administrative and Finance Assistant, APTN
Thailand	Thanakarn Vongvisitsin (Bella)	Senior Researcher & Executive Assistant, Perfect Link Consulting Group Co., Ltd. and Research Associate (Tourism Action Group), College of Innovation, Thammasat University
Thailand	Thanapoon Amatyakul	Staff, APTN
Tonga	Leilani Fainga'a	Tonga Leitis Association
Australia/Tonga	Resitara Apa (Tara)	Pacific Sexual Diversity Network (PSDN)
USA	Darrin Adams	Senior Technical Advisor, HIV, HPP
USA	Nachale Boonyapisompan	Consultant, HPP
USA	Vy Lam	USAID
Vanuatu	Giigii Baxter	VPride Foundation
Viet Nam	Nguyễn Hữu Toàn (Jessica)	
Viet Nam/Bangkok	Lieu Anh Vu	Translator

Appendix E: Reviewers of the draft Blueprint

COUNTRY	NAME	DESIGNATION AND ORGANISATION
Australia	Felicity Young	Senior Director, HPP
Australia	Graham Neilsen	Sexual Health Physician, Stonewall Medical Centre
Australia	Sam Winter	Professor, Curtin University
Bangladesh	Anonnya Banik	Liaison Officer, BSWS
Fiji	Sesenieli Naitala (Bui)	SanFiji
Switzerland	Annette Verster	WHO
Switzerland	Michelle Rodolphm	WHO
Switzerland	Rebekah Thomas Bosco	WHO
Switzerland	Teodora Wi	WHO
Switzerland	Rajat Khosla	WHO
Switzerland	Rachel Clare Baggaley	WHO
Switzerland	Zhan Chiam	Gender Identity & Gender Expression Officer, ILGA (International LGBTI Association)
Hong Kong SAR	Joanne Leung	Transgender Resource Center
Hong Kong SAR	Kaspar Wan	Gender Empowerment
Hong Kong SAR	William Wong	Clinical Associate Professor, Department of Family Medicine & Primary Care, The University of Hong Kong
India	Ernest Noronha	Programme Officer, HIV, Health, and Development Group, UNDP
India	Kalpana Apte	ASG, FPAI
India	Nisha Jagdish	Director, HIV, FPAI
India	Olga B. Aaron	Founder Trustee, Bringing Adequate Values of Humanity (BRAVOH)
India	Razia Pendse	WHO/SEARO
India	Venkatesan Chakrapani	Chairperson/Director, Centre for Sexuality and Health Research and Policy (C-SHaRP)

COUNTRY	NAME	DESIGNATION AND ORGANISATION
Japan	Ichiro Itoda	Director, Shirakaba Clinic
Japan	Jun Koh	Psychiatrist, Department of Neuropsychiatry, Osaka Medical College
Japan	Lily	Executive Director of KAC (Kansai AIDS Council) and TGWAP (TransGender Woman Aids Program)
Japan	Yuko Higashi	Professor, Osaka Prefecture University and Co-chair of Sexual Rights Committee of WAS
Malaysia	Nisha Ayub	TG Programme Manager of Seed Foundation & Advocacy Manager of Justice for Sisters
Nepal	Aakashya Timilsina	Hot Line Operator, BDS
Nepal	Basudev Sharma	Officer, National Human Rights Commission
Nepal	Hari Phuyal	Advocate, Supreme Court
Nepal	Manisha Dhakal	Acting Executive Director, BDS
Nepal	Purnima Dongole	Staff Nurse, Bir Hospital, Kathmandu
Nepal	Shambhu Kafle	Senior Public Health Officer, National Centre for AIDS and STD Control
Netherlands	Louis Gooren	Emeritus Professor, VU medical center, Amsterdam
New Zealand	Mo Harte	Nurse Practitioner, Health West, Auckland
New Zealand	Rachel Johnson	Youth Health Specialist/Paediatrician Counties Manukau Centre For Youth Health
New Zealand	Simon Denny	Associate Professor (Medical and Clinical), Paediatrics, Child and Youth Health, School of Medicine, University of Auckland
Pakistan	Mehrin Abdul Qadir	Monitoring and Evaluation Officer, NMHA
Pakistan	Muhammad Moiz	Technical Support Manager, NMHA
Pakistan	Qasim Iqbal	Executive Director, NMHA
Papua New Guinea	Obert Samba (Elizabeth Taylor)	Clinic Coordinator, Save the Children
Philippines	Kate Montecarlo Cordova	Association of Transgender People in the Philippines (ATP)

COUNTRY	NAME	DESIGNATION AND ORGANISATION
Philippines	Pengfei Zhao	WHO/WPRO
Philippines	Ying-Ru Lo	WHO
Singapore	Vanessa Ho	Project coordinator, Project X
Sri Lanka	Chanaka Thilina Yatiwawala	Equal Ground
Sri Lanka	Thenu Ranketh	Field Officer, Equal Ground
Thailand	Frits van Griensven	Senior Advisor for HIV Prevention, Thai Red Cross AIDS Research Centre
Thailand	Jensen Byrne	LGBT Human Rights Officer, UNDP BRH (Bangkok Regional Hub)
Thailand	Jiraporn Arunakul	Adolescent Medicine Specialist, Faculty of Medicine, Ramathibodi Hospital, Mahidol University
Thailand	Dr Mukta Sharma	Technical Officer – HIV/AIDS/STIs & TB, WHO
Thailand	Joe Wong	Programme Manager, APTN
Thailand	Kevin Halim	Programme Assistant, APTN
Thailand	Matt Avery	FHI 360/USAID-funded LINKAGES Project
Thailand	Midnight Poonkasetwattana	Executive Director, APCOM
Thailand	Mike Burkly	USAID
Thailand	Natt Kraipet	Network Coordinator, APTN
Thailand	Steve Mills	FHI 360/USAID-funded LINKAGES Project
United Kingdom	Daniel McCartney	HIV Officer, International Planned Parenthood Federation
USA	Asa Radix	Director for Research and Education, Callen Lorde Community Health Center
USA	Ashley Gibbs	Health Policy Project
USA	Cameron Hartofellis	Health Policy Project
USA	Eli Coleman	Professor and Department Chair, Human Sexuality, University of Minnesota
USA	Jamison Green	President, WPATH

COUNTRY	NAME	DESIGNATION AND ORGANISATION
USA	JoAnne Keatley	Director, Center of Excellence for Transgender Health, UCSF
USA	Lin Fraser	Global Education Initiative Co-Chair, WPATH
USA	Marcio Maeda	Health Policy Project
USA	Robyn Dayton	FHI 360/USAID-funded LINKAGES Project
USA	Ronald MacInnis	Health Policy Project
USA	Rafael Mazin	PAHO
USA	Tonia Poteat	Johns Hopkins University
Viet Nam	John M. Eyres	Office of Health Director, USAID, Viet Nam

Appendix F: Sample Consent Forms

Informed consent requires a detailed discussion with the client that covers the risks and benefits of treatment. See below for sample forms. Appendix A provides examples of practices for adults in hormone administration, monitoring, and use. Chapter 5 looks at confidentiality and consent issues for health professionals working with trans and gender-diverse children and youth.

Sample Consent Forms

- [Sample #1: Client considering feminising hormones for transition from male to female](#) (PDF, 76KB)
- [Sample #2: Client considering testosterone for transition from female to male](#) (PDF, 79KB)
- [Sample #3: Feminising medications for transgender clients](#) (PDF, 160KB)
- [Sample #4: Testosterone for transgender clients](#) (PDF, 159KB)
- [Sample #5: Feminising medications for transgender clients—minors and parents and guardians](#) (PDF, 127 KB)

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