Implementing Comprehensive HIV and STI Programmes with Transgender People

PRACTICAL GUIDANCE FOR COLLABORATIVE INTERVENTIONS

UNDP
Empowered lives.
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IRGT
A GLOBAL NETWORK of TRANS WOMEN AND HIV
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Acronyms and abbreviations

AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
CBO	community-based organization
CDC	Centers for Disease Control and Prevention (USA)
HAV	hepatitis A virus
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HTS	HIV testing services
ICT	information and communication technology
IRGT	A Global Network of Transgender Women and HIV
LGBTI	lesbian, gay, bisexual, transgender and intersex
M&E	monitoring and evaluation
MSM	men who have sex with men
MSMGF	The Global Forum on MSM & HIV
NGO	non-governmental organization
OST	opioid substitution therapy
PEP	post-exposure prophylaxis
PrEP	pre-exposure prophylaxis
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Glossary

Agency has two distinct meanings: 1) an organization; and 2) the choice, control and power to act for oneself. In chapters where "agency" is used with the second meaning, the definition is given in a footnote at the first occurrence.

Capacity-building: Although this publication uses this term, "capacity development", "organizational development" or a number of other terms would serve equally well.

Community: In most contexts in this tool, "community" refers to populations of trans women or men, rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, "outreach to the community" means outreach to trans people, "community-led interventions" are interventions led by trans people, and "community members" are trans people.

Community outreach is outreach to trans people in order to provide services such as education, commodities and other forms of support. Wherever possible, outreach is best done by empowered and trained community members, i.e. trans people (referred to in this tool as **community outreach workers**—see definition below). However, non-trans people can also be effective outreach workers, especially in contexts where community members are not yet sufficiently empowered to do outreach.

Community outreach worker in this publication means a trans person who conducts outreach to other trans people, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called "staff outreach workers" or simply "outreach workers"). Community outreach workers may also be known by other terms, such as "peer educators". However, the terms "peer" or "community" should not be understood or used to imply that they are less qualified or less capable than staff outreach workers.

Gender-affirming refers to medical procedures that enable a trans person to live more authentically in their gender identity (see **Transition** below).

Gender expression is a person's ways of communicating masculinity and/or femininity externally through their physical appearance (including clothing, hair style and the use of cosmetics), mannerisms, ways of speaking and behavioural patterns.

Gender identity is a person's internal, deeply felt sense of being male, female, an alternative gender or a combination of genders. A person's gender identity may or may not correspond with her or his sex assigned at birth.

Implementing organization is an organization delivering an intervention to trans people with a client-centred approach. It may be a governmental, non-governmental, community-based or community-led organization, and may work at a state, provincial, district or local level. Sometimes a non-governmental organization provides services through subunits at multiple locations within an urban area, and in this case, each of those subunits may also be considered an implementing organization.

Intersex: An intersex person is one who born with sexual anatomy, reproductive organs or chromosome patterns that do not fit the typical definition of male or female, by contrast with a transgender person, who is usually born with a male or female body.

Safe space (drop-in centre) is a place where trans people may gather to relax, meet other community members and hold social events, meetings or training.

Trans-competent refers to the provision of services, especially health-care services, to trans people in a technically competent manner and with a high degree of professionalism that reflects the provider's knowledge of gender identity, human rights and the particular situation and needs of the trans individual being served. In addition, trans-competent care is delivered in a respectful, non-judgemental and compassionate manner, in settings free of stigma and discrimination. (This publication avoids using the term "trans-friendly", which is sometimes used as a synonym for trans-competent, because of its implication that a welcoming attitude might suffice in the absence of professional competence.)

Transgender is used in this publication to describe persons whose gender identity (their internal sense of their gender—see definition above) is different from the sex they were assigned at birth. Transgender is an umbrella term that describes a wide variety of cross-gender behaviours and identities. This publication mostly uses the shortened form of the word, trans.

Transition refers to the process trans people undergo to live authentically in their gender identity. This may involve changes to outward appearance, clothing, mannerisms or to the name someone uses in everyday interactions. These types of changes are sometimes called "social transitions". Transitioning may also involve medical steps that help to align a person's anatomy with their gender identity. These steps are sometimes called "medical transition" and can include feminizing or masculinizing hormone therapy, soft-tissue fillers or surgeries. However, transition is not defined by medical steps taken or not taken.

Transphobia is prejudice directed at trans people because of their actual or perceived gender identity or expression. Transphobia can be structural, i.e. manifested in policies, laws and socio-economic arrangements that discriminate against trans people. It can be societal when trans people are rejected or mistreated by others. Transphobia can also be internalized, when trans people accept and reflect such prejudicial attitudes about themselves or other trans people.

Young trans people are those in the age range 10–24 years, in accordance with the Interagency Working Group on Key Populations *HIV and young transgender people: a technical brief* (Geneva: World Health Organization; 2015).

Introduction

Introduction

While all transgender people are potentially at risk of HIV infection, transgender women have borne the epidemiologic brunt of HIV disease. Transgender women are significantly and disproportionately affected by HIV globally. Time and again, when HIV data specific to transgender women are gathered, they indicate disturbing levels of HIV disease and burden. A 2013 meta-analysis of studies conducted in 15 countries found that a transgender woman in one of these countries was 49 times more likely to be living with HIV than her non-transgender male and female adult counterparts.[1]

Despite documented negative health and HIV outcomes, in many regions data on transgender women are not separated from data collected among gay and other men who have sex with men. It is imperative that conflation of these data stop. Disaggregation of data on transgender people will allow a better understanding of the social determinants of health impacting transgender people in general, and transgender women specifically.

For transgender women, HIV responses at the country level continue to be seriously hampered by experiences of transphobia,[2] discrimination, violence and criminalization, which can have severe and damaging effects on their physical and mental health and limit their access to and use of vital services. For example, transgender women may choose to conceal their gender identity,[3] sexuality or sexual behaviour from their families, friends, neighbours and health-care providers. Addressing transphobia, stigma and discrimination is central to implementing evidence-informed and rights-based services for HIV prevention, diagnosis, treatment and care. In many countries or regions these issue are compounded by lack of a skilled and trans-competent[4] health-care workforce, as well as public and private health plans that often exclude gender-affirming[5] services. Stigma-induced poverty and the lack of legal protections add additional layers of complexity to efforts to address and improve health outcomes for transgender populations.

In 2011 the World Health Organization (WHO) developed a guidance document on *Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people*. The document sets out technical recommendations on interventions for the prevention and treatment of HIV and other sexually transmitted infections (STIs) among transgender people. In 2014, WHO released the *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations.* These bring together all existing guidance related to key

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[1] Baral S, Poteat T, Ströhmdahl S, Wirtz AL, Guadamuz TE, Beyrer C. Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. The Lancet. 2013;13(3):214–222.

[2] Transphobia is prejudice directed at trans people because of their actual or perceived gender identity or expression. Transphobia can be structural, i.e. manifested in policies, laws and socio-economic arrangements that discriminate against trans people. It can be societal when trans people are rejected or mistreated by others. Transphobia can also be internalized, when trans people accept and reflect such prejudicial attitudes about themselves or other trans people. For further information, see Chapter 2.

[3] Gender identity is a person's internal, deeply felt sense of being male, female, an alternative gender or a combination of genders. A person's gender identity may or may not correspond with her or his sex assigned at birth.

[4] Trans-competent refers to the provision of services, especially health-care services, to trans people in a technically competent manner and with a high degree of professionalism that reflects the provider's knowledge of gender identity, human rights and the particular situation and needs of the trans individual being served. In addition, trans-competent care is delivered in a respectful, non-judgemental and compassionate manner, in settings free of stigma and discrimination.

[5] Gender-affirming refers to medical procedures that enable a trans person to live more authentically in their gender identity.

populations, including transgender people, with updates on selected guidance and recommendations. The recommendations of these two publications are summarized in Table 1 at the end of this Introduction. Transgender experts and community activists and other health experts have also collaborated to develop regional publications on transgender health.[6]

Following the dissemination of the 2011 Recommendations and the 2014 Key Populations Consolidated Guidelines describing effective, evidence-based interventions (the *what*), a need was expressed for guidance focused on implementation (the *how*). This publication responds to that need by offering practical advice on implementing HIV and STI programmes for transgender people, with a focus on transgender women, aligned with the 2011 Recommendations and the 2014 Key Populations Consolidated Guidelines. It contains examples of good practice from around the world that may support efforts in planning programmes and services, and describes issues that should be considered and how to overcome challenges.

This tool describes how services can be designed and implemented to be acceptable and accessible to transgender women. To accomplish this, respectful and ongoing engagement with them is essential. This tool gives particular attention to programmes run by transgender people themselves, in contexts where this is possible. It is itself the product of collaboration among transgender people, advocates, service-providers, researchers, government officials and non-governmental organizations (NGOs) from around the world, as well as United Nations agencies, and development partners from the United States.

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[6] Blueprint for the provision of comprehensive care for trans persons and their communities in the Caribbean and other Anglophone countries. Arlington (VA): John Snow, Inc.; 2014.
Blueprint for the provision of comprehensive care for trans people and trans communities in Asia and the Pacific. Washington (DC): Futures Group, Health Policy Project; 2015.

A note on language

Transgender is used in this publication to describe persons whose gender identity (their internal sense of their gender) is different from the sex they were assigned at birth. Transgender is an umbrella term that describes a wide variety of cross-gender behaviours and identities.[7] It is not a diagnostic term and does not imply a medical or psychological condition. This term should be avoided as a noun: a person is not "a transgender"; they may be a transgender person.

It is important to understand that not all people who are considered transgender from an outsider's perspective in fact identify as transgender, nor will they necessarily use this term to describe themselves. In many countries there are indigenous terms that describe similar cross-gender identities. When interacting with transgender people, it is crucial to avoid attaching labels to persons for whom those labels are not comfortable. It is good practice to always ask individuals how they define themselves, and to respect and use their preferred self-definitions and pronouns appropriate to their own gender identity and culture.

Trans: In this publication the abbreviation "trans" is henceforth used for succinctness. As with "transgender", the term "trans" represents an all-inclusive perspective of cross-gender identity and expression.

How to use this tool

This tool is designed for use by public-health officials and managers of HIV and STI programmes; NGOs, including community and civil-society organizations; and health workers. It may also be of interest to international funding agencies, health policy-makers and advocates. It is meant to cover implementation of interventions across the full HIV services continuum, including interventions for prevention, diagnosis, treatment and care. Each chapter explicitly or implicitly addresses one or more of the 2011 Recommendations or the 2014 Key Populations Consolidated Guidelines.

The first two chapters describe approaches and principles to building programmes that are led by trans people. These community-led approaches are themselves essential interventions. Chapters 3 and 4 describe approaches to implementing recommended interventions for HIV prevention, diagnosis, treatment and care. Chapter 5 describes how to manage programmes and build the capacity of organizations of trans people (see Figure 1.).

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[7] Related terms and identities that appear in a few places in this publication are **gender non-conforming, genderqueer** and **non-binary**. These encompass people whose gender expression is different from societal expectations or stereotypes related to gender, but it is important to note that many transgender people may not identify with any of these terms. Some transgender women, just like other women, are very comfortable conforming to societal expectations of what it means to be a woman, while some transgender men simply wish to blend in among other men. Similarly, people who do identify as gender non-conforming, genderqueer or non-binary may not consider themselves to be transgender.

Chapter ❶ Community Empowerment is the foundation of the tool. This chapter describes how empowerment of trans people is both an intervention in itself, and also essential to effective planning, implementation and monitoring of all aspects of HIV and STI prevention, diagnosis, treatment and care.

Chapter ❷ Stigma, Discrimination, Violence and Human Rights focuses on one of the most urgent needs of trans people: to be protected from violence, discrimination and other forms of human-rights violation. The effectiveness of HIV and STI prevention interventions is often compromised when interventions to address violence and promote human rights are not implemented concurrently.

Chapter ❸ Services presents detailed descriptions of gender-affirming health services and HIV-related and other essential health interventions. Gender-affirming health services include primary care, cross-sex hormone therapy, surgical procedures and service integration. HIV-related services include condom and lubricant programming, harm reduction services for substance use and safe injection, pre- and post-exposure prophylaxis, voluntary HIV testing, antiretroviral therapy, sexual and reproductive health, and mental and psychosocial health. The chapter also addresses HIV and hormonal therapy.

Chapter ❹ Service Delivery Approaches describes trans-competent clinical approaches, social and behavioural interventions, approaches to condom and lubricant programming, community-led service delivery, safe spaces (drop-in centres), and the use of information and communication technologies.

Chapter ❺ Programme Management provides practical guidance on planning, starting, scaling up, managing and monitoring an effective programme from two perspectives: (1) a large multi-site programme with centralized management and multiple implementing organizations, and (2) more localized organizations, including community groups, seeking to start or expand services.

Figure 1. Structure of the tool

Key elements of each chapter

Each chapter begins with an introduction that defines the topic and explains why it is important. The introduction presents one or more of the 2014 Key Populations Consolidated Guidelines, where relevant. Interventions are described in detail, and broken down into stages or steps, wherever possible, to make them easy to follow. Topics or points of particular interest are presented in text boxes. Case examples from programmes around the world are presented in shaded boxes. These examples do not describe an entire programme in detail but highlight specific aspects related to programming with trans people that have worked well in their contexts. Their purpose is to illustrate how an issue or challenge has been addressed, and to inspire ideas about approaches that could work in the reader's own context. The forms, charts etc. presented from various programmes have the same purpose. Each chapter ends with a list of resources—tools, guidelines and other practical publications—available online; and further reading—journal articles and other publications—that provide a research or academic perspective on some of the points made in the chapters.

Navigating within and between chapters

Although each chapter is subdivided to make it easier to find and use information, the reader is urged not to view the services and interventions described within the chapter as separate and independent of one another. In the same way, the chapters should not be considered in isolation from one another. Cross-referencing is provided in each chapter to assist the reader in making these connections.

Table 1. Recommendations for all key populations from the 2014 Key Populations Consolidated Guidelines

HIV prevention
The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and STIs. • Condoms and condom-compatible lubricants are recommended for penetrative sex. • Adequate provision of lubricants for trans women and trans men who have sex with men needs emphasis.
Oral PrEP containing tenofovir disoproxil fumarate (TDF) should be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination HIV prevention approaches.[8]
Post-exposure prophylaxis (PEP) should be available to all eligible people from key populations on a voluntary basis after possible exposure to HIV.
Implementing individual-level and community-level behavioural interventions for the prevention of HIV and STIs among trans people is suggested. • The following strategies are recommended to increase safer sexual behaviours and increase uptake of HIV testing among trans people: – targeted Internet-based information – social marketing strategies – sex venue-based outreach.

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[8] This recommendation is from the *Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV* (Geneva: World Health Organization; 2015), which supersedes the 2014 Key Populations Consolidated Guidelines.

HIV testing services (HTS)

Voluntary HTS should be routinely offered to all key populations both in the community and in clinical settings. Community-based HIV testing for key populations, linked to prevention, care and treatment services, is recommended, in addition to provider-initiated testing.

HIV treatment and care

Key populations living with HIV should have the same access to antiretroviral therapy (ART) and to ART management as other populations.

Prevention and management of co-infections and co-morbidities

Key populations should have the same access to tuberculosis (TB) prevention, screening and treatment services as other populations at risk of or living with HIV.

Key populations should have the same access to hepatitis B and C prevention, screening and treatment services as other populations at risk of or living with HIV.

- Trans people should be included in catch-up HBV immunization strategies in settings where infant immunization has not reached full coverage.

Routine screening and management of mental-health disorders (depression and psychosocial stress) should be provided for people from key populations living with HIV in order to optimize health outcomes and improve their adherence to ART. Management can range from co-counselling for HIV and depression to appropriate medical therapies.

Substance use and prevention of blood-borne infections

Trans people who inject drugs should have access to sterile injecting equipment through needle and syringe programmes and opioid substitution therapy.

- Trans people who inject substances for gender affirmation should use sterile injecting equipment and practise safe injecting practices to reduce the risk of infection with blood-borne pathogens such as HIV and viral hepatitis B and C.

Trans people who are dependent on opioids should be offered and have access to opioid substitution therapy.

- There is no evidence of drug interactions between opioid substitution therapy and medications used for gender affirmation; however, research is very limited.

Trans people with harmful alcohol or other substance use should have access to evidence-based brief psychosocial interventions involving assessment, specific feedback and advice.

People likely to witness an opioid overdose should have access to naloxone and be instructed in its use for emergency management of suspected opioid overdose.

Sexual health

Screening, diagnosis and treatment of sexually transmitted infections should be offered routinely as part of comprehensive HIV prevention and care for key populations.

- Health-care providers should be sensitive to and knowledgeable about the specific health needs of trans people. In particular, genital examination and specimen collection can be uncomfortable or upsetting whether or not the person has undergone genital reconstructive surgery.

It is important that contraceptive services are free, voluntary and non-coercive for all people from key populations.

- It is important to counsel trans women who use oral contraceptive pills for feminization about the higher risk of thrombotic events with ethinyl estradiol than with 17-beta estradiol.

People from key populations, including those living with HIV, should be able to experience full, pleasurable sex lives and have access to a range of reproductive options, including family planning services.

Critical enablers
Laws, policies and practices should be reviewed and, where necessary, revised by policy-makers and government leaders, with meaningful engagement of stakeholders from key population groups, to allow and support the implementation and scale-up of health-care services for key populations.
Countries should work towards implementing and enforcing antidiscrimination and protective laws, derived from human-rights standards, to eliminate stigma, discrimination and violence against people from key populations. Health services should be made available, accessible and acceptable to key populations, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health. • Countries should work towards developing policies and laws that decriminalize same-sex behaviours and nonconforming gender identities. • Countries should work towards legal recognition for trans people.
Programmes should work toward implementing a package of interventions to enhance community empowerment among key populations. • Organizations of trans people are essential partners in delivering comprehensive training on human sexuality and gender expression. They also can facilitate interaction with members of communities with diverse gender identities and expressions, thereby generating greater understanding of their emotional health and social needs and the cost of inaction against transphobia.
Violence against people from key populations should be prevented and addressed in partnership with key population-led organizations. All violence against people from key populations should be monitored and reported, and redress mechanisms should be established to provide justice.

Guiding principles for implementing comprehensive HIV and STI programmes with trans people

Several principles underlie the 2011 Recommendations and 2014 Key Populations Consolidated Guidelines and the operational guidance given in this publication. These principles are described in the 2014 Key Populations Consolidated Guidelines (pp.11–12) and are articulated in more detail in this tool. They are included among the principles listed here.

Human rights: Fundamental to development of these guidelines is the protection of human rights for all members of each key population, including trans people. Legislators and other government authorities should establish and enforce antidiscrimination and protective laws, derived from international human-rights standards, in order to eliminate stigma, discrimination and violence faced by trans people and to reduce their vulnerability to HIV.

Promoting gender equality: Gender equality means that the different behaviours, aspirations and needs of all people, including trans people, are valued and treated equally, and that an individual's rights, responsibilities and opportunities do not depend on their sex or gender. All people, regardless of sex, gender expression, gender identity or sexual orientation, have equal rights to health, security, dignity and autonomy. Within the realm of gender equality the concept of transfeminism has emerged, which centres around the view that individuals have the right to their own identity, complete bodily autonomy, and to make their own decision about their gender without regard for societal definitions of what a "real woman" or a "real man" may be. Applying this and adopting feminist theory to communities of trans women can serve as an exercise in empowerment.

Access to high-quality health care is a human right. It includes the right of trans people to appropriate, high-quality health care without discrimination. Health-care providers and institutions must serve trans people based on the principles of medical ethics and the right to health. Health services should be accessible to trans people. HIV programmes and services can be effective only when they are acceptable and high quality and widely implemented. Poor quality and restricted access to services will limit the individual benefit and public-health impact of the recommendations contained in this guidance document.

Access to justice is a major priority for trans people, due to high rates of contact with law-enforcement services and the current illegality of their behaviours in many countries. Access to justice includes freedom from arbitrary arrest and detention, the right to a fair trial, freedom from torture and cruel, inhuman and degrading treatment and the right, including in prisons and other closed settings, to the highest attainable standard of health. The protection of human rights, including the rights to employment, housing and health care, for trans people requires collaboration between health-care and law-enforcement agencies, including those that manage prisons and other closed institutions. Detainment in closed settings should not impede the right to maintain dignity and health.

Acceptability of services is a key aspect of effectiveness: Interventions to reduce the burden of HIV among trans people must be respectful, acceptable, appropriate and affordable to recipients in order to enlist their participation and ensure their retention in care. Services for trans people often employ appropriate models of service delivery but lack expertise in HIV. Conversely, trans people may not find specialized HIV services acceptable. There is a need to build service capacity on both fronts. Services that are acceptable to trans people are more likely to be used by them in a regular and timely way. Consultation with organizations led by trans people and including peer workers in service delivery are effective ways to work towards this goal. A mechanism for regular and ongoing feedback from beneficiaries to service-providers will help inform and improve the acceptability of services to trans people.

Health literacy: Trans people often lack sufficient health and treatment literacy. This may hinder their decision-making on HIV risk behaviours and their health-seeking behaviour. Health services should regularly and routinely provide accurate health and treatment information to trans people. At the same time health services should strengthen providers' ability to prevent and to treat HIV in trans people.

Integrated service provision: Trans people commonly have multiple co-morbidities and poor social situations. For example, HIV, viral hepatitis, tuberculosis, other infectious diseases and mental-health conditions are common in trans people and often linked to stress associated with persistent social stigma and discrimination. Integrated services provide the opportunity for client-centred prevention, diagnosis, treatment and care for the multitude of issues affecting trans people. In addition, integrated services facilitate better communication and care. Thus, wherever feasible, service delivery for trans people should be integrated. When this is not possible, strong links among health services working with trans people should be established and maintained.

Community empowerment is the process whereby trans people are empowered and supported to address for themselves the structural constraints to health, human rights and well-being that they face, and improve their access to services to reduce the risk of acquiring HIV. Community empowerment is an essential approach that underlies all the interventions and programme components described in this tool, and is inseparable from them.

Meaningful community participation and leadership in the design, implementation, monitoring and evaluation of programmes are also essential. Participation and leadership help to build trust with those whom programmes are intended to serve, make programmes more comprehensive and more responsive to the needs of trans people, and create more enabling environments for HIV prevention. Trans people can be the most effective agents of change to move societies toward greater institutional and social acceptance of their human rights. Achieving access to health care for trans people requires sociopolitical acceptance of diverse expressions of identity and gender. Given this, trans people need to be in positions of leadership and decision-making so that engagement in processes of effective implementation and change is possible.

Using participatory methods: Participatory methods of programming that include and are led by trans people should be used to maximize impact. Partnerships that prioritize active involvement of trans individuals should be developed and fostered in all levels of programming. Trans people should be in positions that allow them to engage in processes to identify their problems and priorities, analyse causes and develop solutions. Such methods strengthen programme relevance, build life and relationship skills and help ensure the long-term success of programmes.

1

Community Empowerment


Community mobilization and structural interventions
2 Stigma, Discrimination, Violence & Human Rights
5 Programme Management
1 Community Empowerment
3 Services
Starting, managing, monitoring and scaling up a programme
4 Service Delivery Approaches
Approaches to improving the continuum of HIV and STI prevention, diagnosis, treatment and care

What's in this chapter?

Community empowerment is the foundation for all of the interventions and approaches described in this tool. This chapter:

- **defines community empowerment** and explains why it is fundamental to addressing HIV, STIs and other health issues among trans people in an effective and sustainable way (Section 1.1)
- **describes elements of community empowerment**, with examples from a number of programmes (Sections 1.2–1.9).

The chapter also presents a list of **resources and further reading** (Section 1.10).

1.1 Introduction

2014 Key Populations Consolidated Guidelines[1]

Programmes should implement a package of interventions to enhance community empowerment among key populations. *(p.102)*

"Nothing about us, without us" has been the demand of those affected by, and most at risk of, HIV for over two decades. And so it is with trans people and community empowerment. Communities are groups of people who share common interests, concerns or identities. Empowerment refers to the process by which people gain control over the factors and decisions that shape their lives. In the context of HIV, community empowerment is the process whereby trans people take individual and collective ownership of programmes in order to achieve the most effective HIV responses.[2] Community empowerment addresses the social, cultural, political and economic determinants that underpin HIV vulnerability, and seeks to build partnerships across sectors to address them.

By definition, trans community empowerment is driven by trans people themselves and explicitly aims to create change. This approach represents a paradigm shift, away from trans people being only recipients of services and towards the self-determination of trans communities. Community empowerment builds a social movement where the community collectively exercise their rights, are recognized as an authority, and are equal partners in the planning, implementation and monitoring of health services.

This chapter presents some key elements of community empowerment that may be relevant to trans groups (Figure 1.1). Community empowerment initiatives should be adaptable to each community's needs. There is therefore no fixed order in which the elements must be addressed. Furthermore, trans communities differ from each other and also have diversity within each community. This makes it necessary to pay attention to the local context of trans identities and power dynamics *within* trans communities.

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[1] World Health Organization. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2014.

[2] In most contexts in this publication, "community" refers to populations of trans women or men, rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, "outreach to the community" means outreach to trans people, "community-led interventions" are interventions led by trans people, and "community members" are trans people.

Figure 1.1 Key elements of community empowerment among trans people

1.2 Collaborating with trans communities in programming

Community empowerment is a process that takes significant time and effort. Mutual trust is required in order to develop successful collaborations and partnerships. Building trust involves treating all trans people (regardless of HIV sero-status, gender expression or gender identity)[3] with dignity and respect, listening to and addressing trans community concerns and working with the community throughout the process of developing and implementing interventions.

The meaningful involvement, inclusion and leadership of trans people is essential to establishing partnerships that have integrity and are sustainable. Meaningful engagement in service delivery and in national policy processes means that trans people:

- choose whether to participate
- choose how they are engaged in the process
- choose how they are represented, and by whom
- have an equal voice in how partnerships are managed.

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[3] Gender expression is a person's ways of communicating masculinity and/or femininity externally through their physical appearance (including clothing, hair style and the use of cosmetics), mannerisms, ways of speaking and behavioural patterns. Gender identity is a person's internal, deeply felt sense of being male, female or some alternative gender or combination of genders. A person's gender identity may or may not correspond with her or his sex assigned at birth.

Meaningful engagement of trans people may be challenging for policy-makers and service-providers who are more accustomed to establishing the parameters within which services are provided and prescribing how relationships or partnerships are to be conducted. However, it is key to improving the quality of services used by trans people, including trans-led services.

Table 1.1 summarizes the difference between programmes that are *done for* (or *to*) trans people and those *done with or led by* trans people. Programmes that are *done for* trans people are likely to result in services that are viewed with apprehension and are therefore underused by trans people. Programmes *done with* or *led by* trans people are likely to result in earlier service engagement and improved retention in services, yielding better health outcomes.

Table 1.1 Characteristics of programme approaches

DONE FOR TRANS PEOPLE	DONE WITH OR LED BY TRANS PEOPLE
Prescriptive: Programmes sometimes focus on telling trans people what to do and how to do it.	**Collaborative**: Programmes listen and respond to trans people's ideas about what to do and how to do it.
Paternalistic: Often assume that knowledge, skills and power reside with the programme staff and managers and not with community members.	**Participatory**: Honour and actively seek to leverage the knowledge, skills and power that reside with the community of trans people.
Tokenistic: Involve trans people in programme implementation mainly as volunteers, not as equal partners.	**Inclusive**: Involve trans people as equal partners in programme design, implementation and evaluation, more commonly as paid employees working with the community.
Commodity-oriented: Monitoring mainly focuses on goods and services delivered and targets to be achieved.	**Quality assurance-oriented**: Monitoring mainly focuses on quality, safety, accessibility and acceptability of services and programmes, community engagement, community cohesion and community connectedness, as well as adequacy of service coverage.
Top-down: Focus on building relationships mainly within the health system with health-care providers.	**Bottom-up**: Focus on building relationships within communities of trans people as well as between trans people and other organizations, service-providers, human-rights institutions and similar groups.

In the initial stages of community empowerment, trans people may have less experience in organizing as a group. National, regional and global networks of trans people are able to provide essential technical assistance and support. Allies also have an important role in facilitating meaningful participation of trans people, by intervening on behalf of trans people in places and situations in which they have no voice.

As trans people and trans organizations become more empowered, there will be greater expectations that power be shared and shifted to trans people and trans-led organizations. This is a good thing: programmes run by trans people are often more successful in reaching trans communities and meeting their needs. Trans people know best how to identify their priorities and the context-appropriate strategies to address those priorities. Trans-led organizations should be supported and respected as partners by officials and service-providers in health, law enforcement and social services. This is particularly important when programmes are adapted from previously existing ones (e.g. programmes for men who have sex with men) to serve trans communities (see also Chapter 4, Section 4.3.2).

Partnerships must be built and maintained in a way that does no harm to trans people. Safeguards must be built into partnerships to ensure that trans people are not harmed. Examples of specific safeguards include:

- careful selection of secure locations for meetings and other programme activities
- protecting the confidentiality of information that could be used against trans people
- ensuring legal literacy and rights education of trans people, law enforcement and service-providers
- explicit organizational non-discrimination policies and procedures and their active enforcement.

All partners must share the responsibility for supporting the shift from trans disempowerment to empowerment.

Box 1.1

Actions to foster trans community empowerment and collaboration

- Acknowledge community members' expertise in their own lives.
- Invite trans people to take the lead and support their leadership.
- Support meaningful involvement of trans people in all aspects of programme design, implementation, management and evaluation.
- Identify community capacity and engage in transfer of useful skills.
- Strengthen partnerships between trans communities, government, civil society and local allies.
- Address collective needs in a supportive environment.
- Provide money and resources directly to trans organizations and communities, which become responsible for determining priorities, activities, staffing, and the nature and content of service provision.
- Develop monitoring indicators to measure the progress of empowerment and collaboration.

Box 1.2

Case example: Collaborating to address the needs of transgender and *hijra* communities in India

In India trans women and *hijras*[4] are often subject to discrimination, poor access to education and limited or no opportunities for employment. Their concerns have been mostly unaddressed, mainly for lack of forums where they can feel safe to discuss their issues. In 2009 the United Nations Development Programme supported six regional consultations for the trans and *hijra* populations in India, followed by a final national-level consultation. The goal was to help the communities collaborate in addressing their own development concerns, and to help funding organizations and government officials understand more clearly the various identities of trans and *hijra* communities and the issues they face.

The consultations were planned by experts from trans and *hijra* communities and UNDP staff. At the regional level, consultation participants identified their most pressing issues as being health, violence, stigma and discrimination, social security and access to appropriate information and services. At the national level, mutually agreed definitions of the different communities were finalized to help all parties understand each other more clearly. Recommendations were also made on the communities' issues of concern, including legal, civil and political rights, HIV prevention programming, and community mobilization and strengthening.

The process gave the trans and *hijra* representatives from different parts of the country experience working together for the first time for a common goal, and increased their confidence in representing their issues effectively to larger audiences, including donor agencies and government officials. Community representatives forged links with the National AIDS Control Organisation, donors, government officials, NGO representatives and United Nations agencies. Trans and *hijra* activists were subsequently invited by the government to give input to the government's prevention and care programmes for trans people and *hijras*, and they were able to refer to the consultation recommendations during the programme design process.

1.3 Fostering and supporting trans-led programmes and organizations

Organizations led by trans community members, and organizations working with trans communities, should develop ways to foster and support community leadership. This is critically important to achieving a high impact for programming as well as securing research and data that reflect lived experience. In particular:

- **Decision-making should be collaborative and non-hierarchal** (e.g. via consensus) and take place within safe spaces where the visibility of trans persons will not place them in danger.

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[4] *Hijras* are a distinct socio-religious and cultural group within the wider trans population in India who mostly live in close-knit clans known as *gharanas*. *Hijras* traditionally give blessings and offer songs or dances at public ceremonies such as marriages, in return for money; but changing socio-economic conditions have forced a significant proportion of them into begging and sex work for economic survival, increasing their vulnerability to HIV and other sexually transmitted infections.

- **Organizations should consider how structural inequality may benefit certain segments of the trans community**—such as those with formal educations, privileged racial or ethnic backgrounds or socio-economic status—and work to ensure that those included in programming also represent the most marginalized. It is important not to view a lack of formal education or limited language skills as liabilities or reasons for not placing these persons in leadership positions. Instead, recognizing that these individuals may experience a much greater burden when taking on leadership roles, organizations should ensure that trans persons are provided equitable funding for their labour and institutional support in securing housing, health care and emotional/social support.
- **Programmes led by trans community members should provide fair and appropriate compensation.** This requires a committed effort by funders and parent agencies and may include earmarking funds for trans community members to conduct research and outreach.

Box 1.3

Case example: Trans leadership and equitable compensation in the USA

Some of the most informative research projects addressing trans issues have been primarily led by trans-specific organizations and trans individuals, who have been compensated for their work. One example from the USA is the National Transgender Discrimination Survey (NTDS), a nationwide survey conducted by the National Center for Transgender Equality and the National Gay and Lesbian Task Force in 2008–09. The study team for the NTDS included researchers and trans movement advocates, who designed the survey together. Though most of the questionnaires were collected online, some volunteers were trans people who were given a modest stipend to bring paper surveys to hard-to-reach populations, primarily by working as survey assistants at clinics or small "survey parties" through local lesbian, gay, bisexual and transgender (LGBT) programmes. A follow-up study, the 2015 U.S. Trans Survey (USTS), involved an advisory committee of trans, genderqueer and non-binary members.

At a local level, the Washington DC Transgender Needs Assessments conducted in 1999–2000 and 2010–11 by the DC Trans Coalition made use of community-based research and collaboration, so that non-academically affiliated trans persons would be involved in the research and in project decisions. The primary researchers for the surveys were trans, and all community researchers in the 2011 survey were trained and were paid for their work. Thus not only were trans people empowered through their inclusion in the research process, but their time and labour were also fiscally respected.

www.transequality.org • www.dctranscoalition.org

- **In advocating for or supporting trans leadership, care should be taken to respect and support the diversity within trans communities.** There are many ways in which gender identity and expression are captured in local terminology, and each term has its own connections, nuances and history. Even among trans people in a particular country or region, terms that some use to describe themselves (e.g. *katheoy* in Thailand) may be considered offensive by other trans people. It is essential that programmes avoid making assumptions about terminology and instead ask each individual what term they prefer, and then respect and use this.

- **Programming, whether developed by non-trans organizations or trans persons, should reflect the needs of those in the community.** Organizations seeking to develop or foster trans-specific or trans-led programming are encouraged to first conduct formative research such as a series of community roundtables or short, informal surveys to determine what issues are articulated as most pressing by members of the community. Flexibility, responsiveness and adaptability are essential in implementing programmes. Intervention goals need to be aligned with and address the needs of trans people, even if these change over time, and should recognize that within the trans community in any given country, there will be different priorities and goals.

Box 1.4

Case example: Participatory assessment of community needs in China

Chengdu Tongle, established in 2002, provides HIV testing services, cultural activities, and advocacy on LGBT issues in health-care settings in the Chengdu region. Realizing that the trans community's needs and concerns were different from those of men who have sex with men, the organization adopted three strategies involving the trans community as leaders and primary participants: 1) performing participatory research, 2) improving organizational capacity, and 3) advocating with the government to address trans issues.

Chengdu Tongle implemented a participatory assessment of 60 trans people to understand their needs, expectations and resources. The face-to-face interviews and focus group discussions provided an accurate overview of the challenges and opportunities faced by trans people, including the need for respect and recognition and for doctors trained to deal with their specific issues.

The assessment process empowered the community and led to the creation of New Beauty, Chengdu's first trans organization. New Beauty's mission, goals, work plan and programming were developed by trans activists with facilitation from Chengdu Tongle, which hosts the new organization since the Chinese government has not grated New Beauty legal registration as an independent organization. New Beauty continues to research trans people's health and propose this knowledge for inclusion in official strategies for HIV prevention.

Source: Lessons from the front lines: trans health and rights. New York: amfAR & GATE. http://www.amfar.org/frontlines

1.4 Building organizational capacity

Capacity means the organizational and technical abilities, relationships and values that enable groups and individuals to carry out functions and achieve their development objectives over time. Capacity-building[5] improves an organization's ability to perform effectively, manage resources and deliver services to trans people, and to carry out its mission according to its core values. Capacity-building is therefore essential to community empowerment.

Box 1.5

Elements of organizational capacity

- **Specified objectives:** vision, values, policies, strategies and interests
- **Efforts:** will, energy, concentration, work ethic and efficiency
- **Capabilities:** intelligence, skills and knowledge
- **Resources:** human, natural, technological, cultural and financial
- **Work organization:** planning, designing, sequencing and mobilizing debates and practice

Community-led organizations often experience challenges to growth and sustainability. A well-established organization within the trans community may have a good understanding of community needs and be able to lead or support capacity-building of other community organizations. Newer organizations will likely need guidance and support from the community as well as from established institutions with expertise in capacity-building.

Building capacity for trans organizations must be practical. Organizations can help to empower and support trans efforts through skills transfer around writing proposals, locating funding sources, budgeting funds, networking with trans supportive organizations and prospective partner organizations. This can occur in workshops, lessons, conferences or by appointment. When working with trans organizations and individuals, knowledge and understanding of trans communities' diversity can foster work relationships that will support and sustain mobilization efforts.

The following approaches may be useful:

- **Comprehensive approach:** Fully identify an organization's capacity-building needs and address these in a systematic way, viewing development of the organization holistically.
- **Contextualize and customize:** The support provided should take into account cultural, legal, political and social environments affecting the local trans communities, particularly in relation to gender identity and expression.
- **Local ownership:** Experts brought in to help build capacity may understand the process and be able to identify needs. However, without buy-in and commitment from the organization itself, including its leadership and other members, capacity-building efforts will not be as successful.
- **Readiness-based:** The type, level and amount of capacity-building should be based on the

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[5] Although the term capacity-building is used here, "capacity development", "organizational development" or a number of other terms would serve equally well.

organization's ability to absorb and use the support and guidance being provided. Organizations must be open to learning and adapting, and interventions should build on already existing capacities.

- **Inward/outward orientation:** While an organization needs to ensure the health of its own staff and internal structures, it is also useful to build partnerships and external links with broader trans communities, policy-makers, other service-providers and allies.
- **Sustainability-based:** Capacity-building aims to strengthen an organization's ability to maintain financial sustainability, community support and partnerships for strong, continued functioning.
- **Learning-focused:** An organization that does not continue to learn about its functions, beneficiaries, community, technical areas etc. will become stagnant and cease to be relevant.
- **Long-term:** Capacity-building is a long-term investment that will not produce all its benefits immediately, and it is important that all stakeholders understand this to avoid disappointment.

1.4.1 Elements of a strong organization

Governance

Good governance is essential for responsible management of an organization's strategic vision and resources. Transparency, accountability, effective management and rule of law are essential components of good governance and of an organization's ability to meet its mandate. Organizational assessments help organizations ensure the following best practices in governance:

- clear vision and mission to drive the organization
- an organizational structure that aligns with the mission
- a strong and active governing body (board) that helps guide and advocate
- a participatory selection process for governing body and leadership
- defined processes for decision-making that engage and inform the membership
- community involvement in committees to oversee programmes.

Project management

An organization's agenda is accomplished through concrete activities, often developed as programmes and projects. An organization is on the right track if it:

- identifies the needs of its members
- defines technical interventions that are in line with local and international best practices
- develops and follows realistic work plans with feasible timelines and budgets that are in line with its vision and mission
- ensures that its programmes and projects are responsive to the needs of its members through monitoring its impact
- monitors programmes, including collecting and using data for decision-making (see the WHO *Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations*).

Well-managed, technically sound programmes and projects not only ensure that organizational objectives are achieved, but also instil confidence in donors and key stakeholders about the competence of the organization.

Community systems strengthening

Community systems strengthening is a mechanism to ensure meaningful participation of community-led organizations within the wider policy and programmatic systems of the state, and to address and resolve internal issues and conflicts. At the local level, this means trans-led organizations and networks participate as members on planning, funding and implementation committees and other relevant bodies, ensuring that the needs of the community are addressed. It may also mean that within a trans organization, or across a number of organizations, community-led structures are put in place to monitor and address key issues of concern to the community.

Box 1.6

The community systems strengthening framework: six core components of community systems

In 2009, the Global Fund to Fight AIDS, Tuberculosis and Malaria introduced the concept of community systems strengthening to its funding model. It actively encourages applicant countries to budget and plan for interventions that engage systematically in community mobilization, community-led service delivery and strengthening accountability, in order to increase the scale and impact of responses to disease at the population level. The six core components are described below with cross-references to the parts of this tool that cover these components.

1. **Enabling environments and advocacy** – including community engagement and advocacy for improving the policy, legal and governance environments, and for affecting the social determinants of health (Section 1.5).
2. **Community networks, linkages, partnerships and coordination** – enabling effective activities, service delivery and advocacy, maximizing resources and impacts, and coordinated, collaborative working relationships (Section 1.8).
3. **Resources and capacity-building** – including human resources with appropriate personal, technical and organizational capacities; financing (including operational and core funding); and material resources (infrastructure, information and essential commodities, including medical and other products and technologies) (Section 1.9).
4. **Community activities and service delivery** – accessible to all who need them, evidence-informed and based on community assessments of resources and needs (all chapters).
5. **Organizational and leadership strengthening** – including management, accountability and leadership for organizations and community systems (Section 1.4).
6. **Monitoring and evaluation (M&E) and planning** – including M&E systems, situation assessment, evidence-building and research, learning, planning and knowledge management (Chapter 5, Section 5.2.3).

1.4.2 Forming a registered organization

Organizations providing services for trans communities are likely at first to be informal groupings. Over time, structures and processes may be developed to enable more effective and efficient delivery of a community-led agenda. Depending on the organization's type, size and goals, as well as the country in which it is forming, it may decide to become a legally registered entity. The process for doing this varies from country to country.

It is important that the organization have a clear understanding of its expectations with respect to size, geographic reach, types of activities etc. Mission and vision statements and a strategy statement or strategic plan help an organization to define these elements.

Most countries have coordinating bodies that offer advice or guidance through the process of forming a formal organization. An example is INFOSEM (the Integrated Network for Sexual Minorities), a network of LGBT organizations in India. It has trained around 30 trans or *hijra* organizations on building organizational and individual capacity. Trans-led organizations in neighbouring countries or regional networks of trans or other community-led organizations may also be able to provide advice and support on dealing with registration and overcoming barriers, based on their own experience.

The necessary registration materials must be obtained from the relevant government office. The government sets out precise requirements for documentation. Examples of the types of documentation required are:

- mission and values of the organization
- one of the following: memorandum of association, by-laws, constitution, charter etc.
- report of annual activities
- financial reports/audit reports
- organizational resources
- organizational chart/staffing plan (and human resources manual, if available)
- board of directors and rules and regulations governing the board (board endorsement of registration is also needed)
- letters of support from ministry of health, national HIV authority and relevant civil-society organizations.

Box 1.7

Case example: A trans organization's experience with registration in Thailand

In 2014, the Thai Transgender Alliance (TGA) applied to become a formally registered NGO. Their initial submission was rejected by the Ministry of the Interior, as the name of their organization in Thai uses the term *kathoey*, which is considered derogatory in some contexts, although Thai TGA members have reclaimed use of the term and are proud to have it in their name. The Ministry of the Interior questioned Thai TGA's name and purpose as possibly being "contrary to the morality, ethics and culture of Thailand". If Thai TGA's formal request for registration is not approved, its members plan to launch a national campaign for their right to association.

www.thaitga.com

In countries where it is not possible for trans groups to register as legal organizations, becoming part of a network or functioning under the auspices of a "parent" organization may offer a solution. For example, a trans group could form an agreement with a civil-society organization or NGO which agrees to act as its fiscal sponsor (to accept funding on the group's behalf) and to provide facilities to the organization. Some groups may decide that they can fulfil their aims independently and without registering as a legal organization (Box 1.8).

Box 1.8

Case example: Some advantages and disadvantages of being an unregistered organization in the Russian Federation

FtM Phoenix is a community-led organization based in Russia that provides online support to trans people from 12 countries in Eastern Europe and Central Asia. Although registering as an NGO would not be prohibited under Russian law, the group members did not feel that they had sufficient training or experience to run an NGO when the group formed in 2008, and they have not felt the need to take this step since. Initially FtM Phoenix was able to engage in advocacy and peer counselling using the dedication of its volunteer members, and without funding. FtM Phoenix saw several advantages to remaining unregistered, particularly in its early days:

- no administrative or technical costs
- absolute flexibility to stay at the forefront of trans advocacy, and no need to stick to a prescribed charter
- independence from funders in doing what trans people think is right, not funders
- independence from the state and no risk of being fined or shut down for doing things the government perceives as "wrong".

As the group has matured and expanded its activities, some disadvantages of its unregistered status have become apparent:

- Bigger events cannot be crowd-funded, and it is more difficult to find a venue for them.
- Funding is essential for some activities that must be done quickly and professionally.
- In order to receive funds, it is necessary to find—and come to an agreement with—a fiscal agent.

aronbelkin.narod.ru/FtM_Phoenix.html

1.5 Building advocacy capacity

Advocacy can be defined as active support of an idea or cause expressed through strategies and methods that influence the opinions and decisions of people and organizations. More simply, it means putting a problem on the agenda, providing a solution to that problem and building support for action on both the problem and solution.

Advocacy is a core process for addressing inequity and empowering communities. It can improve the access, funding and quality of programmes and services for trans people by bringing disparities to the top of the agenda of decision-makers. Advocacy efforts are often most powerful and successful when led by those affected by the issue being advocated for, and trans people have demonstrated considerable impact in advocacy for issues relating to their HIV prevention and care needs.

Advocacy efforts typically fall into two categories, which may at times overlap and influence each other:

- **Policy advocacy:** to affect policy and regulations directly by influencing governmental institutions and other policy-makers; or indirectly by influencing organizations, businesses or individuals that can in turn influence the government.
- **Public advocacy:** to influence the behaviour, opinion and practices of the public and build support for the desired change.

Advocacy may be written, spoken or enacted, and it may be undertaken by individuals acting alone or working with others on a small or large scale. It may be short-term or long-term, and its focus may be local, national or international. This depends not only on the issue, but also on the resources and mission of those doing the advocacy and the identified areas of greatest impact (see case examples for reference).

Box 1.9

Participation in advocacy planning

The way planning is done will influence the quality of the advocacy. If trans people are involved in decision-making in advocacy, it fosters their empowerment and facilitates ownership, motivation, trust and impact. Participation in all aspects of advocacy planning helps generate commitment, create shared ideals and directions, speed up action, raise and cope with conflicts and differences, assess political risk and improve organizational accountability.

Box 1.10

Case example: An advocacy network in Argentina

REDLACTRANS (the Latin American and Caribbean Network of Trans Persons) is a network for trans women, with member organizations in 17 countries in Latin America and the Caribbean. The network was founded in 2004 by trans activists, initially as an online group to share information. REDLACTRANS aims to help its members secure the human rights of trans people in the region through advocacy, by increasing trans visibility and by strengthening the ability of member organizations to act.

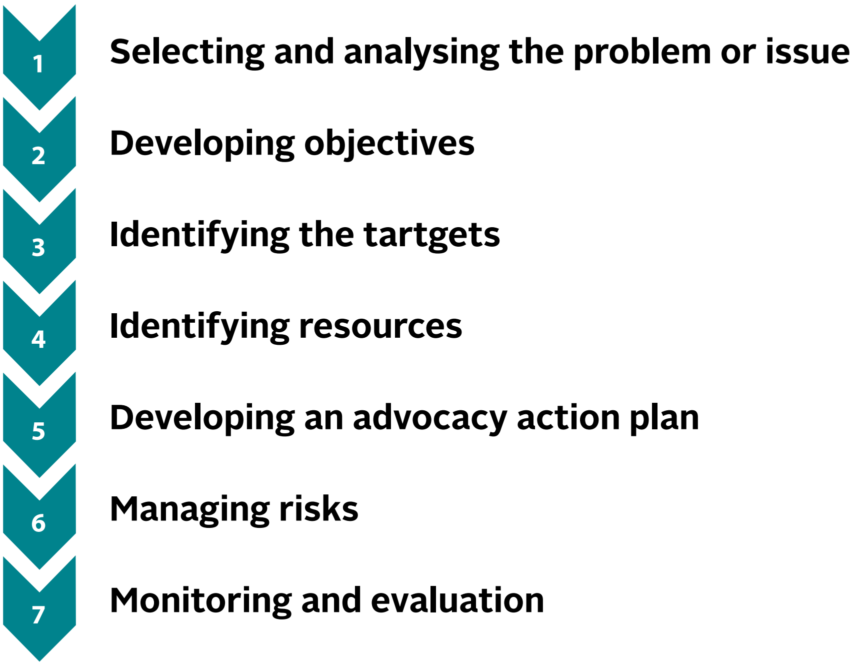
The network's objectives include documenting and combating violence and hate crimes against trans people; advocating for sustainable programmes and resources; improving access to health services, particularly to reduce the incidence of HIV among trans women; and promoting legal frameworks for trans people's rights. REDLACTRANS advocated for passage of Argentina's Gender Identity Law in 2012 by working with the media, politicians and other NGOs.

redlactrans.org.ar

1.5.1 Advocacy framework

Figure 1.2 presents a framework for advocacy which can be used to support community empowerment.

Figure 1.2 Advocacy framework



Step 1. Selecting and analysing the problem or issue

The focus of an advocacy issue should arise from the experience of the trans community. Examining issues as a community through group discussions and meetings helps ensure that the subject of advocacy is relevant to more than just a few individuals and worth the time and effort that will be invested. It is important to consider questions such as:

- Are others already addressing the issue?
- Can we access the kind of information we need as evidence?
- Do we have the skills, time and resources to achieve the solution?

Research should supplement discussions to analyse the issue and provide evidence to support the community's position. Research can include interviews, focus groups, attendance at events, first-hand witness accounts as well as archival work and literature reviews. Research also helps map stakeholders and identify allies and opposition. Data which disaggregate trans women from men who have sex with men can help reveal the extent and root causes of the problems trans people experience.

Step 2. Identifying the targets of advocacy

It is important to focus advocacy efforts on the individuals, groups or institutions that have the greatest capacity to take action and to introduce the desired changes.

Advocacy may be directed at several kinds of institutions:

- **legal:** law-making and law-enforcing bodies
- **civil society:** non-profit organizations, unions, religious institutions, civic clubs and associations in society that operate independently from government and the state
- **government departments**, ministries and agencies
- **private-sector businesses**.

Step 3. Developing objectives

Identifying goals and objectives helps to clarify what actions are necessary to reach the desired solution.

Step 4. Identifying resources

Successful advocacy work requires resources: human, financial, skills and information. It is important to take careful stock of the advocacy resources that already exist and identify what resources are needed. Networking and building partnerships or alliances through outreach and research can be crucial to any advocacy effort. Other resources can include access to media and to distribution networks, e.g. newsletters, e-mail, social media and relevant websites.

Box 1.11

Case example: Trans-led HIV advocacy in Australia

During the International AIDS Conference in Melbourne in 2014, a group of trans men who have sex with men from around Australia came together to discuss what they saw as the gaps in the existing HIV response for Australian trans men who have sex with men. They decided to establish a working group to address these needs, and requested and received logistical and administrative support and a small amount of funding from the Australian Federation of AIDS Organisations (AFAO). Over the course of the next 18 months this group of trans men:

- established themselves as a trans-led, official working group of AFAO, known as PASH.tm (the Peer Advocacy Network for the Sexual Health of Trans Masculinities);
- undertook strategic planning and identified a set of priorities relating to research, promoting best practice HIV service provision and delivering health promotion activity to trans men;
- secured government funding to develop an online hub (currently in development) for resources and sexual-heath content for service-providers and the community;
- presented a paper on trans men who have sex with men in the HIV response at the Australasian HIV and AIDS Conference;
- advocated for meaningful inclusion of trans men who have sex with men in the three major pre-exposure prophylaxis (PrEP) demonstration trials;
- provided feedback on trans inclusion for state and national PrEP access guidelines.

Step 5. Developing an advocacy action plan

An action plan consists of specific activities for implementation. It includes expected outcomes, timeline with deadlines, designated responsible persons/teammates and resources required to meet the outcomes. The activities in the development of an action plan may include:

- lobbying, petitioning government and other civic officials
- public education and awareness
- face-to-face meetings with decision-makers
- writing and delivering position papers and briefing notes
- preparing and giving public presentations
- writing press releases and media advisories
- holding press conferences
- giving media interviews.

Box 1.12

Case example: Trans people's representation in the Global Fund's Country Coordinating Mechanism in Honduras

Honduras' Country Coordinating Mechanism (CCM) was set up in 2002 to channel funding and execution of a national proposal financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria. The CCM was responsible for submitting proposals and supervising their implementation, and recording the needs of the most-affected groups, including trans people. However, the concerns of trans people were unrepresented, with most of the focus being on issues affecting men who have sex with men and female sex workers.

Following an explicit recommendation of the Global Fund to include key population representatives in the composition of the CCM, the Colour Pink Unit Collective submitted a request for inclusion in the CCM. In addition, at meetings with civil-society members, the collective advocated for the direct participation of trans people as full members of the CCM and sought broader support from civil society to take such a proposal to the CCM Assembly. In 2009 the assembly approved this proposal and restructured the CCM to include the trans community as a full member, with direct participation, voice and vote.

Source: Making rights a reality. A compilation of case studies: The experiences of organizations of transgender people, UNAIDS, REDLACTRANS, International HIV/AIDS Alliance, 2012.

http://www.aidsspace.org/getDownload.php?id=1825

Step 6. Managing risks

When an organization does advocacy, there is always a chance that its reputation and its relationships with staff, partners and communities will be affected. Certain advocacy tactics, such as public campaigning and action, may entail more risk than others. It is important to anticipate negative reactions from the broader community, such as hostility from health-care workers, government officials, religious leaders, police or the media.

Trans organizations can manage risk by tracking responses to their advocacy in the media and public bodies, as well as by identifying trans-ally organizations and individuals. Non-trans individuals and organizations can play a vital role in managing risks and may support trans individuals by their visibility in meetings, trans events and conversations.

It is important to draw up contingency plans in advance of hostile reactions. Where possible, budgets should be set aside to cover security for organizational staff and programme participants, bail monies for staff or participants who may face legal challenges from local authorities, and related costs. Data security must be a priority to protect those involved in advocacy and the organization's membership more generally. Resources are available online, such as www.securityinabox.org.

Step 7. Performing monitoring and evaluation

Monitoring progress over time requires careful documentation to ensure that advocacy materials and reports are accurate and credible. Advocacy activities and results should be recorded and the information used to evaluate the campaign and strengthen or improve the efficiency of future work.

1.6 Addressing stigma as a barrier to empowerment

Trans people often experience stigma (referred to as transphobia)[6] due to their perceived transgression of the behaviour and presentation assumed to be "appropriate" for a person of a certain gender. This stigma can be experienced at work, at school or in other settings of everyday life, as well as places where trans people seek professional, social or medical services. Stigma can also be internalized as self-stigma, which may lead a trans person to experience self-loathing or low self-esteem and to isolate themself from others. Experiences of stigma are disempowering and lead to low community engagement. In order for HIV programmes to be empowering and effective, all staff should be trained to address and reduce stigma. Care must especially be taken to ensure that HIV programmes do not lead to further stigmatization as an unintended consequence. For more information on stigma and discrimination, see Chapter 2.

Box 1.13

Case example: Understanding stigma and self-identity in South Africa

The concept of *Transilience* was developed by the Social, Health and Empowerment Feminist Collective of Transgender Women of Africa (S.H.E.) in response to the prevalence of violence against trans women in that country. The project, whose name combines the words *trans* and *resilience*, aims to help trans women understand better their own perceptions of their identity, mobilize against violence, battle stigma and make better use of existing legal protections for gender equality and gender identity.

Self-identification—how trans women feel and think about themselves—is at the root of understanding how they can position themselves securely as individuals and as a community in a violent environment. This issue of self is often connected to the view of women in a given society. Understanding that mistaken concepts of "real" men and women are a root cause of stigma towards trans people who do not conform to these labels is a step towards formulating a positive and supportive environment. It can shift trans women's own view of themselves, and help them to recognize their power and their role in a diverse society. S.H.E. uses this approach to discuss issues of violence with trans women and to formulate an agenda that suits their particular environment.

transfeminists.org

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[6] Transphobia is prejudice directed at trans people because of their actual or perceived gender identity or expression. Transphobia can be structural, i.e. manifested in policies, laws and socio-economic arrangements that discriminate against trans people. It can be societal when trans people are rejected or mistreated by others. Transphobia can also be internalized, when trans people accept and reflect such prejudicial attitudes about themselves or other trans people. For more information, see Chapter 2.

1.7 Promoting a human-rights framework

2014 Key Populations Consolidated Guidelines: Law and Policy

Countries should work toward developing policies and laws that decriminalize same-sex behaviours and nonconforming gender identities. *(p.92)*

Countries should work towards legal recognition for transgender people. *(p.92)*

Laws, policies and practices should be reviewed and, where necessary, revised by policy-makers and government leaders, with meaningful engagement of stakeholders from key population groups, to allow and support the implementation and scale-up of health-care services for key populations. *(p.91)*

Countries should work towards implementing and enforcing antidiscrimination and protective laws, derived from human-rights standards, to eliminate stigma, discrimination and violence against people from key populations. *(p.96)*

Countries should work toward developing non-custodial alternatives to incarceration for drug users, sex workers and people who engage in same-sex activity. *(p.94)*

It is important that countries secure political commitment, with appropriate investment in advocacy and adequate financial resources for HIV-related key population programmes and health services. *(p.95)*

Promoting and protecting the human rights of trans people is central to community empowerment and an effective HIV response. In 2001, the United Nations released the *Declaration of commitment on HIV/AIDS*, which highlights that realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV, and that the vulnerable must be given priority in the response. The *2011 United Nations General Assembly Political Declaration on HIV/AIDS* has 10 targets and elimination commitments, all of which apply to trans persons, including the commitment to "eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms".

Box 1.14

Case example: Advocacy for legislative reform in the Dominican Republic

As part of its aim to promote the human rights of trans women, COTRAVETD (Comunidad de Trans y Travestis Trabajadoras Sexuales Dominicana) focuses on providing HIV prevention, support and treatment access, and community and societal awareness about stigma, discrimination and violence faced by trans people, including those living with HIV and involved in sex work. COTRAVETD conducts advocacy work to promote legislative reform, including improving a draft Gender Identity Law. Its empowerment philosophy is based on the belief that even if the desired law fails to pass, the process of drafting and lobbying itself serves as a tool for movement-building and political visibility.

cotravetd.blogspot.co.uk

Many guidelines on HIV prevention promote health and human rights for trans people, including the 2014 Key Populations Consolidated Guidelines (quoted above) and the *UNAIDS 2016–2021 Strategy*. Strong community-led organizations, mobilization efforts and alliances are crucial to promoting a human-rights framework that facilitates community empowerment. Actions to promote a human-rights framework to support community empowerment for HIV prevention, diagnosis, treatment and care include:

- training law-enforcement officers, judges and parliamentarians on human rights of trans persons and their obligation to respect, protect and fulfil those rights
- ensuring service-providers are aware of their ethical obligation to provide safe, confidential, equitable and non-discriminatory HIV services for trans people including through training in addressing violence against trans people
- establishing mechanisms for the trans community to monitor and evaluate the quality, accessibility and acceptability of HIV services.

Box 1.15

Case example: Gaining legal recognition in India

Tamil Nadu AIDS Initiative (TAI) found that trans women (known in Tamil Nadu as *aravanis*) engaged in high-risk behaviours associated with their marginalization in a society that perceived them only as beggars and prostitutes. TAI, together with strong leaders from the *aravani* community, worked with a few supportive politicians to transform policy, improve access to services and change public perception in support of trans people in the state.

With TAI's support, in 2006, January 18 was declared the first Aravanigal Dinam (Transgender Day) by leaders in Tamil Nadu. The slogan for the first annual observance was "We Too for a Healthy Society", to promote the *aravani* community as socially responsible. They undertook a blood donation drive and gave speeches and street theatre presentations to convey messages about health, HIV and the stigma and discrimination faced by their community. In subsequent years, Aravanigal Dinam has featured activities by as many as 3,000 community members on themes of health and community service. *Aravani* leaders also produced a short film about their lives and their efforts at disease prevention. Aravanigal Dinam now lasts for a week, and the events have helped to mainstream trans people into Tamil Nadu society.

In 2008, the state government established a social welfare board to look into issues concerning *aravanis* and to conduct a statewide census of the community. The government now finances sex reassignment surgery at public hospitals for *aravanis*, who also now have the right to be classified as a "third gender" for the purposes of receiving ration cards and applying for admission to educational institutions.

www.taivhs.org

1.8 Supporting community mobilization and sustaining social movements

Community mobilization is closely linked to community empowerment. It is the process whereby trans people use their knowledge, strengths and skills to address shared concerns through collective action. Advocacy is one form of community mobilization, but it can also involve:

- raising community members' awareness of their rights
- identifying barriers to HIV prevention and access to HIV services
- reducing health risks, including sexual-health risks, and promoting health-seeking behaviours
- offering mutual support to cope with and challenge stigma, discrimination and violence
- developing community leadership.

Networking and relationship-building is an important component of community mobilization. Forming networks, alliances and coalitions can also enhance community mobilization, and over time it can create social movements—larger groups of like-minded organizations that can effect large-scale social or policy change. An example is the Transgender Day of Remembrance, which began in 1999 as an Internet project and candlelight vigil in San Francisco in memory of a murdered trans woman. The Day of Remembrance is now observed around the world and serves not only to memorialize those who have died as a result of anti-trans violence but also to raise global awareness of trans people and the persistence of hate crimes against them.

1.8.1 Networking and building organizational relationships

Developing a strong, successful trans organization is as much about relationships as it is about the system in which it operates. Networking between individuals helps to build relationships and secure partnerships for networks, alliances or coalitions. Networking can occur in person in community meetings, legislative sessions, conferences, workshops, or other convening spaces; online through technology (e.g. social media, email); and via phone communication.

Two areas of relationship-building that are especially important for trans organizations are engagement with the government/state (e.g. politicians, police, health and social-entitlement programmes) and with non-state/non-governmental organizations and institutions (e.g. community-based organizations [CBOs], NGOs, religious groups, media, donors and funders).

Building relationships with the government can enable trans people to advocate for access to health and social services. An organization working with trans communities may have connections that enable trans community members to join oversight committees for health or social programmes, or that facilitate access to politicians and other officials. Building relationships with non-state and non-governmental organizations can help trans organizations understand other, socially powerful groups or institutions. It can lead to contacts with donors interested in funding the advocacy, or change media portrayals of trans persons which humanize the trans community. Over time, relationships with organizations hostile to sexual minorities may change their attitudes and beliefs and facilitate efforts to reduce HIV.

Box 1.16

Case example: Raising awareness with key stakeholders in India

The Hijra Habba (*hijra* festival) is a national event to raise awareness of trans and *hijra* issues in India. First organized in 2012 by India HIV/AIDS Alliance with 30 community participants, it has grown to encompass 350 trans and *hijra* participants from around the country. The event brings them together with representatives of government, media, international agencies and civil-society organizations.

Held in the capital, Delhi, the Hijra Habba includes festive activities such as a fashion show alongside opportunities for community members to talk about their experiences, and discussions on topics such as official recognition of gender identity; violence; stigma and discrimination; and access to health and legal services.

Government representation at the event has been key to raising the profile of the *hijra* and trans communities. In past years, senior officials from the Ministry for Social Justice and Empowerment, the Department of AIDS Control and law-enforcement agencies have been present. The event has helped catalyse the inclusion of the community in the national HIV prevention strategy and raised the media and political profile of initiatives to protect trans and *hijra* rights. An important result has been the April 2014 decision of India's Supreme Court to recognize a "third gender".

Box 1.17

Case example: Alliance-building to advance advocacy in Bolivia

Although Bolivia has had a favourable legal framework prescribing equality for trans people since 2009, violence against them has continued with impunity. In response, the Red Trebol network and the National Working Group (MTN)—the first organizations of trans people in Bolivia to advocate for their rights—galvanized a strategic alliance between LGBT organizations and formed a committee to develop a Plurinational Plan of Action against Discrimination on Sexual Orientation and Gender Identity. The action plan aimed to serve as an advocacy instrument to defend the rights of people with different sexual orientations and gender identities.

Thereafter, a national network of trans women living with HIV was formed with the support of MTN and Red Trebol. The network has addressed medical needs such as access to ART and hormones, and the participation of trans women in decisions affecting their enjoyment of health, education, equal opportunities and access to justice. MTN and Red Trebol also work to strengthen coalitions of trans people in the region as part of the REDLACTRANS network.

1.9 Resource mobilization and sustainability

Organizations should always be engaged in resource mobilization to fund efforts that are sustainable and provide continuity over the long-term. It is important that an organization is strategic and looks beyond immediate priorities, especially if it is currently receiving a short-term grant that will end. While there is no guarantee that an organization will be able to raise support, there are effective practices that increase the chances of funding.

Important issues to consider with respect to resource mobilization include:

- Is the resource mobilization strategy in line with the organization's vision and mission?
- Can resources be raised from members of the organization, e.g. via small monthly or annual membership fee? This increases a sense of ownership, but fees must not be so high that they discourage trans people from joining.
- Are there government schemes that may be able to fund specific activities or programmes?
- It should also be remembered that resource mobilization does not just mean funding, but also includes services, supplies and human resources.

In order to ensure sustainability and better impact of HIV programmes and services, programmes should work with trans-led organizations to increase their administrative capacity to both receive resources and raise and compete for funding, as well as to help them in forming legal organizations that are registered in the countries where they operate, as this can also be a major barrier to receiving resources. (See Section 1.4.2).

1.10 Resources and further reading

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2 Stigma, Discrimination, Violence & Human Rights


Community mobilization and structural interventions
2 Stigma, Discrimination, Violence & Human Rights
5 Programme Management
1 Community Empowerment
3 Services
Starting, managing, monitoring and scaling up a programme
4 Service Delivery Approaches
Approaches to improving the continuum of HIV and STI prevention, diagnosis, treatment and care

What's in this chapter?

This chapter explains:

- the underlying **stigma, discrimination, transphobia** and **violence** that are responsible for human-rights violations against trans people, and how this overarching environment increases vulnerability to HIV (Section 2.1)
- how trans people experience stigma, discrimination and violence in different contexts, and promising **interventions and strategies** to address stigma, discrimination and violence (Sections 2.2 and 2.3)
- approaches to **monitoring and evaluation** of programmes (Section 2.4).

The chapter also provides a list of **resources and further reading** (Section 2.5).

2.1 Introduction

2014 Key Populations Consolidated Guidelines[1]

Countries should work towards implementing and enforcing antidiscrimination and protective laws, derived from human-rights standards, to eliminate stigma, discrimination and violence against people from key populations. *(p.96)*

Every human being is guaranteed inalienable human rights in accordance with international legal standards. For many trans people, these rights exist only in form, not in substance. Trans people are denied not only fundamental rights to equality, dignity, health and security of being, but their very personhood. Trans people experience grave marginalization, discrimination and violence. This debilitating environment has many harmful consequences, one of which is a severe HIV epidemic, particularly among trans women.

Interventions to address transphobia, violence, stigma and discrimination and uphold the human rights of trans people are essential in order to safeguard their health and well-being. This chapter describes how these issues impact the everyday lives, social and economic status and well-being of trans people. It also identifies a number of strategies to prevent and respond to this. Many of these strategies were developed as good practice by groups of trans people, and may serve as examples for programme design.[2] They complement one another and should ideally be implemented together (see also Chapter 5, Figure 5.1). Nevertheless, the onus to implement and expand such strategies lies as much with government actors including health and law-enforcement departments as with other non-state actors and community groups.[3]

2.1.1 Transphobia and violence

Transphobia is prejudice directed at people whose gender identity[4] or gender expression[5] does not conform to social norms and expectations. It is a reaction to the real or perceived difference between the biological sex attributed to a person at birth and their gender identity or expression. Transphobia is a socially created attitude, similar in nature to racism, sexism, xenophobia or religious intolerance. It contributes to the marginalization of trans people and gender non-conforming people, and their resultant vulnerability to HIV.

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[1] Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2014.

[2] Most of these strategies have not been formally evaluated for their impact on reducing risk factors or levels of stigma, discrimination or violence against trans people. Monitoring for unintended consequences and evaluation is important to produce evidence of violence reduction and rationales for programme expansion.

[3] Community, in most contexts in this tool, refers to populations of trans women or men, rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, “outreach to the community” means outreach to trans people, “community-led interventions” are interventions led by trans people, and “community members” are trans people.

[4] Gender identity is a person’s internal, deeply felt sense of being male, female or some alternative gender or combination of genders. A person’s gender identity may or may not correspond with her or his sex assigned at birth.

[5] Gender expression is a person’s ways of communicating masculinity, femininity or some combination externally through their physical appearance (including clothing, hair styles and the use of cosmetics), mannerisms, ways of speaking and behavioural patterns.

Transphobia can be directed at individuals or groups and manifests in many ways, including violence or other aggressive behaviour, stigmatization, hostility, disgust or other negative attitudes. It is often institutionalized through criminalization, discrimination, social exclusion, hate speech and hostile media coverage that pathologize and stigmatize trans people. A person's experience of transphobia may be aggravated (or mitigated) by their nationality, race, class, religion, economic circumstances or disability. Trans people living with HIV also report HIV-related stigma, discrimination and violence from within their own communities, as well as from families and intimate partners.

Transphobic violence has various manifestations, and can be seen as a form of gender-based violence. The Trans Murder Monitoring Project recorded 1,700 transphobic killings of trans and gender non-conforming individuals worldwide between 2008 and 2014, the vast majority of them trans women. Many other killings go unreported. In the United States, three-quarters of lesbian, gay, bisexual and trans (LGBT) homicide victims in 2013 were trans women. Transphobia is sometimes particularly intense against those who are marginalized in other ways, such as sex workers: two-thirds of the 1,700 murdered trans people whose profession was known were sex workers, and the levels of violence in these cases were extreme. Along with these murders, activists and organizations worldwide have documented cases of arbitrary detention, torture, mutilation and other inhumane and degrading treatment of trans people by individuals and state perpetrators.

Transphobia contributes to other risk dynamics disproportionately experienced by trans people, including economic and educational disenfranchisement and poor mental health (see Section 2.2). It negatively impacts the health and well-being of trans people within health-care settings themselves. For example, trans people are often unable to change the way their sex and name are listed on their medical record to reflect their gender identity. Other barriers to health care include cost, access to specialists and a lack of providers who are knowledgeable and accepting of trans people. This is due in part to the exclusion of trans people's health-related issues from standard medical training.

Access to HIV testing, care and treatment among trans people can be limited by experiences of stigma, discrimination or violence within the health-care setting. Trans women experience serious challenges in adhering to HIV care and treatment and therefore have low virological suppression rates. Being HIV positive can compound trans identity-related stigma and discrimination. If incarcerated, trans women living with HIV face interpersonal violence, a lack of safety, and threats to privacy, which create barriers for accessing ART.

2.1.2 Discrimination and action for legal gender recognition

Trans people in many countries suffer from a lack of legal recognition, equality and protection, and fundamental citizenship rights. These include the right to a legal identity based on the gender of their choosing, and the right to gender equality and equity, i.e. non-discrimination in all spheres of life based on their gender identity or gender expression.

In many contexts trans women are legally identified as male and are unable to change their gender on identification cards and passports. Trans men also face similar challenges. The violation of the fundamental right to personhood perpetuates serious disadvantages in everyday life. The lack of legal gender recognition can make it impossible for trans people to obtain any identification document, let alone one that describes their correct gender. Simple everyday activities—obtaining railway tickets, a phone line, state rations, a job, opening a bank account or attending school or college—are made burdensome or even impossible. In countries where the law states that only a person's sex at birth can be listed on a passport or other official identification, confusion may arise in situations where official identification is required, causing uncomfortable scrutiny of trans persons and forcing them to reveal their sex assigned at birth, even if they would prefer not to do so. Such scrutiny also violates their right to privacy. Difficulties obtaining legal gender recognition can block the access of trans people to health services, shelter, housing, steady employment or education and contribute significantly to compromised health.

Some countries have recognized gender identities beyond the male–female binary and thereby extended constitutional rights to greater numbers of trans people:

- In 2007, the Supreme Court of Nepal paved the way to recognize a third gender officially in citizenship documents.
- In 2007, the Supreme Court of Pakistan directed the National Database and Registration Authority to add a "third gender" column to national identity cards for trans people, thus giving them the right to register to vote.
- In 2014, India's Supreme Court directed the government to recognize trans people as a third gender and trans women who identify as female, and trans men who identify as male, while guaranteeing the right to equality under the country's constitution. It called for special health and welfare programmes to support the needs of trans people.

In many countries, changes cannot be made to state identification documents unless the individual has undergone gender reassignment surgery. A precondition of such surgery may be a clinical diagnosis of gender identity disorder or gender dysphoria. In some cases this diagnosis requires registration, mandatory psychotherapy or an extended stay at a psychiatric hospital. Furthermore, some countries retain controversial sterilization requirements for those who seek gender reassignment or identification in a new gender. However, there has recently been positive change:

- Argentine activists and lawmakers succeeded in passing a Gender Identity Law in 2012, the first of its kind in assuring access to legal gender recognition to trans people without judicial, psychiatric or medical intervention, and in accessing free and voluntary health care for transition.
- In 2014 Denmark passed a law that permitted citizens to change their legal gender identity without needing to undergo sterilization or surgery, which had previously been required.
- In 2015, Mexico City reformed its Civil Code to introduce provisions similar to the Argentine law.
- In 2015, Columbia issued a ministerial decree permitting gender markers on birth certificates to be rectified through a simple administrative procedure.
- In 2015, the European Court of Human Rights ruled that requiring sterilization prior to gender reassignment, and the failure of the state to alter the birth certificate of a person to their preferred gender, are violations of the individual's right to a private life.

Box 2.1

Case example: Gender identity recognition in Malta

"Gender identity is considered to be an inherent part of a person which may or may not need surgical or hormonal treatment or therapy and the bill provides for a simplified procedure which respects the privacy of the person requesting that one's official documents be changed to reflect the person's gender." (From the Objects and Reasons of Malta's Gender Identity, Gender Expression and Sex Characteristics Act, 2015)

In 2015 Malta passed the Gender Identity, Gender Expression and Sex Characteristics Act, which provides a self-determined, speedy and accessible gender-recognition process. It envisages minors being able to exercise choice about their gender identity, while recognizing parental participation and the minor's best interests. The law also guarantees non-discrimination in the public and private sector, and rejects the pathologizing of gender identity by stipulating that people "shall not be required to provide proof of a surgical procedure for total or partial genital reassignment, hormonal therapies or any other psychiatric, psychological or medical treatment". The law also calls for a working group on trans health care to research international best practices. Following the law's passage, the Maltese Ministry of Education, working with activists, devised a policy to accommodate trans, gender non-conforming and intersex[6] children in the educational system.

Box 2.2

Case example: The Philippine's largest city passes a "Gender Fair" ordinance

In 2014 the municipal council of Quezon City unanimously passed a "Gender Fair City" ordinance to protect the rights of LGBT individuals in all aspects of life including education, the workplace and politics. The ordinance promotes zero tolerance of discrimination, including bullying, teasing and negative portrayals in the media. In addition, it calls for increased options for stating sexual orientation or gender on various forms; providing gender-neutral bathrooms in public spaces and at work; and antidiscrimination activities in educational institutions and in the workplace. The city's Pride Council was tasked with executing and monitoring the ordinance. While this is a small step towards eliminating discrimination against the trans community in the Philippines, the ordinance's local focus supports change at the city level.

2.1.3 Legal and policy frameworks

International

Predicated on fundamental notions of dignity, equality and security of personhood, the key international conventions that govern human rights articulate important rights-based claims that are applicable to all human beings, including trans people:

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[6] An intersex person is one who born with sexual anatomy, reproductive organs or chromosome patterns that do not fit the typical definition of male or female, by contrast with a transgender person, who is usually born with a male or female body.

- **The International Covenant on Civil and Political Rights (ICCPR)**, signed by 195 countries, specifically prohibits discrimination based on "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" (Article 26). In 1994, the United Nations Human Rights Committee ruled that "sex" as used in the ICCPR also includes sexual orientation, thereby making discrimination against sexual minorities a violation. An interpretation of this kind is an important precedent; it has the potential to expand grounds for protection against discrimination within "other status" in the ICCPR to issues such as gender identity and gender expression.
- **The International Covenant on Economic, Social and Cultural Rights (ICESCR)**, which has been signed by 164 countries, recognizes the right to enjoy "the highest attainable standard of physical and mental health" by all persons (Article 12).
- **The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)**, which has been signed by 189 countries, recognizes the equality of women in all spheres of life, particularly education, employment and health. The CEDAW Committee, the convention's reporting mechanism, has received shadow reports highlighting the human-rights concerns of trans people.
- **The United Nations Human Rights Council resolution on sexual orientation and gender identity** in 2011 (updated in 2014), which has been signed by 96 countries, asserted the principles of universality of human rights and brought focus to violence and discrimination based on sexual orientation and gender identity. A 2011 report by the UN High Commissioner for Human Rights (also updated in 2014) called on UN member states to repeal discriminatory policies, enact anti-discrimination laws, and ensure protection for sexual minorities. A second report by the high commissioner was issued in 2015. The 2015 WHO publication *Sexual health, human rights and the law* addresses the particular vulnerabilities of trans people.

Regional

Regional mechanisms also articulate fundamental human rights for all persons within their jurisdictions, rights which apply as much to trans people as to other human beings:

- **The Inter-American Convention against All Forms of Discrimination and Intolerance** was approved in 2013 by the General Assembly of the Organization of American States (OAS). Based on the American Convention on Human Rights, it proscribes any form of discrimination and intolerance specifically on grounds of sexual orientation, gender identity and gender expression. The Inter-American Commission on Human Rights, an OAS body, instituted a Rapporteurship on the Rights of Lesbian, Gay, Bisexual, Trans and Intersex Persons, aimed at monitoring the human-rights situation, advising and providing technical assistance to the Commission and member states, and preparing reports and recommendations on law and policy reform in relation to LGBT and intersex persons.
- **The African Charter on Human and Peoples' Rights**, signed and ratified by all but one country on the continent, stipulates the rights to life, personal liberty, free expression, humane treatment, inherent dignity and equality for all persons.
- **The European Convention on Human Rights**. In 2010 the 47 member states of the Council of Europe agreed to take a broad range of measures to combat discrimination based on sexual orientation and gender identity. These measures are set out in a Council of Europe recommendation, which was the first comprehensive intergovernmental agreement on the rights of LGBT people. Building on this, the council's Parliamentary Assembly adopted a resolution on measures to prevent discrimination against trans people in Europe.

National

In addition to these international and regional human-rights frameworks and commitments, the constitutions of several countries, while lacking specific provisions related to trans people, guarantee equality of all persons and protection and respect of human dignity. In some countries quasi-judicial forums have been created for trans people to seek relief from human-rights violations. For instance, in El Salvador the Human Rights Ombudsperson (Procuraduría para la Defensa de los Derechos Humanos) receives and documents such complaints. Such procedures have been used effectively by advocates in making significant advances in trans people's human rights. Such norm-setting processes are vital to addressing the discrimination faced by trans people, and they play a crucial role in mitigating stigma. In many of these instances, law and policy reform has been led by trans activists in partnership with allies and law- and policy-makers.

Box 2.3

Case example: Addressing trans rights and needs at the policy level in India

Building on the success of activists who had worked with the national government to establish a Transgender Welfare Board, the *hijra*[7] and trans women community in the Indian state of Maharashtra advocated successfully for the Women Policy 2014. The policy, which was developed by the state's Women and Child Development Department, acknowledged for the first time the human rights and the needs of *hijras* and trans women and committed to take action in several areas:

- **Law and crime:** Sensitize the police department to prevent the unjustified use of criminal law against *hijras* and trans women, and make available medical and legal help for *hijras* and trans women in police custody.
- **Shelter:** Allocate land and funds to build shelters for *hijras* and trans women.
- **Public health:** Provide free trans-focused health-service facilities, pre-surgery schemes like health insurance and regular medical check-ups. Conduct sensitization training for doctors and other hospital staff.
- **Education:** Coordinate work of the education and health departments and the state's HIV prevention structures to make education opportunities available, and conduct sensitization training for teaching and non-teaching staff. Implement a literacy drive for adult *hijras* and trans women, and a scholarship scheme for young *hijras* and trans women.

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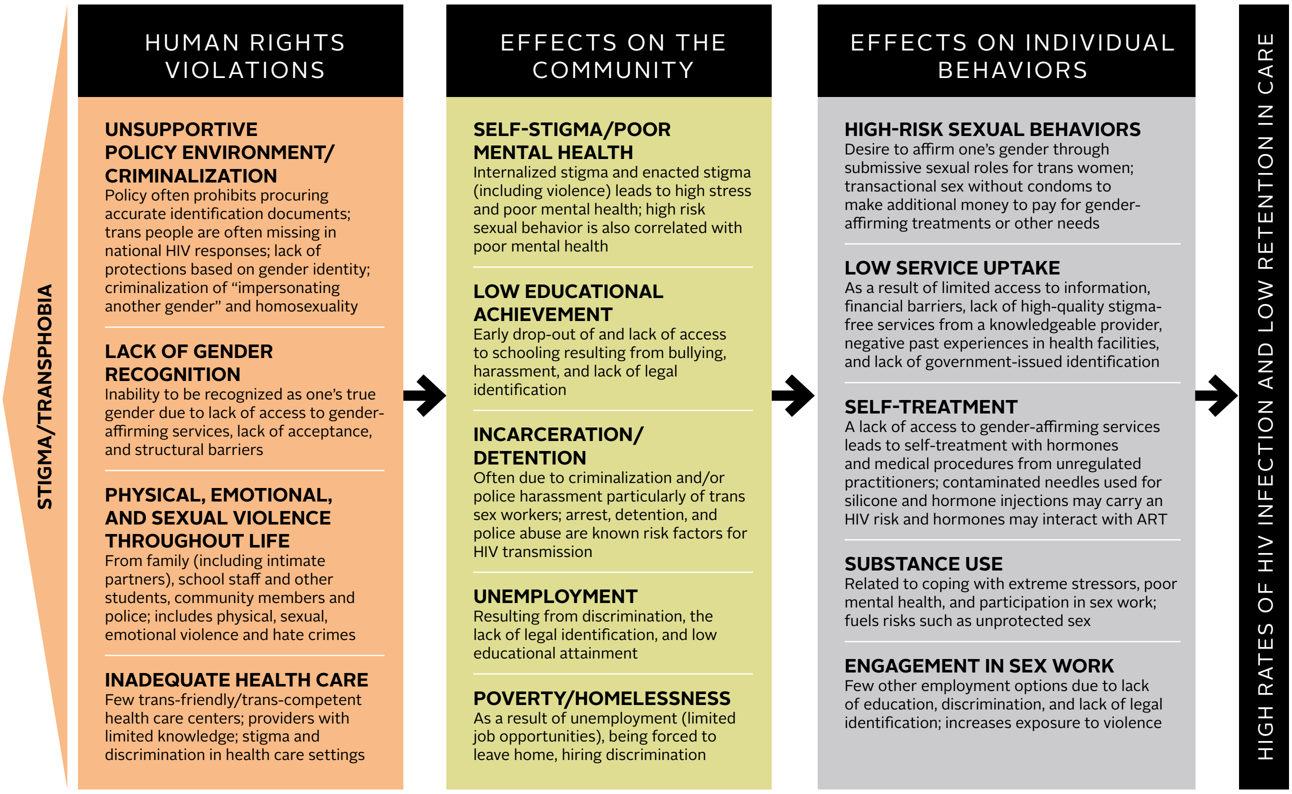
[7] *Hijras* are a distinct socio-religious and cultural group within the wider trans population in India who mostly live in close-knit clans known as *gharanas*. *Hijras* traditionally give blessings and offer songs or dances at public ceremonies such as marriages, in return for money; but changing socio-economic conditions have forced a significant proportion of them into begging and sex work for economic survival, increasing their vulnerability to HIV and other sexually transmitted infections.

2.2 Addressing stigma, discrimination and violence

Like other human beings, trans people live in multiple contexts, and their lives are informed by a complex web of dynamics. Understanding these is key to designing appropriate programmatic responses. Figure 2.1 shows how structural factors that violate their human rights affect trans people in general and as individuals.

Figure 2.1 Social determinants of health



HUMAN RIGHTS VIOLATIONS

UNSUPPORTIVE POLICY ENVIRONMENT/ CRIMINALIZATION
Policy often prohibits procuring accurate identification documents; trans people are often missing in national HIV responses; lack of protections based on gender identity; criminalization of "impersonating another gender" and homosexuality

LACK OF GENDER RECOGNITION
Inability to be recognized as one's true gender due to lack of access to gender-affirming services, lack of acceptance, and structural barriers

PHYSICAL, EMOTIONAL, AND SEXUAL VIOLENCE THROUGHOUT LIFE
From family (including intimate partners), school staff and other students, community members and police; includes physical, sexual, emotional violence and hate crimes

INADEQUATE HEALTH CARE
Few trans-friendly/trans-competent health care centers; providers with limited knowledge; stigma and discrimination in health care settings

EFFECTS ON THE COMMUNITY

SELF-STIGMA/POOR MENTAL HEALTH
Internalized stigma and enacted stigma (including violence) leads to high stress and poor mental health; high risk sexual behavior is also correlated with poor mental health

LOW EDUCATIONAL ACHIEVEMENT
Early drop-out of and lack of access to schooling resulting from bullying, harassment, and lack of legal identification

INCARCERATION/ DETENTION
Often due to criminalization and/or police harassment particularly of trans sex workers; arrest, detention, and police abuse are known risk factors for HIV transmission

UNEMPLOYMENT
Resulting from discrimination, the lack of legal identification, and low educational attainment

POVERTY/HOMELESSNESS
As a result of unemployment (limited job opportunities), being forced to leave home, hiring discrimination

EFFECTS ON INDIVIDUAL BEHAVIORS

HIGH-RISK SEXUAL BEHAVIORS
Desire to affirm one's gender through submissive sexual roles for trans women; transactional sex without condoms to make additional money to pay for gender-affirming treatments or other needs

LOW SERVICE UPTAKE
As a result of limited access to information, financial barriers, lack of high-quality stigma-free services from a knowledgeable provider, negative past experiences in health facilities, and lack of government-issued identification

SELF-TREATMENT
A lack of access to gender-affirming services leads to self-treatment with hormones and medical procedures from unregulated practitioners; contaminated needles used for silicone and hormone injections may carry an HIV risk and hormones may interact with ART

SUBSTANCE USE
Related to coping with extreme stressors, poor mental health, and participation in sex work; fuels risks such as unprotected sex

ENGAGEMENT IN SEX WORK
Few other employment options due to lack of education, discrimination, and lack of legal identification; increases exposure to violence

HIGH RATES OF HIV INFECTION AND LOW RETENTION IN CARE

Source: FHI 360/LINKAGES

2.2.1 Family

> *"My parents threatened to disown me. 'It was a sin,' 'I was sick,' 'I wanted to mutilate my body,' etc. I drank fairly heavily from when I was 14 on. And I just kept drinking."*
>
> From *Injustice at every turn – a report of the National Transgender Discrimination Survey*, USA

Trans people are often not safe even among their own family members. While some parents, siblings and other relatives may feel love and concern for a trans family member, many are frequently ashamed or embarrassed or feel that their child is dishonouring the family. Trans people can suffer beatings from family members or banishment from the family. In some places there is the threat of "honour" killings, or trans women/men may be forced into marriage to a female/male partner, subjecting the trans individual to grave danger and denying them the life of their choice. This ongoing lack of support puts trans people at risk of poor outcomes for physical and psychosocial health. Research found that trans individuals in the USA who experienced domestic violence from family members had significantly higher rates of homelessness, incarceration and HIV, and they were more likely to be involved in the underground economy, attempt suicide, and be drug- or alcohol-dependent. For trans people living with HIV, transphobia among family members can be compounded by HIV-related stigma.

Family support can protect against health risks among trans people and can improve self-esteem. An example of current efforts to address family violence is the Family Acceptance Project at San Francisco State University, USA. The project uses a research-driven, evidence-informed family model of wellness, prevention and care to strengthen families by providing LGBT-specific training and consultations on family-based prevention and intervention approaches. The training, consultation and programme development is tailored to the needs of individual agencies, institutions, congregations and communities.

2.2.2 Intimate partner violence

> *"When we find a new intimate partner, we tend to indulge in sex with him with the promise that both sides will be faithful to each other. So we go all the way and have unprotected sex with the new partner. But many of them do not keep their promise and disclose the relationship to their friends. Their friends then blackmail us into having non-consensual sex with them. This is one of the worst kinds of violence suffered by us. It leads to depression, attempts at suicide, loss of trust, and above all a feeling of losing all: family, friends and love itself."*
>
> —Respondents in focus group discussion in Delhi in a study
> on violence conducted by HIV/AIDS Alliance

Trans people are significantly more likely to experience violence at the hands of intimate partners than other groups, and trans women more so than trans men. Such violence includes not only physical aggression, but also outing trans people to strangers or at work, prohibiting them from interacting with other trans people, using their fear of the police to abuse them without repercussions, as well as forced or unprotected sex, sexual manipulation and blackmail.

Discrimination in the social-service sector results in inadequate access to shelters for trans victims of intimate partner violence, while police stigma and transphobia in the health-care system can deter them from reporting violence, seeking medical care for their injuries or getting access to shelters.

Box 2.4

Case example: A toolkit to address intimate partner violence in the USA

The USA-based National Coalition of Anti-Violence Programs produced a *Community Action Toolkit for Addressing IPV [intimate partner violence] against Transgender People*. The toolkit outlines (1) pathways of abuse that trans people can experience in an intimate relationship, (2) community actions that can be taken to prevent and address intimate partner violence in the community, (3) policy and institutional activities needed to address such violence, and (4) personal planning, precautions and actions that one can take to protect oneself and seek support and help.

For example, at the community level the toolkit instructs organizations and activists to:

- **engage** community members through outreach
- **locate** community members through mapping
- **listen** to what community members have to say about intimate partner violence
- **educate** community members about intimate partner violence and what can be done
- **involve** community members by building momentum and meeting regularly.

Although focused on the USA, the toolkit can be adapted to other environments and is available online: nbjc.org/sites/default/files/files/ncavp_trans_ipvtoolkit.pdf

A similar resource to prevent domestic and intimate partner violence has been developed by the UK-based AVA (Against Violence and Abuse):

http://www.avaproject.org.uk/our-resources/reports--publications/domestic-violence-a-resource-for-trans-people-(2009).aspx

2.2.3 Education

In many countries trans people can be stigmatized from an early age and may drop out of education due to bullying and institutional discrimination, such as forced dress codes (including school uniforms and hair length) or inappropriate toilet facilities. This occurs in both secular and religiously affiliated schools and universities. The values of religious institutions may make life particularly difficult for trans and gender non-conforming children. The education gap caused by high rates of dropout (i.e. exclusion) causes social marginalization and poverty among trans people. Many trans women surveyed in South Africa had an advanced education but generally worked in positions that were below their level of education and experience.

Although legal frameworks generally fail to protect trans people within schools and universities, there are a few positive examples, such as in Japan, where in 2015 the Ministry of Education ordered schools to accept trans students according to their preferred gender identity. To help prevent bullying of Brazilian trans school students and their dropping out of school, a 2015 resolution of a government council on LGBT rights established that trans students were allowed to attend schools (public and private) using their names and uniforms of choice, ask to be addressed as such, and to access bathrooms according to their preferred gender identity and expression.

Box 2.5

Case example: Upholding a trans student's right to gender identity in Colombia

In August 2013, a trans girl (self-identified as Briana) filed a case against a high school in Magalena for denying her admission due to her gender identity, claiming that her fundamental rights to education, equality, free development of the personality and human dignity were violated. A lower court decided that homosexuality was an abnormal condition, that the free development of the personality was not absolute, and that therefore the student must conform to the norms of the institution. The Constitutional Court reviewed this decision, upheld the right of Briana to study, and directed the school to accept her according to her gender identity. It also ordered the school to introduce a course concerning lesbian, gay, bisexual, trans and intersex (LGBTI) rights for students and teachers. The Constitutional Court also directed the lower court to abstain from using pejorative language against LGBTI people. Following this decision, the Ministry of Internal Affairs issued a ruling allowing trans people to officially change their sex and name according to their gender identity, without first undergoing a psychiatric evaluation, as is also the case in Argentina, Uruguay and Mexico City.

Box 2.6

Case example: Addressing the religious education needs of trans people in Indonesia

Muslim trans people in Yogyakarta have found it challenging to obtain Islamic learning and offer prayers at public mosques, where men and women are often separated at the time of prayer. In response, in 2008 a local trans woman started a boarding school to provide a safe space for trans people to learn about Islam and to raise public awareness of their right to worship. The informal education includes teachings of the Quran, discussions and talks related to trans issues in the context of Islam.

The school is supported by community volunteers, with engagement from local and neighbourhood religious leaders and provincial religious authorities. It has developed an agreement with a local university to help educate the students, who now number 41. The general public in Yogyakarta has also been accepting of the school, and it has helped change negative attitudes towards trans people.

This experience has shown that it is possible to influence attitudes toward trans people by first working informally with religious leaders to develop understanding, and creating alliances that support advocacy at higher provincial levels. This is vital in the Indonesian context, where decentralization vests key authority with provincial governments.

2.2.4 Employment

Trans workers are often excluded from much of the workforce. Discrimination occurs at all levels of the employment process, including recruitment, training opportunities and access to job advancement and partner benefits. Even where gender identity laws have been passed, employment-related issues have not been addressed, especially at the entry level. The majority of trans women find that their job opportunities are limited to being beauticians, entertainers or sex workers. Unemployment results in poverty, further social exclusion and homelessness. In countries where health insurance is funded by employers, unemployment also excludes trans people from health care.

Many trans people identify gender recognition as a precursor to gainful employment—if a person's gender is legally recognized it can empower them to apply for jobs they are qualified for, and there is less confusion in the hiring process. Ensuring legal gender recognition, providing equal access to employment opportunities, developing and improving anti-discrimination policies that protect trans workers, and protecting safety and security in the workplace are essential for ensuring that trans individuals are treated equally in the labour market. Governments should be responsible for providing such protections, but in the absence of such efforts, trans activists have explored other approaches to create opportunities for trans workers.

Box 2.7

Case example: Creating opportunities for trans workers in Argentina

Launched by a group of trans women in 2006, when trans individuals did not yet enjoy the full spectrum of their rights in Argentina, the Nadia Echazu cooperative provided trans women with economic opportunities and taught a skilled trade. Making products that were in high demand, the cooperative was successful and allowed members to launch their own businesses. Activists from the cooperative were involved in establishing a school for gender non-conforming teens and children who would otherwise be at risk of dropping out from mainstream educational institutions due to discrimination.

ATTTA (Asociacion Travestis, Transexuales, Transgénero Argentinas) collaborated with the Ministry of Social Development and Labour to train trans women as in-home caretakers for the elderly. The effort has resulted in comprehensive joint programming between the ministry and trans organizations. Meanwhile, the National Institute against Discrimination, Xenophobia and Racism (INADI) has promoted sounder policies for trans workers and collaborates with labour unions to conduct sensitization trainings and dialogues on sexual diversity.

Source: http://newint.org/features/2013/06/01/argentina-transgender-rights
http://www.argentinaindependent.com/socialissues/humanrights/transsexuals-democracys-forgotten

It is important to note that trans workers should not be trained to work only in selected professions. To achieve equality and to fully realize their potential, efforts are needed to expand access of trans people to comprehensive employment opportunities.

Box 2.8

Case example: Improving employment prospects for trans people in the USA

The Transgender Economic Empowerment Initiative is a community-led initiative launched in 2008 in the San Francisco Bay area. It provides a comprehensive range of employment, career development and other trans-centric services. On the client side these services include:

- resume writing and interview skills-building workshops
- mentoring and networking clubs and events
- career coaching
- skills and education assessments
- career fairs with trans-respectful, equal-opportunity employers
- employment placement.

The initiative provides sensitization and advocacy trainings to employers, and trainings that expand employer knowledge of anti-discrimination provisions of local laws. It also advocates with local employment authorities and governments. This dual approach allows development of a trained and well-prepared employee base and sensitized employers who are aware of qualified candidates.

www.sfcenter.org

2.2.5 Homelessness and poverty

Numerous factors such as family rejection, access to education, and discrimination in the workplace all contribute to the downward mobility of trans people. Research in the USA shows that one in five trans people has been homeless and that trans people are four times more likely to be in poverty.

Box 2.9

Case example: An initiative for social inclusion of trans people in Uruguay

A study conducted by Uruguay's Ministry of Social Inclusion revealed that almost all trans people surveyed were living on the fringes of extreme poverty. The ministry created a subsidy programme for trans people, with a debit card through which individuals could access money credited to the card each month for the purchase of food and medicines. In 2014 the ministry established a quota for trans people within public services, increasing their employment opportunities.

The situation is amplified by discrimination and harassment in the social-service systems. When trans people who are homeless try to access shelters they face particular challenges, since shelters are categorized by sex, and trans people are assigned according to their sex assigned at birth instead of their preferred gender, forcing them to share often hostile or dangerous spaces in the shelter. Many trans people choose to be homeless rather than face this. However, some innovative community efforts have been made to ensure that trans people have the ability to access housing (Box 2.10), showing that significant accomplishments are possible despite considerable challenges.

Box 2.10

Case example: Direct housing support in Zambia and Jamaica

Two examples illustrate both the possibilities and challenges of providing much-needed housing support to members of the trans community.

TransBantu Zambia, an organization serving the country's trans community, established a community house to accommodate three trans men and three trans women for a period of three to six months to help them get back on their feet. As part of the programme, residents would help with office activities and attend trainings with the organization. Due to hostility towards trans people in Zambia, high levels of security were necessary at the house.

The Safe House Project in New Kingston, Jamaica, was created through the fundraising efforts of the LGBT community, spearheaded by young trans women. The three-bedroom transitional living programme in New Kingston offered LGBT persons aged 16–25 who had been rejected by their families a free place to stay for up to nine months while they developed life skills to become independent. Dorm-style co-ed rooms accommodated the residents, with a closet space and freedom to decorate their rooms. Meals were prepared by residents skilled in the kitchen. Programme officers from the Jamaica AIDS Support for Life (JASL) and the Jamaica Forum for Lesbians, All-Sexuals & Gays (JFLAG) helped residents get official identification, enrol in school, find and keep jobs and manage their savings. Staff were available round the clock to help residents keep their appointments, help them through challenges, facilitate weekly support group meetings, arrange excursions and entertainment and share in celebration of their accomplishments. Residents who displayed progress in the overall programme were given the opportunity to volunteer and in some cases work in the offices of JASL and JFLAG.

Each of these programmes has faced the challenge of ensuring the security of residents in environments hostile towards trans people. At the time of publication, both projects have been suspended due to security concerns or lack of sustained funding.

Box 2.11

Case example: Housing support for trans people in the USA and the United Kingdom

The Transgender Legal Defence & Education Fund in the USA works to protect trans people from housing discrimination, such as landlords who refuse to rent apartments to them or real estate brokers who steer trans people away from such properties. Support is also provided to trans people facing harassment or threats of eviction from their landlords.

In London, UK, Stonewall Housing provides a monthly drop-in housing advice service at CliniQ, the UK's only trans-led sexual-health service. The service enables clients to obtain a comprehensive, holistic range of services and support at a single point of access.

www.tldef.org • www.stonewallhousing.org

2.2.6 Sex work

Trans women and some trans men often have to resort to sex work as their only viable option for employment after being rejected by their families and friends and faced with systemic societal discrimination and exclusion. Some work in the sex industry because of peer pressure, the need to have the commodities of life and also for funds to finance costly medical transition.

Sex work is illegal in most countries around the world and criminalized in many countries. Criminalization is often compounded by "sodomy" laws punishing sex that is not penile–vaginal. Therefore, trans sex workers are especially vulnerable to rape as well as other forms of violence and human-rights violation. Frequently, police are the perpetrators of such violence. Many laws against rape do not include anal sex, leaving trans people without legal protection if they are anally raped. The general environment of criminalization both creates and enhances this lack of safety and sometimes compromises safer sex practices such as condom use, due to the fear of being harassed or detained by law enforcers for possessing condoms.

Within the sex worker community and sex work organizations, recognizing trans sex workers is important in order to ensure that their particular needs are addressed. For example, the New Zealand Prostitute's Collective runs an outreach project that works exclusively with trans sex workers to address their social, medical and employment needs. Since sex work is decriminalized in New Zealand, sex workers may report workplace injustice; however, due to stigma trans sex workers may be less empowered to do so.

2.2.7 Legal and political stigmatization and violence

Trans people are excluded from society in various ways, and their marginalization reduces their access to services and increases their risk of experiencing violence and acquiring HIV. Some specific types of legal and political stigmatization are summarized here.

- **Criminalization:** In many countries which ban same-sex sexual relationships, sex between trans women or trans men and non-trans men, or between trans men and non-trans women, is effectively criminalized. In some countries, prohibitions against "homosexual propaganda" make trans people especially susceptible to police and societal abuse, due to assumptions that trans people are homosexual. Since little protection from the law is available to trans people in such environments, perpetrators of violence are rarely punished and the right to due process before the judicial system is often denied.
- **Police harassment and violence:** The application of laws such as those mentioned above, the criminalization of sex work, conservative social attitudes and non-accountability make police violence and extortion directed at trans people commonplace. In several countries broad "public nuisance", "vagrancy" and "public order" laws are freely used by the police to harass or abuse trans people. Some countries in Asia, Africa, the Caribbean and the Pacific retain laws against "cross-dressing" that can be used to target trans people.

Once they are deprived of liberty, trans people face abuse not only from police, but also from fellow inmates, since they are often put in cells based on their sex at birth and not on the gender with which they identify.

- **Migration:** Barriers to mobility can limit important life activities of trans people. Countries where same-sex relations and/or gender reassignment are criminalized may prevent trans people from entering or seeking asylum even when fleeing persecution due to transphobia in their home country. HIV positive status can be another factor leading to infringement of trans people's fundamental right to leave or enter a country.
- **Religious stigma:** Conservative religious attitudes can influence laws and policies in ways that affect trans people negatively. For example, religious groups have taken issue with laws on domestic violence that did not have rigid definitions of the gender of the parties involved and that could otherwise have served to protect trans people.

Finding solutions

Engaging with police and social-services staff is essential to address the needs of trans people in crisis. Police sensitization trainings have taken place in the USA, where after a wave of anti-trans violence the country's Department of Justice began training law-enforcement officials on trans identities, and in the Philippines, where national police took part in gender and sexuality trainings that included a focus on the needs of trans people. While such interventions can have meaningful impacts, they must be sustained over the long term and formalized into policies and procedures.

Trans persons who are incarcerated should be placed in the sex-segregated facility that matches their gender identity rather than the sex assigned to them at birth, and should have access to appropriate gender-affirming treatment (see Chapter 3, Section 3.2.3). If a trans person who has previously been receiving hormone therapy is suddenly prevented from accessing it, the undesired regression could cause serious physical and emotional harm.

Some communities have approached the issue of anti-trans violence through community dialogues and drawing up municipal violence and stigma prevention plans with extensive input from stakeholders, thus establishing a sustaining policy framework to prevent violence. These plans express municipal commitment to stigma prevention and describe actions that police, social-service agencies, and community organizations need to take in order to address and prevent violence.

Providing access to justice and bringing cases to account for violations against trans people is essential to ensure that a shift in policy occurs. In hostile environments, provision of legal aid and advocacy are difficult but necessary, and international mechanisms should be considered for submitting cases and putting pressure on governments to address violations. Since legal aid can be costly, negotiating pro-bono services with interested lawyers and involving trans activists who have a legal background in this work can be effective. In addition, in countries where trans people's movements are nascent, forming a library of cases and building legal precedents or remedies can contribute to improving the situation in the long term.

Box 2.12

Case example: Advocating for legal recognition of gender identity in the Russian Federation

The Transgender Legal Defence Project, launched in 2012, is operated by a group of volunteer lawyers and paralegals who are trans-rights activists and deals with issues related to legal gender recognition. The organization responds to requests from all of Russia's regions and connects individuals who live outside Russia to organizations that can help them obtain legal support in their own country.

While provisions for changing name and gender markers exist in Russia, they can be complicated by significant legal and operational hurdles. The project helps prepare legal documents and supports and counsels trans clients in the process of legal gender recognition. Lawyers also represent clients in court. The organization maintains a Facebook page and a page on the Russian-language social media site vkontakte.ru to report on its activities and seek new clients. In 2014, the project won a case in the Moscow City Court using provisions of the European Convention on Human Rights and established that gender reassignment dictates all aspects of an individual's private life and should be supported by the state.

By providing over 380 consultations and representation for 40 court cases in 2014, the organization is also building a database of cases that can serve to influence future court decisions and the enforcement of laws. Along with its partners, the organization also collaborates on submission of more complex cases within and outside the realm of identification needs and violations to the European Court of Human Rights.

http://pravo-trans.eu/about-us

Access to legal aid can also be leveraged by empowerment and education. Understanding what legal mechanisms and protections are available and forming resilience in a community to stand their ground for fundamental rights can be effective in fending off violations. Crisis or legal response teams that arrive at the time of police harassment or wrongful arrests can provide legal aid and help defuse the situation. They can be effective in preventing incarceration and reducing violence. These teams typically consist of lawyers, paralegals and trained community members.

Box 2.13

Case example: Legal aid collaboration between a women's centre and sex work collectives in South Africa

The Women's Legal Centre provides legal advice and collaborates closely with the Sex Workers Education and Advocacy Task Force and Sisonke, South Africa's national sex worker movement. This began with workshops on human rights and the law, after which some sex workers became community-based paralegals providing male, female and trans sex workers with legal advice and assistance with bail applications, and accompanying them to the courts. This initiative has included producing pamphlets that explain sex workers' legal rights, including those applicable upon arrest or detention. The initiative has also developed an information card, "My Rights When Dealing with the Police", which sex workers can carry on their person for ease of reference.

Through the legal aid and related support provided to sex workers, a marked improvement in the attitudes of police toward sex work has been witnessed, along with increased empowerment of sex workers through legal literacy efforts.

Source: http://www.opensocietyfoundations.org/sites/default/files/bringing-justice-health-20130923_0.pdf

Box 2.14

Case example: Legal advocacy in the USA

The Transgender Law Center is a national, multi-disciplinary organization that works to change law, policy and attitudes so that all people can live safely, authentically and free from discrimination regardless of their gender identity or expression. The Legal Information Helpline provides basic information about laws that affect trans people, including employment, health care, civil rights, family law and identity document changes.

The centre has a legal information helpline that can be accessed via phone or the Internet. Callers can leave a message detailing their legal queries, and the centre also accepts collect (reverse-charge) phone calls from people who are incarcerated. The recorded message is in both Spanish and English. On the Internet the helpline provides fields for the user to complete to provide contact and demographic information in addition to details of the legal concern for which assistance is being requested. Each helpline request is reviewed and responded to by a legal team member. When appropriate, a helpline submission may be referred to a Transgender Law Center staff attorney for additional review and possible representation.

www.transgenderlawcenter.org/help

2.2.8 Health care

> *"At the clinic, the public-health inspector laughed at me because of my appearance before sending me the doctor, who then insulted me for trying to become a woman and having sex with men. He asked me to get rid of all this 'rubbish' and live a good life. I was very disappointed with their treatment and regretted that I had come, telling myself that would be the last time."*
>
> —A young trans woman from Sri Lanka
>
> From *Jumping hurdles: discussion paper on access to HIV health services for young men who have sex with men and young transgender persons in Asia and the Pacific*, Youth Voices Count

Trans people in many settings contend with barriers to health care, including experiences of stigma, discrimination and violence. Studies show that trans individuals experience multiple challenges when attempting to access both routine and transition-related medical care, including denial of care, harassment and lack of competent and sensitive providers with adequate knowledge of their specific needs.

- **Primary care:** Stigmatization by health-care providers can take the form of derogatory labelling, demeaning interactions, outright insults and breaches of confidentiality. Discrimination is often institutionalized from the first moment of contact if staff at registration desks insist on the use of sex assigned at birth on registration forms, and when staff prove not to be trained, sensitive and non-judgemental. Such experiences result in low HIV testing rates and limited engagement in HIV care among trans people, and a similar reluctance to seek drug treatment and other coping services.
- **Mental-health care:** Transphobia also contributes in worsening the mental health of trans people, who suffer disproportionately from depression and suicidal thoughts. In most settings, psychosocial services for trans people are underdeveloped or nonexistent, and where they are available they can be inaccessible due to prohibitive costs. Because the approval of mental-health institutions is often needed to obtain a diagnosis of gender dysphoria in order to transition, mental-health services are viewed negatively by many trans people. The focus on a specific "diagnosis" related to binary gender norms, and the overall unpreparedness of mental-health professionals to address other mental-health needs of trans people, may lead to service-providers failing to diagnose real mental-health needs or making diagnoses which pathologize and stigmatize the trans person and cause additional suffering.
- **Gender-affirming care:** One of the most important services sought by trans people—gender-affirming[8] surgical and medical interventions—is often inaccessible to them. While hormones or other surgical interventions may be offered for cancer treatment, contraception or reproductive health, they are frequently denied to trans people out of the belief that in their case these interventions are cosmetic, medically unnecessary, or even the expression of

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[8] Gender-affirming refers to medical procedures that enable a trans person to live more authentically in their gender identity.

a mental disorder. Where they are offered, such services are prohibitively expensive and are often not covered under national or private health insurance schemes. Denying and making these essential services inaccessible to trans people makes many individuals consider unsafe hormonal injections from unqualified persons, which are purchased illegally and may carry risks of infection through unsafe use of injecting equipment.

> *"I was told to sort out my sexuality when I came to the clinic to get tested. Like many other transgender sisters, I avoid using health-care services in Fiji in fear of discrimination. They don't understand and respect gender and sexual diversity."*
>
> —A young trans woman from Fiji
>
> From *Jumping hurdles: discussion paper on access to HIV health services for young men who have sex with men and young transgender persons in Asia and the Pacific*, Youth Voices Count

Finding solutions

Identifying barriers and facilitators of trans women's participation in HIV vaccine clinical trials has led to the following recommendations: trans community sensitivity training; trans-competent[9] environments; true partnerships with local trans-competent organizations and health-care providers; protocols that focus on trans-specific concerns; and collecting and tracking data on trans individuals. Some countries, such as Uruguay, Brazil and Chile, issue special identification cards to trans people who apply for them, to be used to access health care and other services.

In many countries, activists have attempted to tackle barriers to health care by training providers. While effective for improving the situation in a particular community, one-off interventions may not have long-term impact because of staff turnover. Sustained impact requires systematic training of health-care workers, usually with the involvement of the ministry of health and in-country educational systems that can facilitate introduction of special courses at universities and recertification institutions. Forming centres of best practice can also help develop health professionals who can further facilitate peer learning (Boxes 2.15 and 2.16).

Addressing the psychosocial health needs of trans individuals is crucial, but this essential service is often forgotten. Organizations and health professionals that work with trans people have focused on peer-based and group interventions and some organizations have established training and best-practice standards for providing psychosocial services.

In addition to training health professionals, learning and empowerment on the part of trans people about their rights as clients of health services is also crucially important.

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[9] Trans-competent refers to the provision of services, especially health-care services, to trans people in a technically competent manner and with a high degree of professionalism that reflects the provider's knowledge of gender identity, human rights and the particular situation and needs of the trans individual being served. In addition, trans-competent care is delivered in a respectful, non-judgemental and compassionate manner, in settings free of stigma and discrimination.

Box 2.15

Case example: Creating a safe space for trans health in Lebanon

Marsa Sexual Health Centre in Beirut, established in 2011, is one of the Middle East's first centres serving marginalized individuals, including young people, women, LGBT individuals and people living with HIV. The centre provides comprehensive sexual-health services as well as subsidized psychological and social counselling. Marsa quickly became the most popular such facility in Lebanon due to its respectful and non-judgemental environment that emphasizes anonymity and confidentiality. The clinic also created a referral unit for professionals experienced in working with trans people, such as psychotherapists, psychiatrists, endocrinologists, lawyers and others relevant to the transitioning process.

The centre conducted a qualitative needs assessment among local trans populations and in 2014 launched a project to provide a space for trans people to discuss their health concerns and considerations for transition, either online or in person. The centre also distributes printed materials about transition, legal issues, and other topics relevant to trans people.

www.marsa.me/trans

Box 2.16

Case example: Collaborating with government to address health needs in Ecuador

Alfil Association started as a support organization for gay men and has expanded to include lesbians, bisexuals and trans people. Its work on trans issues focuses on overcoming obstacles to accessing health care. After consulting with the trans community about their health needs, Alfil arranged training and awareness meetings for health professionals and obtained the support of the health ministry in Pichincha province to establish a trans health clinic at Alfil's offices in Quito. The clinic was first staffed by government physicians trained by Alfil, along with volunteers and support staff. A study demonstrated the clinic's positive impact on trans clients' health, despite the irregular availability of doctors. This challenge has now been overcome and two doctors and two psychologists are readily available. The clinic has become both a meeting place and a reference centre for the trans community, and continues to demonstrate the positive impact that good medical practices can have on trans communities.

Source:
Lessons from the front lines: trans health and rights. New York: amfAR, the Foundation for AIDS Research & Global Action for Trans* Equality.

http://www.amfar.org/frontlines

Since trans people face multiple barriers when accessing health services, including stigma, costs and transportation, they may sometimes seek health support in a discreet manner, as illustrated below.

Box 2.17

Case example: Navigating health-care and legal environments in Eastern Europe and Central Asia

Russia-based FtM Phoenix provides online support to trans people from 12 countries in Eastern Europe and Central Asia. In all these countries legal gender recognition requires a medical diagnosis of transsexualism. However, the Ministry of Health approved the relevant procedures in only three of the countries; to get a new identification documents in the others, trans people must prove their identity at a registry office or in court. Navigating these requirements and obtaining documents from health-care providers can be overwhelming. Following several years of research and advocacy, FtM Phoenix has since 2008 connected trans people to trans-competent health-care providers for gender-affirming services and other services. The group also provides paralegal, social and peer support services. This comprehensive case management takes time, but delivers results through referrals to health-care providers and support for complex medical and legal processes.

www.facebook.com/transsovetnik

For more examples of successfully addressing stigma in health-care settings and providing trans-competent health services, please refer to Chapter 3 and 4.

2.2.9 Everyday settings

In hostile environments, safety is a particularly challenging issue for trans people. According to the LGBTI organization Kyrgyz Indigo, safety for trans women is a combination of a multitude of factors, beginning with financial independence and supportive legislation, which leads to personal and emotional safety and security. Safety and security concerns cannot be viewed independently of other issues encountered by trans women and can sometimes result from these challenges.

When safety and security are assured, it can greatly benefit the effectiveness of programming. For example, the Ukrainian organization Insight, which works with LGBT individuals, has experienced multiple attacks on its offices, but after it installed security equipment for the offices and technology to enhance the security of information stored on its computers and website, it experienced a 30% increase in client attendance. Other practical ways that community-led organizations can enhance their members' safety include disseminating reports on aggressors, ensuring that emergency phone numbers (e.g. for crisis response teams) are circulated, and by contributing to or participating in anti-transphobia campaigns (for example, see Chapter 3, Box 3.15).

Box 2.18

Case example: Fostering safety for trans people on public transport in Belize

The Collaborative Network of Persons Living with HIV (CNET+) conducts workshops for trans women on safety in everyday situations, such as using public transport. The solutions are driven by the community's challenges—the group has sensitized some bus companies to the presence and safety needs of trans passengers, as well as giving practical advice to trans women on dealing with hostile or aggressive behaviour from other passengers.

Tips on general safety are also discussed at the workshops, such as never posting one's location on social media, never going out alone, avoiding areas known for violence and going to social venues known to be welcoming to trans people. CNET+ also considers the issues of emotional safety important and provides sensitization training to government office representatives, police and medical workers, as well as providing counselling to trans clients.

2.3 Complementary interventions and strategies

2.3.1 Collecting data as evidence of stigma, discrimination and violence

In order to address stigma and discrimination among trans people, strategies for measuring, documenting and monitoring it must be developed and improved. Documenting stigma, abuse and discrimination can be challenging if fear leads trans community members to refuse to participate, but it is an important component of programming that can aid advocacy for trans people's human rights. In addition, recording stigma, discrimination and other violations can help attract donor funding.

The People Living with HIV Stigma Index is a tool that has been used in over 50 countries to measure and detect HIV-related stigma. As an example, the report from Nepal found that more trans respondents reported experiencing stigma and discrimination than male and female respondents, including psychological pressure from a partner, sexual rejection, discrimination by other people living with HIV and by household members. All participating trans respondents experienced self-stigma and many blamed themselves for acquiring HIV. These documentation efforts are essential for progress in reducing the occurrences and mitigating the impacts of stigma and discrimination.

The HIV Stigma Index UK, published in 2015, purposefully included trans people and explored intersections of trans- and HIV-related discrimination through accurate and inclusive gender-identity monitoring. Surprisingly, 52% of the trans people surveyed reported that their HIV disclosure had been an empowering experience for them, with one trans woman stating "it's strengthened some of my most important relationships". The experiences of both HIV-related and trans-related stigma are surprising, particularly as anecdotal evidence from trans HIV services in London suggest that stigma within the trans communities is commonplace, particularly among trans women in sex work. However, trans and non-binary people who responded to the survey did report a range of negative experiences when accessing health and social-care services, which corresponds with a recent survey of health-care staff which indicated that 1 in 5 health-care workers had heard their colleagues make derogatory remarks about trans people.

Although advocacy and political will are needed to bring perpetrators of violence and discrimination to justice, and this can be difficult to achieve when governments themselves are involved in these violations, trans organizations and allies can use existing international, regional and national human-rights mechanisms to bring violations to light. For instance, they can contribute to "shadow reports" for UN human-rights processes such as the Universal Periodic Review (UPR), and entities like the Committee to Eliminate all Forms of Discrimination Against Women (CEDAW) and the Committee on Economic, Social and Cultural Rights (CESCR), and offices of ombudspersons and human-rights commissions. Shadow reports are submitted by civil-society actors to supplement government reports and direct global and UN attention to issues such as trans people in detention and limited access to gender recognition or to gender-affirming health services.

Box 2.19

Case example: Documenting human-rights violations in Kyrgyzstan

Two organizations working with LGBT individuals in Kyrgyzstan, Kyrgyz Indigo and Labris, regularly document and collect cases of violations against trans women. The organizations contributed to several shadow reports to CEDAW and on the implementation of the International Covenant on Civil and Political Rights, highlighting violations against trans women in Kyrgyzstan. In 2012, as a result of the organizations' advocacy and meetings with the country's Ombudsman, violations against LGBT individuals were included in the Ombudsman's periodic report on the country's human-rights situation. Kyrgyz Indigo participated in the Universal Periodic Review process by submitting an alternative report on the situation of LGBT people in the country and actively representing their interests at the United Nations. As a result, Kyrgyzstan received around 20 recommendations on issues of sexual orientation and gender identity and expression, and on introducing national anti-discrimination legislation that would also protect the rights of trans women.

www. indigo.kg • www.labrys.kg

Sometimes documentation can have a different purpose and still have greatly beneficial impact on the life and well-being of trans people.

Box 2.20

Case example: Storytelling as documentation in South Africa

The South African organization Gender DynamiX hosts a "Life stories" section on its website: members of the trans community or their friends or partners record stories to discuss challenges they have faced and ways in which they have overcome them. These stories help to build and support the trans community and to inspire change.

http://genderdynamix.org.za.www53.jnb2.host-h.net/document-categories/life-stories

Monitoring violations of trans rights is important to build the evidence in support of the necessary policy change and law reform. A global-level example has been influential in highlighting concerns of violence against trans people (Box 2.21).

Box 2.21

Case example: Mapping trans rights in Europe

Starting in 2008, Transgender Europe has monitored trans homicides around the world, relying on data from collaborating organizations. This has evolved into Transrespect vs Transphobia, a comprehensive mapping project that tracks and reports on trans community activism, governmental good practices, incidents against trans individuals, and global legal and social frameworks for trans people. By providing comprehensive maps, and qualitative and quantitative data, the project aims to influence policy-making and human-rights frameworks and to inspire trans activism around the world.

www.transrespect.org

2.3.2 Using information and communication technology

Online social networking and community-building can offer a safe space for trans people to explore and receive support for their gender identity and expression without having to reveal themselves fully. Information and communication technology (ICT) can also be a powerful means for marginalized communities such as trans people to collectivize and organize to counter stigma, discrimination and violence. New technologies allow for real-time citizen reporting, and some platforms also provide levels of protection and anonymity, making their use safe for individuals who might otherwise be targeted for retaliation. Initiatives to include human-rights monitoring for affected communities are underway, and can be enhanced further by including links to legal aid providers and know-your-rights information.

However, trans-specific health services and information on the Internet remain sparse, especially in languages other than English (see also Chapter 4, Section 4.7). In addition, programme implementers report that high levels of illiteracy sometimes prevent trans community members from accessing web-based interventions even if they have access to technology such as smartphones. This calls for creative approaches that can help reach and engage populations in their local languages, including people with varying levels of reading literacy.

Box 2.22

Using software to monitor human-rights violations and identify HIV services

The systematic documentation of rights violations is made more robust if evidence is cross-checked with witnesses and police records. **Martus** is a free, open-source software that allows researchers to store records and information about participants and witnesses in a systematic and secure way. In Uganda, Martus was used to interview 106 individuals, including seven trans women and six trans men, and to document 78 verified cases of human-rights violations. In environments where there is a risk of police confiscating computers from LGBT organizations, Martus has been used to compile lists of members in a secure password-protected database. Martus also functions as a phone application, providing an opportunity to report encrypted data in real time. martus.org

OpenEvsys is an open-source software enabling secure reporting of human-rights violations. Developed by HURIDOCS (a global network of organizations concerned with human rights), it has been used by the Transgender Europe project (TGEU) to monitor transphobic incidents. Information on TGEU's approach to monitoring transphobic violence and the use of OpenEvsys is available in a brochure: tgeu.org/wp-content/uploads/2013/11/Monitoring_Transphobic_Incidents_final.pdf; www.huridocs.org/openevsys/

Another free open-source software, **Ushahidi**, provides powerful visualization tools, such as Crowdmap, that allow individuals to supply data on cases of violence via their mobile phones. The software then helps produce maps that indicate where the violence is occurring. Multiple women's-rights organizations have used Ushahidi and Crowdmap to track cases of sexual harassment and violence and to identify perpetrators. Trans communities can adopt these tools for their needs. Neither Martus nor Ushahidi requires a technical background and both provide training and support for community organizations. www.ushahidi.com

iMonitor+ is a UNAIDS-supported mobile phone app being tested in the Asia-Pacific region that allows any community to identify HIV prevention and treatment programmes, report HIV medication stockouts and report incidents of stigma and discrimination when obtaining services. The Indonesian AIDS Coalition has been running a trial project with iMonitor+ and reports that health authorities are receiving real-time alerts registered in iMonitor+ faster than with past reporting mechanisms. live.imonitorplus.org

In addition to specific secure databases and mapping tools, Twitter, Facebook and other social media can also aid in maintaining safety and security and in conducting country-wide workshops and consultations that would otherwise be costly (Box 2.23).

Box 2.23

Case example: Using social media to protect safety in Belize

In a legal environment that prohibits same-sex activity, Trans in Action's (TIA) constituents are particularly vulnerable to violence. Ensuring that their voices are heard at national events while maintaining anonymity is important. TIA uses WhatsApp messaging software and chat rooms to keep in touch with community members when they travel, go out or might otherwise be exposed to violence. Private Facebook groups and pages are also used for community consultations, for examples to prepare a concept note for the Global Fund. Using these simple and relatively anonymous resources, the organization maintains constant contact with the community that it serves and seeks to mobilize.

Using social media can greatly aid in empowering trans communities, as demonstrated in Malaysia.

Box 2.24

Case example: Using social media to empower and engage trans women in Malaysia

In February 2011, Justice for Sisters, a grassroots campaign in Malaysia, assisted a group of trans women in filing an application for constitutional review of a law criminalizing a "male person ... who wears a woman's attire and poses as a woman", following a series of arbitrary and violent raids and arrests of trans women in Seremban, the capital of the state of Negeri Sembilan.

Justice for sisters launched a talk show series—"Chit chat with Jelita"—for the trans community to explain some of the issues arising in the constitutional review. The series used talent from within the community, particularly those working in the field of HIV prevention. The seven episodes, in the Malay language, highlighted the intersections of sex work, HIV and urban poverty, as well as police powers, transphobia and discrimination in education. The videos were supplemented by Twitter discussions in collaboration with human-rights groups and civil-society organizations. An example of the series is available here:

https://www.youtube.com/watch?v=yLQiir54qrg

Following this Justice for Sisters launched the "I AM YOU: be a trans ally" campaign in 2013. A series of thematic videos on discrimination, family acceptance, health, and employment aimed to educate the general public to support the constitutional review, which is ongoing. Information on the campaign is available on Facebook, Twitter and YouTube, and

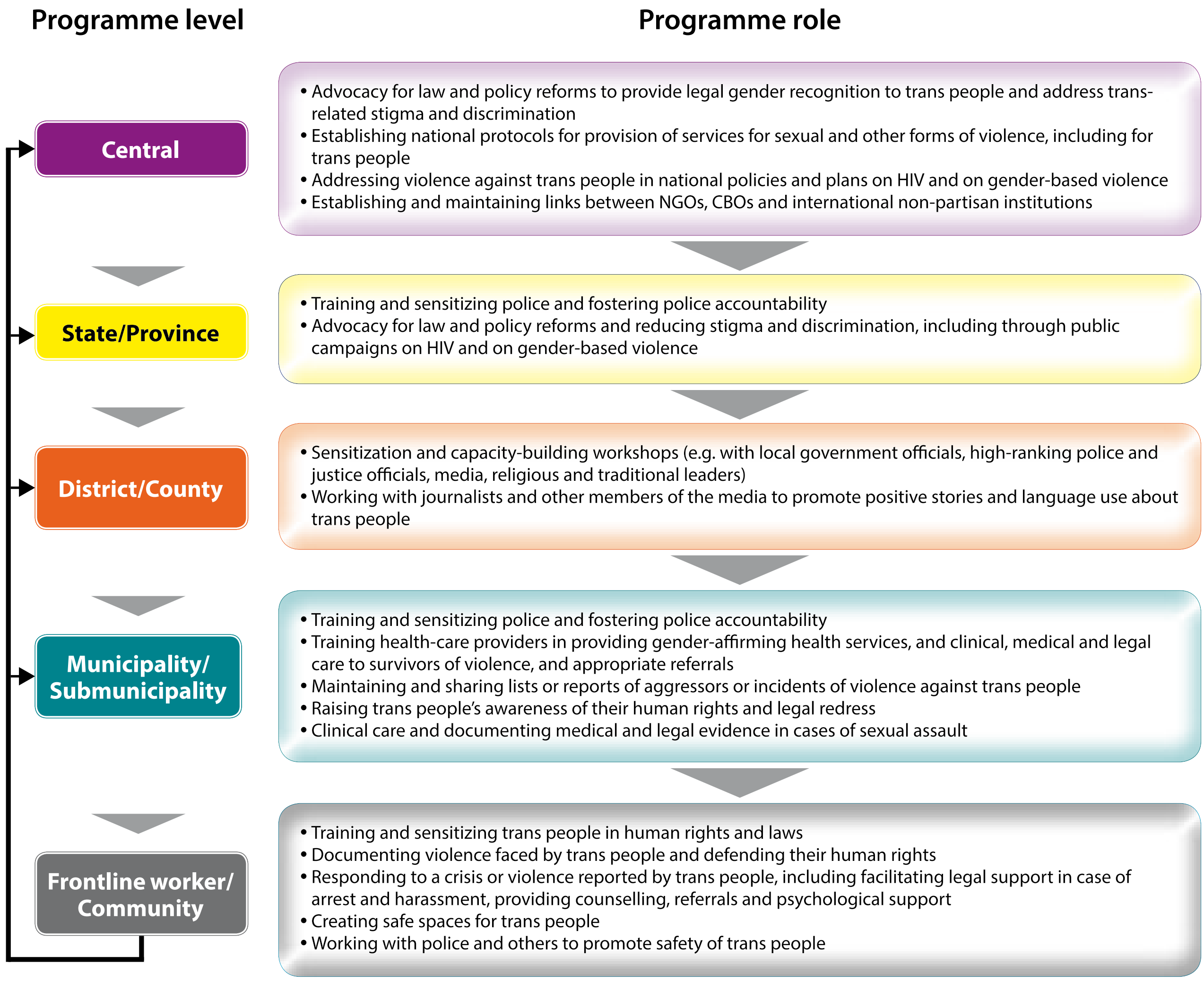
http://mytransally.weebly.com.

The use of ICT for trans community organizing, health monitoring and other purposes is discussed in detail in Chapter 4.

2.4 Monitoring and evaluation

The interventions illustrated in this chapter are not only implemented at a local level but also require engagement at subnational and national levels (some even at the international level). This is particularly true for sensitization and advocacy work. Figure 2.2 shows the roles of each of the levels of implementation, although in many contexts interventions may be required at multiple levels.

Figure 2.2 Illustrative multi-level approach to addressing stigma, discrimination and violence against trans people



Programme level	Programme role
Central	• Advocacy for law and policy reforms to provide legal gender recognition to trans people and address trans-related stigma and discrimination • Establishing national protocols for provision of services for sexual and other forms of violence, including for trans people • Addressing violence against trans people in national policies and plans on HIV and on gender-based violence • Establishing and maintaining links between NGOs, CBOs and international non-partisan institutions
State/Province	• Training and sensitizing police and fostering police accountability • Advocacy for law and policy reforms and reducing stigma and discrimination, including through public campaigns on HIV and on gender-based violence
District/County	• Sensitization and capacity-building workshops (e.g. with local government officials, high-ranking police and justice officials, media, religious and traditional leaders) • Working with journalists and other members of the media to promote positive stories and language use about trans people
Municipality/ Submunicipality	• Training and sensitizing police and fostering police accountability • Training health-care providers in providing gender-affirming health services, and clinical, medical and legal care to survivors of violence, and appropriate referrals • Maintaining and sharing lists or reports of aggressors or incidents of violence against trans people • Raising trans people's awareness of their human rights and legal redress • Clinical care and documenting medical and legal evidence in cases of sexual assault
Frontline worker/ Community	• Training and sensitizing trans people in human rights and laws • Documenting violence faced by trans people and defending their human rights • Responding to a crisis or violence reported by trans people, including facilitating legal support in case of arrest and harassment, providing counselling, referrals and psychological support • Creating safe spaces for trans people • Working with police and others to promote safety of trans people

Current global campaigns such as 90–90–90, Fast Track and Quarter for Prevention call for concerted efforts to stall the HIV epidemic by 2030. The Fast Track initiative also seeks to set antidiscrimination targets informed by the evidence that HIV can only be defeated by ensuring enabling environments for key populations. Thus monitoring and evaluation of stigma, discrimination, and violence prevention and response efforts are important because:

- These indicators are becoming a key component of successful HIV prevention, diagnosis, treatment and care programmes globally.

- Data on the specific forms of these phenomena faced by trans people, and the contexts in which they occur, provide a basis for planning and designing appropriate strategies, such as addressing stigma in health-care settings, violence from state perpetrators etc.
- Including indicators on these phenomena in the routine monitoring framework allows programmes to monitor whether there are any unintended consequences of programmes and interventions, e.g. "backlash" violence.
- Evidence on these phenomena faced by trans people is a powerful tool for advocacy efforts to change laws and policies related to them and create an enabling environment for promoting the rights of trans people.

Evaluation of stigma, discrimination and violence prevention and response strategies with trans people is necessary before most of the options presented in Sections 2.2 and 2.3 are scaled up. Care must be taken that collection of data or documentation of incidents of stigma, discrimination or violence does not further endanger the safety of trans people or stigmatize them. Building trust depends on the ethical and safety measures included in data collection, and the skills of data collectors in sensitively asking relevant questions. Prior research on these phenomena against trans populations can provide guidelines for researching violence and gathering data. Trans people must be equal partners in the design, implementation and dissemination of results from any data-collection activity related to violence and other human-rights violations against them.

At the time of writing there is a dearth of validated and internationally agreed-upon population-based impact or programmatic indicators that are specific to stigma, discrimination and violence faced by trans people. This has been a particular challenge since data on trans people have only recently been disaggregated from those on men who have sex with men in the realm of HIV.

The WHO *Tool for setting and monitoring targets for HIV prevention diagnosis, treatment and care for key populations* provides indicators that can apply to trans people in the context of human rights and enabling environments.

To monitor stigma and discrimination:

- stigma and discrimination experienced by trans people (also can be used to monitor change—for example: percentage of trans people still experiencing stigma and discrimination)
- attitudes towards trans individuals held by service-providers (also can be used to monitor change).

To assess work in the area of providing an enabling environment:

- involvement of trans people in policy and strategy formulation
- legal support services for trans people
- support services for trans people who experience violence
- sensitization trainings on trans people for health-care providers/law-enforcement officers.

See also the *UNAIDS 2016–2021 Strategy*, which contains an illustrative list of indicators, including ones relevant to access to tailored HIV combination prevention services; addressing punitive laws, policies, stigma and discrimination; and ensuring social protections.

A document produced jointly by multiple UN and bilateral agencies with civil-society partners, *Operational guidelines for monitoring and evaluation of HIV programmes for sex workers, men who have sex with men, and transgender people*, suggests that law-enforcement or human-rights agencies track and report on the frequency of discrimination or violence reported by members of key populations due to their sexual orientation. In the context of trans people "sexual orientation" would be replaced by "gender identity or gender expression". This recommendation provides for monitoring the advancement of the enabling environment and whether or not there are mechanisms at the national level to report violations, as well as how these violations are being addressed. Illustrative indicators proposed by the document specifically in relation to trans people are:

- number of trans individuals that participate in gender equality and HIV training
- outcome indicator: Percentage of trans individuals reached by gender equality and HIV training
- output indicator: Percentage of trans individuals reached by community-led participatory education challenging harmful gender norms.

In India, where the Avahan AIDS Initiative included crisis response systems to address violence, programmes have also collected data on reported incidents of violence which can be adapted to address the needs of trans people. These indicators include:

- number of trans people who report incidents of physical violence
- number of trans people who report incidents of sexual violence
- perpetrators of any violence reported by trans people, by category (e.g. police, intimate partner, client).

Programme monitoring data that rely on self-reported incidents of violence are susceptible to bias. It may therefore be challenging to interpret monitoring efforts that track increases or declines in reported incidents over time. Some forms of violence may be more likely to be reported when programme monitoring systems are established than others, and this will vary across different contexts over time.

It is essential to involve trans communities in monitoring and evaluation processes to enhance and support data collection and ensure that data accurately reflect the community's experiences. Trans communities can also provide oversight of programming intended to benefit them, report rights violations, and inform change. Implementing community monitoring systems will encourage trans participation and increase capacity for collecting data relevant to those receiving services. Such systems can be designed by including trans people on local, regional, and national programme design and review committees. Trans-led organizations can establish their own monitoring processes by periodically surveying their client base about key services they are receiving or rights violations they are experiencing. In certain locales, trans communities use social media networks such as Facebook and Twitter to report on health services, health outcomes and violations (see also Box 2.22).

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3

Services


Community mobilization
and structural interventions
2 Stigma,
Discrimination,
Violence &
Human Rights
5
Programme
Management
1
Community
Empowerment
3
Services
Starting, managing,
monitoring and scaling
up a programme
4
Service Delivery
Approaches
Approaches to improving
the continuum of HIV and
STI prevention, diagnosis,
treatment and care

What’s in this chapter?

- a description of the continuum of HIV prevention, diagnosis, treatment and care (Section 3.1)
- the gender-affirming health services that should be offered and can serve as a critical entry point for HIV prevention, diagnosis, treatment and care (Section 3.2)
- essential interventions related to HIV (Section 3.3).

The chapter also includes a list of resources and further reading (Section 3.4).

3.1 Introduction

This chapter describes the comprehensive package of services recommended to provide trans people with HIV prevention, diagnosis, treatment and care. The package is based on the World Health Organization's (WHO) 2014 *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* and the WHO 2015 *Policy brief: transgender people and HIV*.

Box 3.1

The comprehensive package of HIV prevention, diagnosis, treatment and care services for trans people

Essential health-sector interventions

a. Comprehensive condom and lubricant programming
b. Harm reduction interventions for substance use (in particular needle and syringe programmes and opioid substitution therapy)
c. Behavioural interventions
d. HIV testing services
e. HIV care, support and treatment
f. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental-health conditions
g. Sexual and reproductive health interventions

Essential strategies for an enabling environment

a. Supportive legislation, policy, and financial commitment, including decriminalization of certain behaviours of key populations (see Chapter 2)
b. Addressing stigma and discrimination, including making health services available, accessible and acceptable (see Chapter 2)
c. Community empowerment (see Chapter 1)
d. Addressing violence against people from key populations (see Chapter 2)

Source: Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2014.

The package of services for HIV prevention, diagnosis, treatment and care should be available to all trans people regardless of their environment. Chapter 4 discusses different ways that trans-led organizations and other organizations have delivered services, including approaches to ensure that services are trans-competent.[1] Trans-competency is essential to the successful delivery of all the services described in this chapter (see Section 3.2.1), and this is true for primary-health services (Section 3.2.2) as much as for HIV prevention, diagnosis, treatment and care.

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[1] Trans-competent means that services, especially health-care services, for trans people are provided in a technically competent manner and with a high degree of professionalism that reflects the provider's knowledge of gender identity, human rights and the particular situation and needs of the trans individual being served. In addition, trans-competent care is delivered in a respectful, non-judgemental and compassionate manner, in settings free of stigma and discrimination.

In addition, any intervention that addresses the high burden of HIV among trans persons, whether specifically or as part of a broader HIV strategy, will need to assess the availability and provision of gender-affirming[2] health services. Gender-affirming health services are a significant priority for trans people and may serve as an important means of reaching and engaging the community in the HIV prevention, diagnosis, treatment and care continuum. For this reason, this chapter addresses such services (see Section 3.2.3).

3.1.1 The HIV prevention, diagnosis, treatment and care continuum

Figure 3.1 illustrates the HIV prevention, diagnosis, treatment and care continuum. The aim of the continuum is to 1) reach those who are HIV negative, 2) help them to stay negative over time, and 3) diagnose, refer and retain those who test positive into treatment and care. It starts by emphasizing the importance of estimating the size and locations of the key population—in this case, trans people—followed by assessing their risk levels and needs and reaching them with HIV prevention products and services through a combination of approaches.

Trans people who are HIV negative and at risk of infection should be continually encouraged to use condoms and lubricant and to undergo repeat testing on a regular basis. It is important that trans people diagnosed with HIV be referred promptly to care and support programmes and begin antiretroviral therapy (ART) as soon as possible. Delays in beginning ART can cause further complications and may reduce the efficacy of treatment. Different approaches can be used to achieve sustained adherence and retention, depending on individual needs and preferences (see Chapter 4). Ongoing support, follow-up and engagement are essential for long-term adherence to ART, which ultimately leads to a suppressed viral load.

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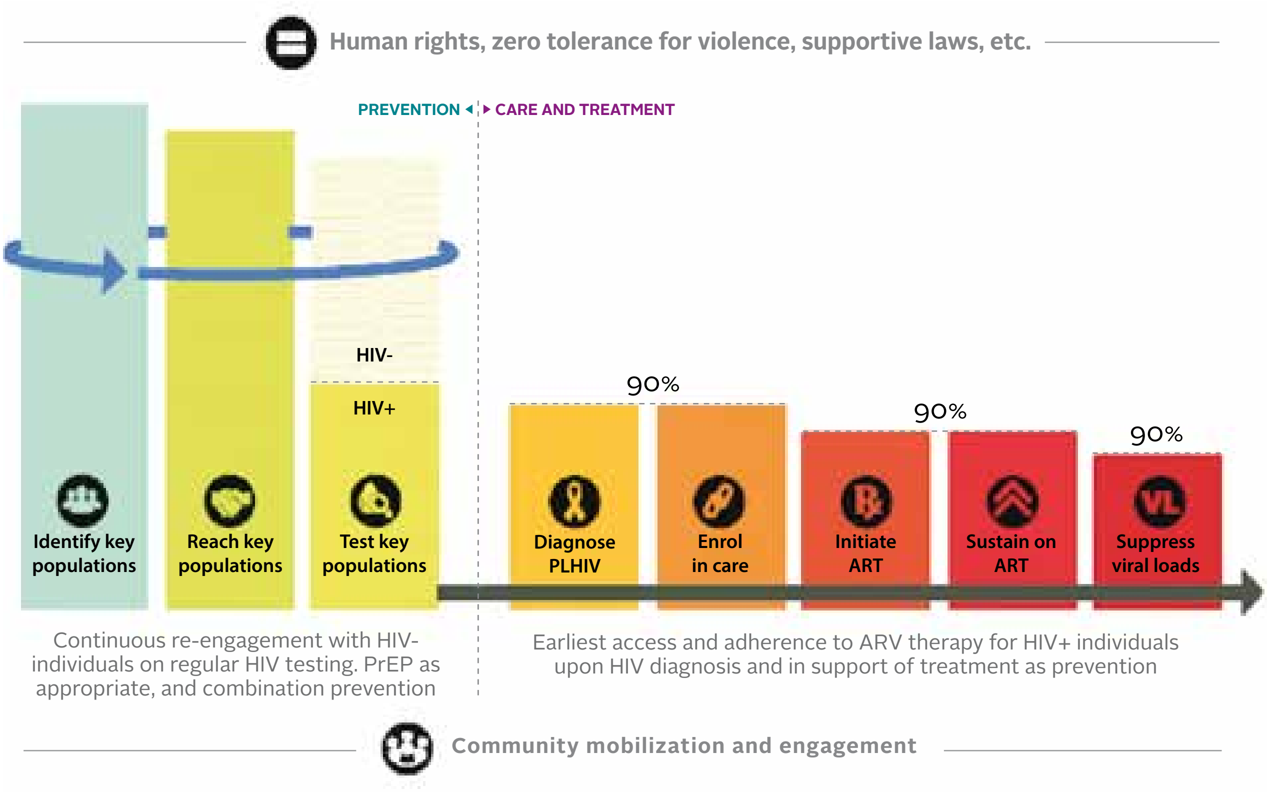
[2] Gender-affirming refers to medical procedures that enable a trans person to live more authentically in their gender identity.

Figure 3.1 HIV prevention, diagnosis, treatment and care continuum



Source: FHI 360/LINKAGES

The continuum is a practical diagnostic, advocacy, planning and monitoring tool that applies to all actors in the HIV response. Each component represents a single objective that is common to all forms of HIV programming. The continuum illustrates how all these objectives are connected and interdependent. By studying the objectives as they relate to current programming, it is possible to identify gaps where trans people are unable to access or follow through with services, and to analyse the causes. Once it is determined where along the continuum individuals are not being reached, the most effective solutions can be identified to close gaps and strengthen interventions to reach and retain the maximum number of individuals.

The framework emphasizes the importance of "reach–test–treat–retain" to meet the UNAIDS targets of 90–90–90 by 2020:

1. 90% of all people living with HIV will know their HIV status.
2. 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.
3. 90% of all people receiving antiretroviral therapy will have viral suppression.

UNAIDS has also called for 90% coverage of key populations, including trans people, with combination prevention packages that include condoms, lubricant and pre-exposure prophylaxis (PrEP).

3.2 Trans-competent health services

3.2.1 Principles for providing trans-competent health services

It is essential to build trust between health-care workers and trans persons seeking care. This may be done by ensuring that services integrate the following principles, which are described in more detail in Chapter 4, Section 4.2.1. See also especially Chapter 4, Box 4.1 (Ensuring trans cultural competency) and Box 4.2 (A checklist for trans-competent care).

- **Trans-competent care:** Health services should be provided in a sensitive, respectful and compassionate manner, in settings that are free of stigma and discrimination, by health-care workers who are technically competent and knowledgeable about gender identity,[3] human rights and the particular situation and needs of the trans individual being served.
- **Service integration:** Health services for trans people should not focus exclusively on HIV or hormone therapy, but provide access to high-quality clinical care and psychosocial support services as needed.
- **Accessible and affordable care:** All necessary health care, whether primary care, for transition[4] or for HIV, should be of high quality and affordable for trans people.
- **Client safety and confidentiality:** Trans people must be free from real or perceived threats of physical, emotional or verbal harm at all times during the provision of health services. All health information and other personal information must remain confidential.

3.2.2 Primary care

2014 Key Populations Consolidated Guidelines[5]

Health-care workers should be sensitive to and knowledgeable about the specific health needs of trans people. *(p.80)*

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[3] Gender identity is a person's internal, deeply felt sense of being male, female or some alternative gender or combination of genders. A person's gender identity may or may not correspond with her or his sex assigned at birth.

[4] Transition refers to the process transgender people undergo to live authentically in their gender identity. Transitioning may also involve medical steps that help to align a person's anatomy with their gender identity. These steps are sometimes called "medical transition" and can include feminizing or masculinizing hormone therapy, soft-tissue fillers or surgeries. However, transition is not defined by medical steps taken or not taken.

[5] Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2014.

Box 3.2

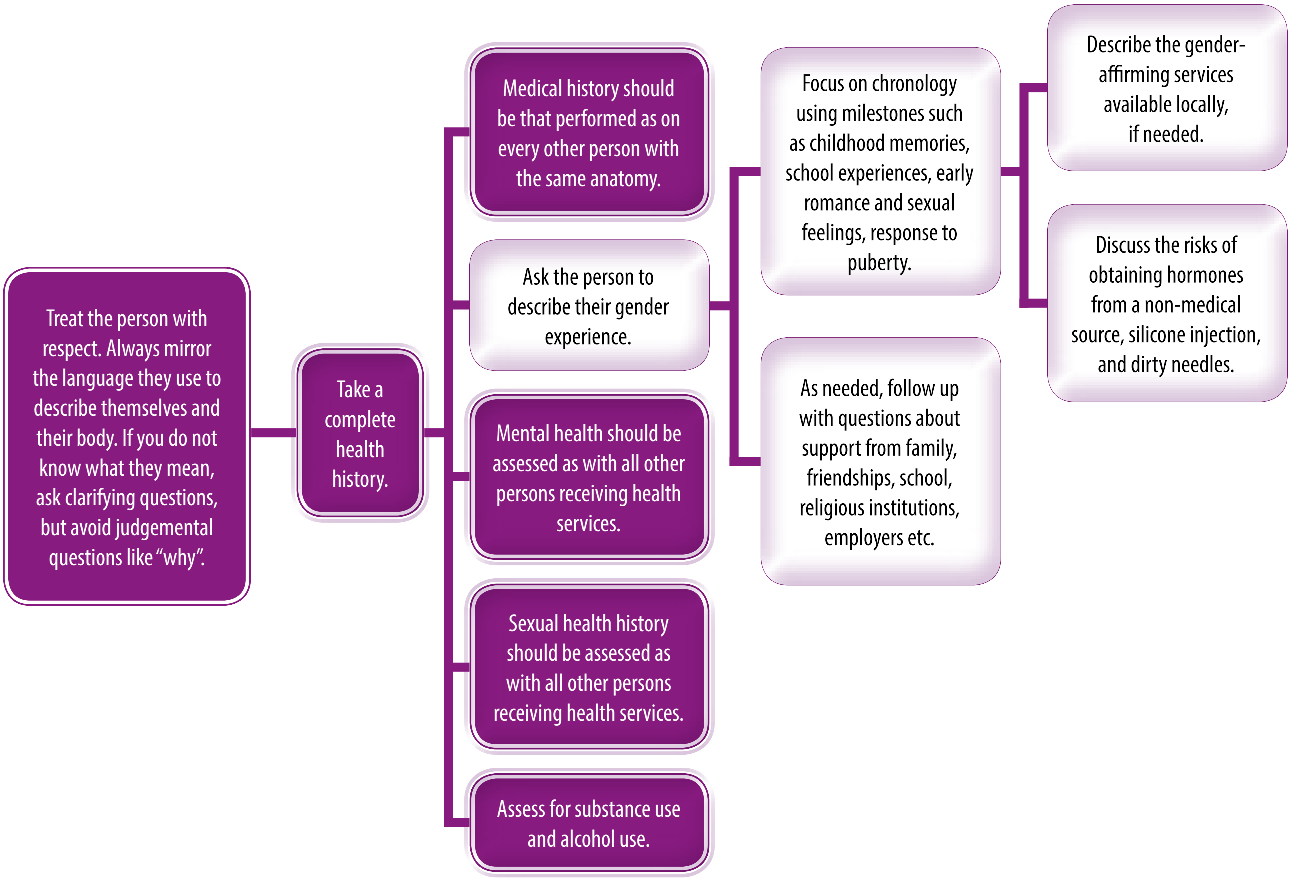
Recommended treatment protocols and guidelines for trans-competent health care

The Center of Excellence for Transgender Health at the University of California San Francisco, USA offers medical protocols for the primary care of trans clients, including hormone therapy, at http://transhealth.ucsf.edu/trans?page=protocol-00-00. The protocols are also available in Spanish.

The World Professional Association for Transgender Health (WPATH) publishes guidelines for the care of trans clients at http://www.wpath.org. These guidelines include some medical information but focus more on psychosocial aspects of trans health care. The guidelines are available in multiple languages.

While it is important that health-care workers understand the available protocols for transition-related care, support and treatment (see Section 3.2.3), in other respects primary-health services for trans people are no different from those for non-trans people. Trans clients require health services for the anatomy that is present (including tissue remaining after surgical procedures, such as breast tissue present after mastectomies or "top surgery"). Health-care workers should therefore provide the same assessment and screening for trans people as for non-trans clients with the same anatomy or health needs. Health-care workers can also serve an important role in advocating that trans clients receive the available high-quality health services that are appropriate.

Figure 3.2 Flowchart for a trans-competent health assessment



3.2.3 Gender-affirming health services

The goal of providing gender-affirming health services for trans people is to ensure they are comfortable with their gender identity, gender expression[6] and physical characteristics. This may or may not include hormone therapy or other procedures like surgeries. What is required is dependent on what will help them to have a fulfilling life and what is available in their country.

Box 3.3

Case example: Trans-led integrated health services in the United Kingdom

The UK's National Health Service allows trans people to receive some gender-affirming care, but integrated specialist services for trans people that include sexual and reproductive health services are not available. Following a comprehensive period of trans community consultation, planning and innovation, cliniQ became the first (and at present remains the only) trans-led integrated sexual-health and well-being centre in the UK. cliniQ's services are developed and delivered by trans people for trans people, with the ethos "nothing about us without us".

cliniQ is open one day a week for three hours in a space provided free of charge by 56 Dean Street, a sexual-health clinic in London. It offers a range of holistic well-being services, including counselling, mentoring and mental health; sexual health; social work; benefits and housing support; alcohol and substance use programmes; acupuncture and yoga; and community- and esteem-building events. All of the services are provided by experienced practitioners on a pro bono basis, except for the nurses and doctors, who are paid by the National Health Service. By providing regular career development opportunities to trans people interested in delivering health services, cliniQ builds community capacity. Its annual Trans Health Matters conference encourages others to provide integrated trans health services.

cliniQ uses community events and social media to let the trans community know that it is a trans-led and integrated health-service provider. cliniQ does not receive funding from the National Health Service and raises funds by offering training programmes and conferences.

www.cliniq.org.uk

Hormone therapy

Trans people may take hormone therapy in order to align their appearance with their gender identity. Hormones include estrogens and androgen-blockers for trans women and testosterone for trans men. The lack of access to health services leads many trans women to acquire and use unsafe and illicit hormones (see Section 3.3.4).

- Hormones should be prescribed by trained health-care workers using acceptable guidelines (for a list of protocols for hormone therapy, see Section 3.4).
- Clients should be informed of the risks and benefits of hormones, as well as the reversible and irreversible effects of hormones.

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[6] Gender expression is a person's ways of communicating masculinity, femininity or some combination externally through their physical appearance (including clothing, hair styles and the use of cosmetics), mannerisms, ways of speaking and behavioural patterns.

- Health-care workers should provide risk-reduction and harm-reduction counselling. From a harm-reduction perspective, a fully informed client who is able to provide legal consent is ultimately the most important voice when considering treatment options.

As with any medication, it is important to consider possible drug interactions. For trans persons on hormone therapy who are also HIV positive and in need of antiretroviral therapy, see Section 3.3.9. While providing hormone therapy, health-care workers can also address their clients' primary health-care concerns, including HIV prevention, diagnosis, treatment and care. For this reason, it would be beneficial for transition-related health-care services to share a location and be integrated with primary care services, particularly HIV services, as part of a comprehensive, integrated sexual-health strategy that meets the needs of trans persons.

Surgical procedures

Some trans people may have surgery to more closely align their appearance with their gender identity. There is no single sex-change surgery, but rather a variety of surgeries that people may choose (see Table 3.1). Even in high-income countries, gender-affirming surgical procedures are not widely available because there are few surgeons specifically trained and the cost is often prohibitive, and not covered by most insurance providers. For trans people who plan to undergo (or have recently undergone) surgery, it is important for the HIV or primary care provider to communicate about appropriate pre-operative and post-operative care with the surgeon.

Table 3.1 Gender-affirming surgeries

MEDICAL TERM	COMMON TERM/DESCRIPTION
Feminizing surgeries	
Orchiectomy	Castration/removal of testicles
Penectomy	Removal of the penis
Vaginoplasty	Surgical construction of a vagina
Breast augmentations	Breast implants
Laryngeal reduction	Reduction of "Adam's Apple"
Reduction thyroidchondoplasty	Facial feminization
Masculinizing surgeries	
Mastectomy	Breast removal
Hysterectomy/oophorectomy	Removal of the uterus/ovaries/cervix
Metoidioplasty	Lengthening the clitoris to form a small penis
Scrotoplasty/testicular implants	Constructing a scrotum/testicles from the labia majora
Phalloplasty	Constructing a neo-penis
Stiffener	Inserts of fillers or malleable rods to construct a penis that can be erect
Mons resection	Surgical procedure to bring the penis and testicles to a forward position
Urethroplasty	Extension of the urethra to allow for urination while standing
Vaginectomy	General term for all vaginal reconstruction surgeries. The most common of these is colpocleisis, which closes the vaginal canal.

3.2.4 Coding

Some health systems require a provider to make a diagnosis using a specific code in order to provide treatment. If the system is tied to traditional gender norms, rather than the individual anatomy present, people can be prevented from accessing care. For example, a trans woman who medically requires breast reconstructive surgery could be denied coverage for the operation due to having "male" noted on insurance cards or documents, even though a non-trans woman with a medical need for the same surgery could receive it within the same health system. If this happens, it is important for health-care workers and support staff to advocate for their trans clients to receive necessary medical services. Even if an organization has to use codes to receive funding for the medical services provided, the provider does not have to use these when talking with clients. Rather than telling trans clients that they have gender dysphoria and need treatment for it, health-care workers can discuss gender identity and the available gender-affirming and transition-related care, support and treatment services. These strategies ensure trans clients receive necessary health services in a non-stigmatizing manner.

Box 3.4

Case example: Advocating for a client's transition-related health needs in the USA

Health-care providers often become advocates for their clients and can be liaisons between pharmacists and other service-providers involved in treatment and care. In the case of Thomas, a trans man in the US state of Oregon, the interventions of a health-care provider made all the difference in the quality of his care. Thomas was on the state-provided medical programme for low-income people and had limited choice of health-care workers or service centres. For a long time he avoided medical care because he disliked feeling that every health-care worker required an explanation about trans people and treated him more like a science experiment than a person.

Eventually Thomas began seeing a new health-care worker who was very educated about trans health and frequently advocated for him. When the health-care worker changed Thomas' testosterone dose, she advised him that he might have difficulty filling the prescription at the pharmacy and that she would call the pharmacy to ensure it was filled. The health-care worker also petitioned Thomas's insurance provider to cover chest surgery as necessary medical care. The competency and ethical behaviour of this health-care worker are reassuring to Thomas, who no longer avoids medical services and feels empowered, knowing that he is not alone in advocating for his health and well-being.

While this is a single example from the United States, health-care workers are encouraged to offer guidance and assistance to their clients in their interactions with agencies and individuals involved in all aspects of their ongoing health care and treatment.

3.2.5 Life course

Specific considerations must be taken into account in order to appropriately address the HIV and health needs of trans persons throughout the course of their life. An individual's experiences and consciousness, and the appropriate care, support and treatment approaches, will differ depending on the stage of their life at which they identify that their gender identity does not align with their sex assigned at birth. It is essential to understand that while each individual develops in a unique way throughout their life, and experiences vary from person to person, there are some patterns of human development that are shared by significant numbers of trans individuals on a population level. Additional research is needed on gender identity development in children, adolescents and adults in different populations worldwide because formal epidemiological studies are lacking.

Trans individuals of all ages commonly experience stigmatization, rejection, discrimination or violence, and poverty due to social rejection and institutional discrimination. As such, trans people at every stage of life should be evaluated for trauma, depression and minority stress (see Section 3.3.10 on mental health).

Childhood

Some children as young as 2 years can assert their gender identity which may not align with their sex assigned at birth. The behaviour that a child exhibits can range from a very extreme discomfort with their sex characteristics accompanied by anxiety and depression to a less intense discomfort or only partial presence of these characteristics. The child may express their unhappiness about their physical characteristics and express a desire for clothes, toys, games etc. that align with another gender.

Adolescence

Children's desire to experiment with their gender identity can change before or during puberty. However, for some children the feelings of discomfort with their sex characteristics will become more intense with the development of their secondary sex characteristics. For some trans adolescents and adults there may be no childhood history of expressing a gender identity different from their assigned sex. Moreover, the way someone identifies their gender during childhood does not always determine how they will identify later in life. As such, childhood gender expression alone cannot be used to qualify a person as "trans". An individual may change the way they self-identify at any age or stage of life, and all must be treated as equally valid. Primary-care providers (including general practitioners and paediatricians) are often the first professionals whom families and youth contact for advice and can assist with negotiating complex medical, legal, social and economic challenges and facilitating access to safe, culturally competent and appropriate health-care services.

Adulthood

Regardless of when an individual begins to identify with a gender that does not align with their physical traits at birth, all must be offered the highest standard of trans-competent health care. In the case of individuals who identify as trans as adults, medical professionals should evaluate the person's psychosocial adjustment, which includes a thorough assessment, impact of gender variance on mental health, and available social support. Health-care workers should consider whether any symptoms are better accounted for by other diagnoses. If the client is indeed trans, they should help educate, prepare and refer the client for desired medical interventions. Hormonal therapy for gender affirmation has no age limit, although the time to respond to hormonal therapies often slows with age.

Family, friends, and peers may be less accepting and the trans community may be less welcoming to those who transition later in life rather than earlier. In consequence, there may be less community[7] support, peer navigation, and resources available to trans people transitioning later in life. It is very important to ensure that competent care, support and treatment services are available to middle-aged and older adults who are just starting to identify as trans, and that appropriate support, navigation and other resources that are non-stigmatizing will also be available.

Older adults

An older person seeking gender-affirming health services should be evaluated, assessed and referred for appropriate and competent care to address health needs and concerns.

The health needs of trans people who have been receiving gender-affirming health services should be monitored and evaluated as they age. The maintenance dose of hormones may need to be adjusted, and the individual may have changes in their health or experience other lifestyle changes. As with any long-term medication, it is important to consider the long-term risks of hormone use and the individual's general health when assessing their dose and form of hormones. Persons with co-morbidities may need more frequent monitoring. For persons in resource-poor settings, alternatives such as telehealth or cooperation with local health-care workers can be used to the maximum extent possible (see Chapter 4).

Surgical procedures for gender affirmation may not be feasible for older trans persons 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.

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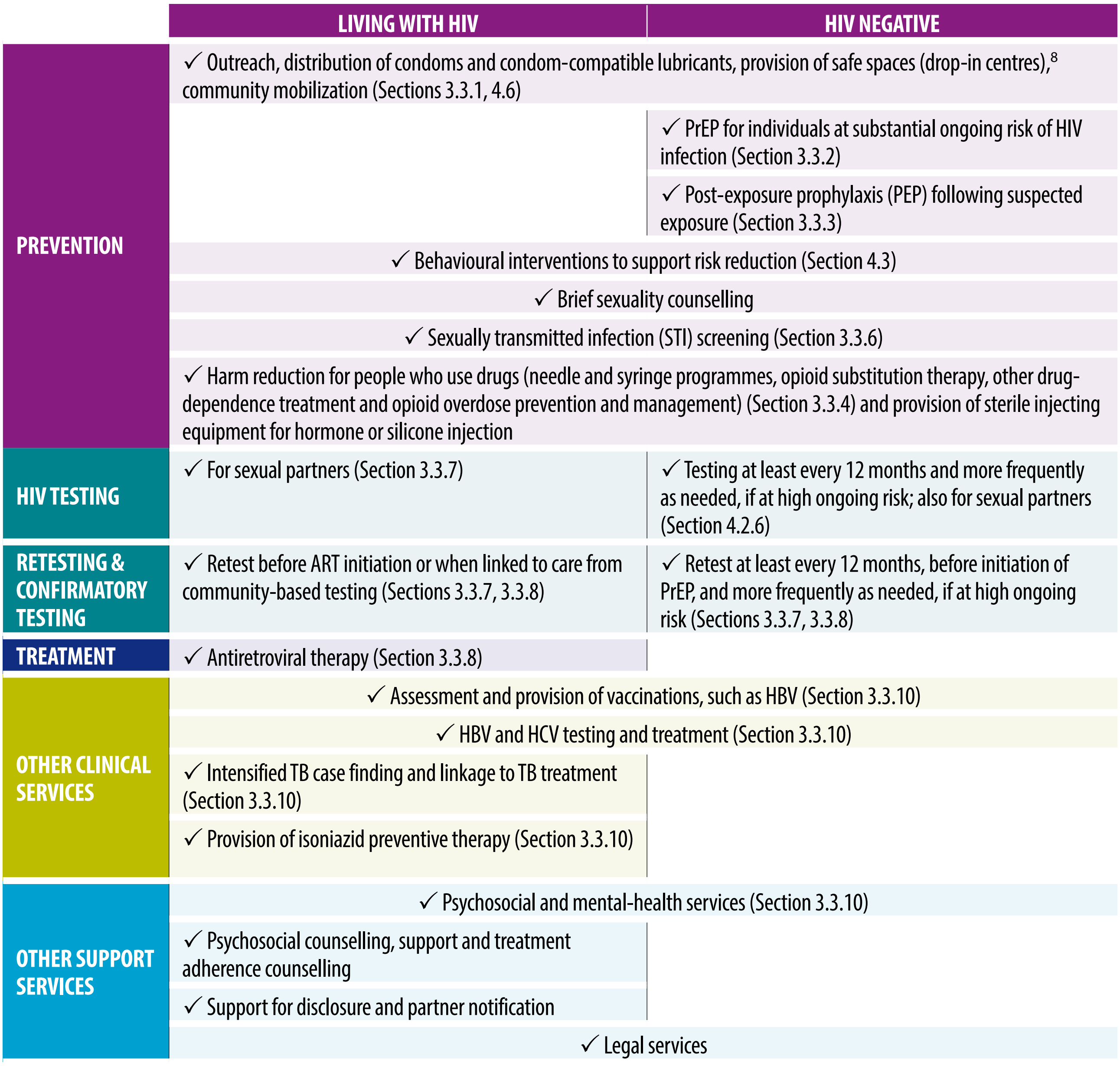
[7] Community, in most contexts in this tool, refers to populations of trans women or men, rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, "outreach to the community" means outreach to trans people, "community-led interventions" are interventions led by trans people, and "community members" are trans people.

3.3 HIV-related interventions and other essential health-sector interventions

The package of comprehensive HIV prevention, diagnosis, treatment and care services required to adequately address the HIV epidemic among trans people is depicted in Figure 3.3. To be effective, the prevention interventions should be combined with appropriate gender-affirming care in order to reach and retain trans people in HIV prevention, diagnosis, treatment and care services (see Section 3.2.3).

Figure 3.3 Blueprint of WHO-recommended package of prevention, diagnosis, treatment and care services for trans people



<table>
<tr><th></th><th>LIVING WITH HIV</th><th>HIV NEGATIVE</th></tr>
<tr><td rowspan="7">PREVENTION</td><td colspan="2">✓ Outreach, distribution of condoms and condom-compatible lubricants, provision of safe spaces (drop-in centres),[8] community mobilization (Sections 3.3.1, 4.6)</td></tr>
<tr><td></td><td>✓ PrEP for individuals at substantial ongoing risk of HIV infection (Section 3.3.2)</td></tr>
<tr><td></td><td>✓ Post-exposure prophylaxis (PEP) following suspected exposure (Section 3.3.3)</td></tr>
<tr><td colspan="2">✓ Behavioural interventions to support risk reduction (Section 4.3)</td></tr>
<tr><td colspan="2">✓ Brief sexuality counselling</td></tr>
<tr><td colspan="2">✓ Sexually transmitted infection (STI) screening (Section 3.3.6)</td></tr>
<tr><td colspan="2">✓ Harm reduction for people who use drugs (needle and syringe programmes, opioid substitution therapy, other drug-dependence treatment and opioid overdose prevention and management) (Section 3.3.4) and provision of sterile injecting equipment for hormone or silicone injection</td></tr>
<tr><td>HIV TESTING</td><td>✓ For sexual partners (Section 3.3.7)</td><td>✓ Testing at least every 12 months and more frequently as needed, if at high ongoing risk; also for sexual partners (Section 4.2.6)</td></tr>
<tr><td>RETESTING & CONFIRMATORY TESTING</td><td>✓ Retest before ART initiation or when linked to care from community-based testing (Sections 3.3.7, 3.3.8)</td><td>✓ Retest at least every 12 months, before initiation of PrEP, and more frequently as needed, if at high ongoing risk (Sections 3.3.7, 3.3.8)</td></tr>
<tr><td>TREATMENT</td><td>✓ Antiretroviral therapy (Section 3.3.8)</td><td></td></tr>
<tr><td rowspan="4">OTHER CLINICAL SERVICES</td><td colspan="2">✓ Assessment and provision of vaccinations, such as HBV (Section 3.3.10)</td></tr>
<tr><td colspan="2">✓ HBV and HCV testing and treatment (Section 3.3.10)</td></tr>
<tr><td>✓ Intensified TB case finding and linkage to TB treatment (Section 3.3.10)</td><td></td></tr>
<tr><td>✓ Provision of isoniazid preventive therapy (Section 3.3.10)</td><td></td></tr>
<tr><td rowspan="4">OTHER SUPPORT SERVICES</td><td colspan="2">✓ Psychosocial and mental-health services (Section 3.3.10)</td></tr>
<tr><td>✓ Psychosocial counselling, support and treatment adherence counselling</td><td></td></tr>
<tr><td>✓ Support for disclosure and partner notification</td><td></td></tr>
<tr><td colspan="2">✓ Legal services</td></tr>
</table>

Source: WHO, 2014; WHO, 2013; WHO, 2012; WHO, 2008.

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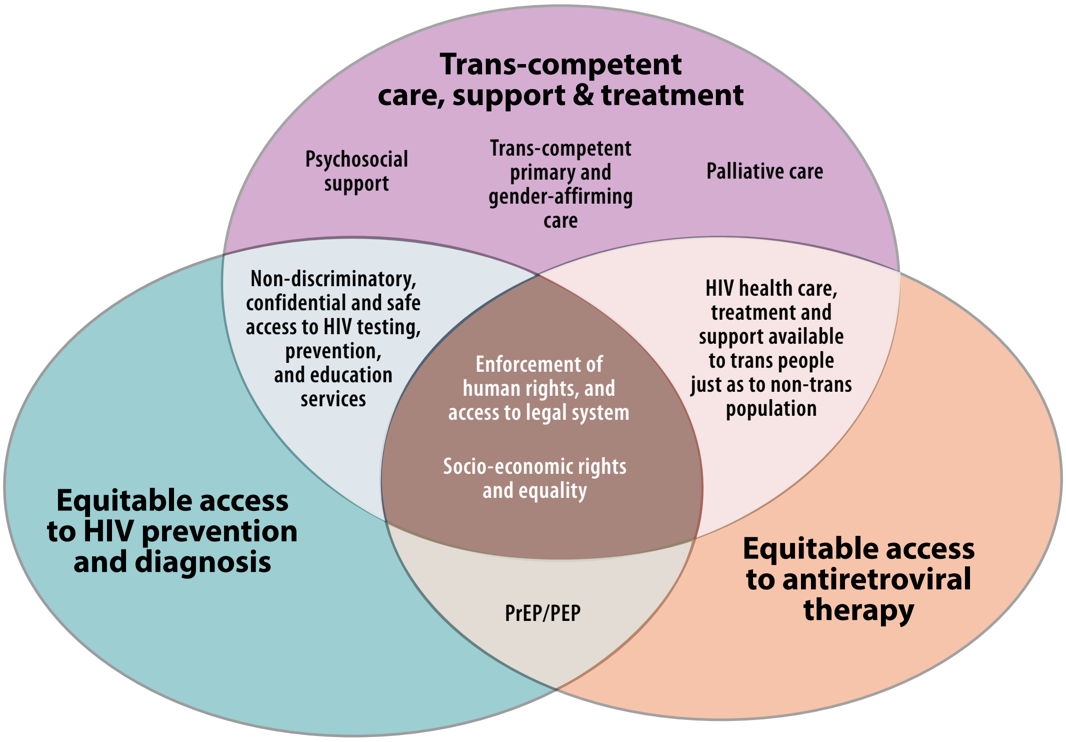
[8] A safe space (drop-in centre) is a place where trans people may gather to relax, meet other community members and hold social events, meetings or training. For more information, see Chapter 4, Section 4.6.

Trans populations living with HIV have the right to access the same care, support and treatment services that are available to the non-trans population. At the core of ensuring trans people have the care, support and treatment services they need is a legal system that ensures their socio-economic and human rights are not being violated (Figure 3.4). Care and support integrates palliative care that focuses on addressing pain, other symptoms and stress of serious illness, mental-health and psychosocial needs, and existential and spiritual support where relevant. Care and support services are needed from the point of diagnosis throughout the course of HIV-related illness, regardless of ability to access antiretroviral therapy. Care and support services are often delivered through community and home-based care, but can equally be provided in health facilities, at safe spaces (drop-in centres) or other locations (see Chapter 4, Section 4.6). These services are crucial to the well-being and survival of trans people living with HIV and their caregivers and families.

Treatment for HIV includes equitable access to ART. Providing treatment without also ensuring that it is available equitably, confidentially and without discrimination will decrease access and adherence.

Figure 3.4 Ecosystem of care, support and treatment



Box 3.5

Case example: Integrating clinical and community services in El Salvador

Community Centres of Integrated Prevention (CCPIs) were established in El Salvador with the support of the Global Fund to enable each segment of the lesbian, gay, bisexual, trans and intersex[9] (LGBTI) population to access comprehensive health care in a safe and affirming environment. The objective of CCPIs is to deliver comprehensive packages of basic services for HIV and STI prevention. Alongside HIV testing and other prevention and treatment services, they offer psychological counselling, general primary care, support in referral to health centres that provide ART, and also dispense condoms and lubricant.

The CCPIs have become hubs for peer health education, primarily for trans women. Psycho-emotional support groups for trans women that centre on discussing issues of feminization are facilitated at the centres or at other sites by community health educators who are affiliated with them. Gathering to discuss intimate issues related to enhancing one's feminine appearance and developing desired feminine aesthetics in a structured way has also served as an important intervention in harmful practices such as off-label use of hormonal medications or "do it yourself" beauty enhancement procedures such as self-injection with potentially dangerous silicone products.

By training and supporting community health workers who themselves are trans-identified, CCPIs also address issues relating to violence and domestic abuse that impact clients' risk for HIV and other STIs.

3.3.1 Condoms and lubricants

2014 Key Populations Consolidated Guidelines

ALL KEY POPULATIONS

The correct and consistent use of condoms with condom-compatible lubricants is recommended to prevent sexual transmission of HIV and STIs. *(p.26)*

TRANS PEOPLE

- Condoms and condom-compatible lubricants are recommended for penetrative sex.
- Adequate provision of lubricants for trans women and trans men who have sex with men needs emphasis. *(p.27)*

The supply, distribution and promotion of condoms and lubricants are core elements of HIV prevention among trans people, offering triple protection against HIV, STIs and unintended pregnancy. No other preventive intervention offers the same range of protection, and for many people, condoms and lubricant remain the most convenient and cost-effective choice. Within a sex-positive

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[9] An intersex person is one who born with sexual anatomy, reproductive organs or chromosome patterns that do not fit the typical definition of male or female, by contrast with a transgender person, who is usually born with a male or female body.

framework (i.e. affirming and non-judgemental of sex, sexuality and gender expression), condom and lubricant use is a means for trans individuals to exercise agency[10] in preventing transmission of HIV and STIs. While female condoms are not approved by WHO or UNFPA for use in anal intercourse, in practice, female condoms are used by some trans people to provide protection during anal sex. A variety of condoms with compatible lubricants should be made available to trans persons and their partners who engage in penetrative sex, particularly receptive anal intercourse given the increased risk for HIV and other STIs.

Lubricants are a feature of healthy, empowering and affirming sex lives for many individuals. Use of correct lubricant with condoms is essential and has been shown to decrease condom breakage rates from 21% to 3%. In the absence of affordable and accessible condom-compatible lubricants, some individuals may choose to use other types of lubricant (e.g. body lotion, soap, cooking oil) which can damage the condom. In order to prevent this, condom-compatible lubricants must go together with condoms in every aspect of programme planning and facilitation. Current advice discourages use of lubricants containing spermicides, medicinal or other active substances for trans persons.

Health-care workers should discuss effective use of condoms and lubricants with their clients. It is important for health-care workers to understand that sexual desirability can be gender-affirming for some trans people, and this may increase the likelihood that they will have sex without a condom to avoid rejection. In addition, some trans sex workers may have sex without a condom with their primary partners as a way to distinguish intimacy within their relationship from sex with their clients. Discussion should include the effect of hormone therapy on condom use and how to maintain safer-sex practices. For instance, trans women taking feminizing hormones may experience loss of erections and decreased tumescence, which can reduce condom use and increase slippage or breakage. Trans men taking masculinizing hormones may experience heightened sex drive leading to an increased number of sexual encounters.

For details of organizing and managing condom and lubricant promotion and distribution, see Chapter 4, Section 4.4.

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[10] Agency means the choice, control and power to act for oneself.

3.3.2 Pre-exposure prophylaxis (PrEP)

2015 ART and PrEP Guidelines[11]

Oral PrEP containing tenofovir disoproxil fumarate (TDF) should be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination HIV prevention approaches. *(p.42)*

Oral pre-exposure prophylaxis (PrEP) is the use of antiretroviral drugs by people who do not have HIV in order to protect themselves from acquiring HIV. PrEP has been documented to be an effective intervention among all populations at high risk for HIV.[12] WHO recommends offering PrEP to all population groups at substantial risk of HIV infection. Substantial risk is defined as population groups in which there is an HIV incidence greater than 3 per 100 person-years. Countries where there is high HIV incidence in certain geographical areas or in specific populations may therefore consider introducing PrEP as an additional HIV prevention option. In these high-incidence populations, programmes can use simple screening questions to identify, and then offer PrEP to, people who would benefit most from it.

Trans people who have sexual partners with undiagnosed or untreated HIV infection may be at substantial risk of acquiring HIV, depending on their sexual behaviours. They should have the same access to PrEP as non-trans people with substantial HIV risk.

Implementation considerations

WHO will publish comprehensive implementation guidance for PrEP in 2016. A brief summary is provided here.

Health-care providers should be trained and supported to explore sexual and injecting risk behaviour with trans clients and help them consider their risk of acquiring HIV infection, and the full range of available prevention options, including PrEP. A combination prevention approach to using PrEP includes HTS, condom and lubricant access, and management of other STIs. Service-providers should be aware of the emotional and physical trauma that may have been experienced by trans people at substantial risk of acquiring HIV.

PrEP may only be needed during periods of risk, rather than for life. Such periods of risk may begin and end with changes in relationship status, alcohol and drug use, leaving school, leaving home, trauma, migration or other events. PrEP can be discontinued if a person taking PrEP is no longer at risk, and is likely to remain not at risk.

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[11] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015.

[12] Liu A, Cohen S, Vittinghoff E, et al. Adherence, sexual behavior and HIV/STI incidence among men who have sex with men (MSM) and transgender women (TGW) in the US PrEP demonstration (Demo) project. 8th International AIDS Society Conference on HIV Pathogenesis, Treatment, and Prevention. Vancouver, July 19–22, 2015. AbstractTUAC0202.

HIV testing should be done before PrEP is offered and regularly while it is taken. It is essential to refer people who test HIV positive to HIV treatment and care services. Before starting PrEP, people should also be tested for hepatitis B infection and have their renal functions tested.

The most important way to support adherence to PrEP is to offer it as a choice. Support for adherence should include information that PrEP is highly effective when used and that consistent use requires that the medications be included in the individual's daily routine. People who start PrEP may report side-effects in the first few weeks of use. These can include nausea, abdominal cramping or headache and are typically mild and self-limited and do not require discontinuation of PrEP. People starting PrEP who are advised of this "start-up syndrome" may be more adherent. PrEP users should be advised that five to seven days of PrEP use are needed before achieving full protection for anal intercourse, and 20 days are needed before achieving full protection for vaginal intercourse. If an individual taking PrEP is also receiving hormone therapy, health-care providers should also monitor possible interactions between medications (see Section 3.3.9).

Trans-led organizations can play a significant role in reaching people at higher risk, informing them about PrEP availability as well as about when PrEP should be used, providing links to health-care services for those who are interested, and assuring adherence.

New WHO recommendations for treatment and PrEP are expected to facilitate the identification of people recently infected with HIV. Whenever possible, people in their social and sexual networks should be offered HIV testing, prevention and treatment services. PEP and PrEP should be considered, in combination with other prevention services, for HIV negative partners of recently diagnosed people.

3.3.3 Post-exposure prophylaxis (PEP)

2014 Key Populations Consolidated Guidelines

Post-exposure prophylaxis (PEP) should be available to all eligible people from key populations on a voluntary basis after possible exposure to HIV. *(p.51)*

Post-exposure prophylaxis (PEP) is the administration of antiretroviral medications to an individual as soon as possible after they have been exposed, or potentially exposed, to HIV in order to reduce the chance of becoming HIV positive. It is the only known way to reduce the risk of infection after exposure to HIV.

WHO Recommendations for PEP[13]

PEP should be offered to anyone exposed to bodily fluids of an individual who is HIV positive or has an unknown HIV status, including exposure through:

- any sexual exposure (condomless or condom broke)
- any splashes to the eye, nose or oral cavity
- any blood, bloodstained saliva, breast-milk or genital secretions.

PEP is not indicated when:

- the exposed individual is already infected with HIV or the source of exposure does not have an HIV infection
- the exposure was through non-bloodstained saliva, tears, urine or sweat
- the exposure occurred more than 72 hours prior.

Although PEP has been proven effective for occupational exposure, in other settings it may be less effective because of lower adherence to the prescribed course and delay in initiation post-exposure. Initiating PEP could be particularly difficult for trans persons who were exposed via sexual assault or occupational exposure through sex work, because of stigma and discrimination in the health and justice systems where they live.

PEP should be offered to all persons treated for sexual assault. Because of the prevalence of sexual violence perpetrated against trans women, health-care workers should ask any trans woman who seeks trauma-related care about her risk of HIV exposure. Trans people and community outreach workers[14] should receive education on PEP and know where it can be accessed in a timely, trans-competent manner.

Treatment regimen

PEP should be available to all individuals on a voluntary basis after possible HIV exposure. WHO recommends that PEP be initiated as soon as possible and within 72 hours of exposure. The duration of therapy should be 28 days. It is recommended that PrEP be initiated after the 28-day regimen of PEP if there is a risk of repeated exposure or a repeated PEP regimen.

HIV testing with informed consent and pre- and post-test counselling should be conducted. Follow-up HIV testing should also take place. Additional laboratory tests should be considered, including haemoglobin for zidovudine-containing PEP regimens, hepatitis B and C screening if available and based on the prevalence of the diseases. Counselling focused on adherence, side-effects and risk reduction

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[13] Guidelines on post-exposure prophylaxis for HIV and the use of co-trimoxazole prophylaxis for HIV-related infections among adults, adolescents and children: recommendations for a public health approach. December 2014 supplement to the 2013 consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization; 2014.

[14] A community outreach worker is a trans person who conducts outreach to other trans people, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called "staff outreach workers" or simply "outreach workers"). Community outreach workers may also be known by other terms, such as "peer educators". However, the terms "peer" or "community" should not be understood or used to imply that they are less qualified or less capable than staff outreach workers.

is important, as well as attention to psychosocial needs like mental-health services and issues of social support. It is essential that guidelines for confidentiality be strictly followed. Since research on the use of antiretroviral medications is evolving rapidly, it is recommended that programme developers consult WHO for the most recent guidelines. (See WHO 2015 *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection* and WHO *Post-exposure prophylaxis for HIV supplement*; and Sections 3.3.7 and 3.3.10.)

3.3.4 Harm reduction interventions

2014 Key Populations Consolidated Guidelines

ALL KEY POPULATIONS

- People who inject drugs should have access to sterile injecting equipment through needle and syringe programmes. *(p.31)*
- People who are dependent on opioids should be offered opioid substitution therapy (OST) in keeping with WHO guidance. *(p.34)*
- People with harmful alcohol or other substance use should have access to evidence-based brief psychosocial interventions involving assessment, specific feedback and advice. *(p.37)*
- People likely to witness an opioid overdose should have access to naloxone and be instructed in its use for emergency management of suspected opioid overdose. *(p.39)*

TRANS PEOPLE

- Trans people who inject substances for gender affirmation should use sterile injecting equipment and practise safe injecting practices to reduce the risk of infection with blood-borne pathogens such as HIV, viral hepatitis B and C. *(p.32)*
- There is no evidence of drug interactions between OST and medications used for gender affirmation; however, research is very limited. *(p.35)*

Harm reduction is a range of public-health policies and practices that aim to mitigate the consequences associated with certain behaviours. Harm reduction programmes for trans women who inject soft-tissue fillers, Botox or hormones (see below) can reduce adverse side-effects and lower the risk of infection. Similarly, harm reduction programmes for trans people who use drugs can prevent overdose, reduce the spread of infections like HIV and hepatitis C, promote safer-sex practices and reduce drug- and alcohol-related fatalities. Needle and syringe programmes and opioid substitution therapy are part of the comprehensive harm reduction package recommended in the 2014 Key Populations Consolidated Guidelines.

The gauge, size and shape of needles and syringes used for soft-tissue fillers, Botox, and hormones are different from those used to inject opioids. Needle and syringe programmes should be prepared to meet the needs for various types of syringes used by trans people. If the appropriate gauge of needle is not used the medication may not be administered properly and harm can result. Health-care workers and trans people should be trained on safe injecting practices, including the appropriate needle gauge, in order to reduce the likelihood of an improper injection. This is essential for anyone who takes medication via subcutaneous injection.

Trans women face multiple barriers to accessing appropriate gender transition services, and these make them more likely to self-medicate and self-inject without appropriate supervision, training, equipment or drugs and medications. The sections below provide information about the different substances and about risky practices that harm reduction programmes serving trans women should aim to prevent.

Soft-tissue fillers

Trans women who wish to feminize their bodies often seek hormonal treatments (estrogens and androgen blockers). The timeline for seeing effects from hormone therapy varies, but many of the changes, such as breast growth, can take an average of two years. For trans women who want to have more rapid changes, or for those who are unable to access transition care, the non-medical use of soft tissue fillers may be the only available option. Injectable fillers provide rapid and welcome physical changes and many trans women are willing to risk potential complications. Some will seek out soft-tissue filler injections, usually from an unlicensed or non-medical practitioner. Soft-tissue fillers, or silicones (dimethyl polysiloxane), are usually injected into the hips, buttocks, thighs, breasts, lips and face. The silicone is usually not medical grade and may be contaminated or mixed with sealants, baby or cooking oils or even concrete. The use of soft-tissue filler injections may be associated with several adverse outcomes, including blood-borne and tissue infections, granuloma formation, metabolic abnormalities, silicone migration, cosmetic defects, nodules and ulceration.

Some centres apply a harm reduction approach to soft-tissue fillers, where health-care workers provide clean needles, gloves and advice about aseptic technique to reduce injection site infections and refer to medical support where available. Clients should be advised against sharing needles or participating in pumping parties, where the risk of blood-borne contamination is greatest.

Botox

Another common augmentation is injecting Botox to remove fine lines and wrinkles. Unlike silicone injection, Botox can be administered by experienced health-care workers in some settings. Due to the expense, many trans women opt to have Botox injected informally, such as at a “Botox party”, where people inject one another with Botox without a licensed health-care worker or the medical equipment necessary to respond to complications or side-effects. If the injections are not placed correctly, eyelid droop, cockeyed eyebrows, crooked smile and dry or excessive tearing may result. Botulism-like signs and symptoms (muscle weakness all over the body, vision problems, trouble speaking or swallowing, trouble breathing, and loss of bladder control) are possible if the botulin toxin spreads to other parts of the body, but this is rare. If needles for the injection are shared between people the risk of blood-borne infection significantly increases. Health-care workers should discuss risks of injecting Botox without appropriate medical supervision or equipment and offer safer alternatives, like medical supervision or clean needles, to reduce side-effects and possible blood-borne infection.

Hormones

An additional source of injection risk for trans people is hormone injection. Trans people who cannot obtain hormones from a legitimate source may inject hormones from an alternate source. It is important that trans people have access to hormones and other gender-affirming health services from a competent health-care worker. Moreover, it is crucial that they have access to the items necessary to perform a safe injection, as with anyone who has an injectable medication.

Box 3.6

Case example: A self-injection workshop in the USA

Callen-Lorde Community Health Center in New York began offering self-injection education workshops in 2015 to support its more than 4,000 trans and gender non-conforming clients. The free Hormone Safe Self-Injection Workshops teach clients who are receiving injectable hormone therapy how to properly and safely inject their hormones at home. Each workshop lasts approximately 1–1.5 hours and is facilitated by a Patient Educator and taught by a Licensed Practical Nurse. Topics of discussion include step-by-step instructions for self-injection, education on the use of proper needle gauge, and the importance of hygiene and injection site rotation to prevent infection or irritation.

One of the most critical components of the workshops is to help clients alleviate their fears of needles and self-injection in a confidential and supportive environment. To address this, a flesh-like practice injection pad is employed in order to allow participants an opportunity to become more comfortable with the process before injecting themselves. Participants are also sent home with health education literature and a take-home practice kit.

The self-injection workshops have so far helped over 50 clients, and their frequency has been doubled in response to increasing demand. Results of pre- and post-workshops quizzes and feedback surveys demonstrate an overall increase in knowledge and confidence among participants as well as satisfaction with this style of teaching.

www.callen-lorde.org

Alcohol and substance use

2014 Key Populations Consolidated Guidelines

All key populations with harmful alcohol or other substance use should have access to evidence-based interventions, including brief psychosocial interventions involving assessment, specific feedback and advice. *(p.37)*

Substance use, violence and HIV are highly interconnected for trans women and have been shown to increase sexual risk behaviour and HIV infection, reduce adherence to anti-retroviral therapy and increase likelihood of having detectable viral loads. Trans people have higher rates of substance use than among the general population. This is associated with social prejudice, discriminatory laws and lack of access to trans-competent treatment for substance use.

Substance and alcohol use are linked to morbidity and mortality among trans people. The use of contaminated injecting equipment creates a significant risk of infection. Additionally, the use of alcohol and other substances often inhibits the capacity to negotiate or use preventative practices. Engaging in sex in order to access drugs or alcohol also increases the risk of infection. Box 3.7 describes some substance use screening tools that can help determine if further care and support are needed.

Box 3.7

Substance use screening tools

The **Alcohol Use Disorders Identification Test (AUDIT-C)** is a 10-question tool developed by WHO to screen for hazardous or harmful alcohol consumption: http://www.integration.samhsa.gov/AUDIT_screener_for_alcohol.pdf

The **mhGAP Intervention guide for mental, neurological and substance use disorders in non-specialized health settings** includes protocols for clinical decision-making: http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en

CAGE-AID is 5-question tool to screen for drug and alcohol use. If a person answers yes to two or more questions, a complete assessment is advised: http://www.integration.samhsa.gov/images/res/CAGEAID.pdf

The **Drug Abuse Screening Test (DAST-10)** is a 10-item yes/no self-report screening tool that takes less than 8 minutes to complete and can be used with adults and older youth: http://www.bu.edu/bniart/files/2012/04/DAST-10_Institute.pdf

Needle and syringe exchange programmes are cost-effective and are likely to increase primary health-care access and prevent other common infections. Providing needles and syringes, for example through an exchange programme, des not increase initiation, continuation or frequency of substance use.

Providers of OST should assess all medications clients are taking for potential drug interactions. If a trans woman is taking estrogen for feminization and also needs OST, health-care workers must consider the potential drug interactions. If the individual is HIV positive and is receiving ART, the health-care worker must also consider the potential interactions between the antiretrovirals and OST (see Section 3.3.9). See also the WHO *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence*.

3.3.5 Sexual and reproductive health

> *When providing sexual and reproductive health services to trans persons, it is important to mirror the terms that the individual uses to refer to their body and genitalia. Doing so helps to establish rapport, awareness and trust between the health-care worker and the trans individual.*
>
> *Primary Care Protocol for Transgender Patient Care*
>
> Center of Excellence for Transgender Health,
> University of California, San Francisco[15]

Sexual and reproductive health services are an essential component of basic health services that should be provided to all trans people as they are to all non-trans people. Trans people, like all

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[15] http://transhealth.ucsf.edu/trans?page=protocol-00-00.

people, should be able to make decisions regarding their sexual and reproductive health without discrimination, coercion or violence.

Disclosing one's gender identity is not the same as indicating one's physical anatomy, sexual history or fertility wishes. Moreover, gender identity and sexual behaviour can be fluid and may change and be redefined over time. Health-care workers must therefore refrain from making assumptions about trans people and the type of sexual activity they may be engaged in, and instead should work to develop a rapport for open discussion.

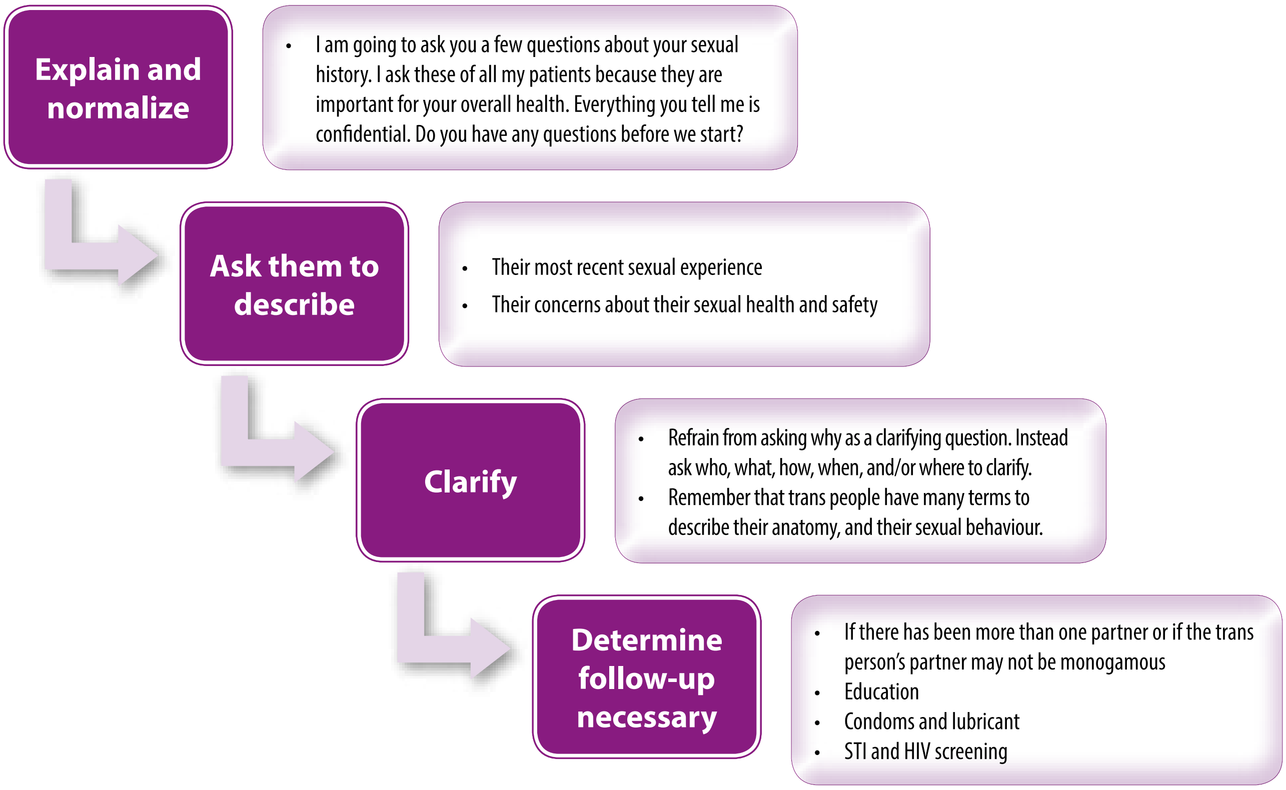
Sexual-health history

Taking a sexual-health history is an essential part of performing a sexual and reproductive health exam; it is particularly important when determining what parts of the body need to be screened for STIs, including HIV. When discussing sexual practices, health-care workers should ask open-ended questions and not make assumptions about the anatomy or sexual practices of their trans clients. It is essential to ask clarifying questions rather than guessing or assuming what the individual actually meant. At the same time, as with other clients, it is important to ask only those questions that are relevant to providing health care.

Any physical exam should be conducted in a respectful, private setting and only when necessary. In particular, genital examination and specimen collection can be uncomfortable or upsetting for trans people, regardless of genital reconstructive surgery. Health-care workers should mirror language that their trans client uses to describe themselves and their body. For instance, if a trans woman indicates that a partner has had anal penetrative sex with her, she may refer to that as vaginal sex. Health-care workers should ask clarifying questions in order to provide appropriate screening, but mirror their language and refer to it as vaginal sex. Speaking with a client about STIs and the symptoms associated with them can be difficult if the client is embarrassed about speaking openly about them. This barrier can often be overcome by explaining to the client that STIs are very common and that many are easily treated.

Sexual-health history-taking helps health-care workers identify symptoms of possible HIV and other STIs. Figure 3.5 outlines a basic assessment to determine what additional health services are needed. Trans people who report any symptoms or other symptoms associated with the ano-genital area during HTS should be referred for clinical management.

Figure 3.5 Sexual-health history taking



Explain and normalize

- I am going to ask you a few questions about your sexual history. I ask these of all my patients because they are important for your overall health. Everything you tell me is confidential. Do you have any questions before we start?

Ask them to describe

- Their most recent sexual experience
- Their concerns about their sexual health and safety

Clarify

- Refrain from asking why as a clarifying question. Instead ask who, what, how, when, and/or where to clarify.
- Remember that trans people have many terms to describe their anatomy, and their sexual behaviour.

Determine follow-up necessary

- If there has been more than one partner or if the trans person's partner may not be monogamous
- Education
- Condoms and lubricant
- STI and HIV screening

Fertility considerations

2014 Key Populations Consolidated Guidelines

It is important that contraceptive services are free, voluntary and non-coercive for all people from key populations. *(p.81)*

Trans persons have specific sexual- and reproductive-health (SRH) needs and concerns that health-care workers should be knowledgeable and sensitive about.

The basic steps in effective family planning and contraceptive counselling for trans individuals are:

- Provide counselling to determine the individual's desire to have biological offspring.
- Discuss available methods of contraception, including double methods of protection.
- Determine medical eligibility for the desired family planning method.
- Provide or prescribe the family planning method.
- Promote and provide condoms and lubricant.
- For individuals who are HIV positive, discuss the impact hormone therapy and hormone contraceptives may have on ART (see Section 3.3.9).

The following information should be provided so that trans individuals may make an informed, voluntary choice of contraceptive method(s):

- relative effectiveness of each method
- correct use
- how it works
- common side-effects
- health risks and benefits
- signs and symptoms that would necessitate a return to the clinic
- return to fertility after discontinuing the contraceptive method(s).

Some trans individuals might be less willing to negotiate using condoms or other contraceptive methods with their partners, in order not to disclose that they are trans or to affirm their gender identity. Thus they may need double methods of protection against pregnancy (for themselves or their partners) as well as against STIs and HIV (see Section 3.3.5).

Hormonal contraceptives

When providing SRH services for trans women, it is important to try to help them access appropriate gender-affirming treatment and warn of the higher risk of thrombosis from estrogens in oral contraceptives (ethinyl estradiol) compared to feminizing hormone therapy. Although estrogens may significantly reduce fertility, they may not prevent pregnancy. Fertility and contraception should therefore be discussed with trans women who retain their penis and testes and have unprotected sex with fertile non-trans women. Trans women who desire biological offspring should discuss their reproductive options, such as freezing and storing sperm, before starting feminizing hormone therapy since it is unclear whether viable sperm will be produced after estrogen is taken.

Trans men who have a uterus and ovaries can become pregnant when having vaginal intercourse, even when taking androgens. Trans men who desire pregnancy should be informed that testosterone reduces fertility, and it is unclear if full fertility returns when androgens are stopped. Before starting masculinizing hormone therapy, reproductive options, including egg retrieval and storage, should be discussed with trans men who desire biological offspring. Even though testosterone reduces fertility, it is not a contraceptive and trans men having unprotected sex with fertile non-trans men are at risk for pregnancy and STIs and should be screened and provided information about their contraceptive options.

Box 3.8

Case example: Focusing on health services for trans sex workers in New Zealand

The New Zealand Prostitutes' Collective's (NZPC) Ongoing Network Transgender Outreach Project (ONTOP) provides outreach to trans sex workers throughout New Zealand—both at their sex work venues and at NZPC's community centres. A peer-led project based on rights and empowerment, ONTOP includes HIV prevention and support for those living with HIV. The project provides weekly sexual and reproductive health clinics. These operate from NZPC community centres in collaboration with doctors and nurses from Sexual Health Services. Clinics are free and confidential, and where possible, only de-identified anonymous data are kept. Trans women, trans men and other gender-minority people can access hormones and receive medical check-ups, including testing for STIs and HIV.

Free safer-sex supplies are provided, along with peer support and information. ONTOP works with clinic staff to ensure that approaches are sensitive to the needs of trans people. ONTOP is also involved in formal training for third- and fourth-year medical students at Otago University. The project estimates that through the clinic and outreach they have contact with over 95% of trans people who are involved in sex work.

www.nzpc.org.nz

3.3.6 Sexually transmitted infections

2014 Key Populations Consolidated Guidelines

ALL KEY POPULATIONS

Screening, diagnosis, care, support and treatment of STIs are crucial parts of a comprehensive response to HIV; this includes services for key populations. STI management should be in accord with existing WHO guidance and be adapted to the national context. Also, it should be confidential and free from coercion, and patients must give informed consent for treatment.

Periodic screening of people from key populations for asymptomatic STIs is recommended.

In the absence of laboratory tests, symptomatic people from key populations should be managed syndromically in line with national STI management guidelines. *(p.79)*

TRANS PEOPLE

Health-care workers should be sensitive to and knowledgeable about the specific health needs of trans people. In particular, genital examination and specimen collection can be uncomfortable or upsetting whether or not the person has undergone genital reconstructive surgery. *(p.80)*

Screening

Clients with symptomatic STIs may be aware they are infected and are more likely to seek care. Regular screening for asymptomatic infections among trans people using laboratory tests is cost-effective given the high rates of STIs, and can reduce STI prevalence over time. It is therefore essential to invest in STI screening. Where laboratory diagnosis is available, laboratories should be staffed by qualified personnel with adequate training to perform technically demanding procedures, with quality assurance systems in place.

Absence of laboratory tests should not be a barrier to screening and treating trans people for STIs. A regular STI check-up is an opportunity to reinforce prevention and address other health needs. The check-up may consist of probing for symptoms of STIs and checking for signs of ano-genital infections, including anal, vaginal and proctoscopic examinations.

Box 3.9

STI treatment guidelines

WHO *Guidelines for the management of sexually transmitted infections* (2004, to be updated in 2016)

http://www.who.int/hiv/pub/sti/pub6/en

US Centers for Disease Control and Prevention, *Sexually transmitted disease treatment guidelines*, 2015.

http://www.cdc.gov/std/tg2015/default.htm

Even in high-income countries there are limitations both to diagnoses of STIs made through a clinical examination and those made through a laboratory test. While laboratory tests are often more accurate, they can be expensive, time-consuming and resource-intensive (i.e. laboratory tests, trained laboratory personnel etc.). The wait time sometimes involved to receive a diagnosis can delay treatment. With clinical diagnosis, STIs may be incorrectly identified, especially if the client has several infections.

In resource-limited settings where reliable STI testing is not readily available, WHO recommends a "syndromic" approach to manage infections that have physical symptoms. Syndromic case management focuses on the client's symptoms and addresses the possibility of co-infections. Treatment occurs with the initial assessment, following a flowchart designed to guide the health-care worker in making diagnostic and treatment decisions. Challenges commonly seen in resource-limited settings are minimized, as care is accessible.

Asking about symptoms and potential exposure should be standard practice during HIV testing sessions and during sexual-health history-taking.

3.3.7 HIV testing services

2015 WHO HIV Testing Services Guidelines[16]

HIV testing services should be routinely offered to all key populations in the community, in closed settings such as prisons and in facility-based settings. *(p.xxi)*

Community-based HIV testing services for key populations linked to prevention, treatment and care services are recommended, in addition to routine facility-based HIV testing services, in all settings. *(p.xxi)*

Lay providers who are trained and supervised to use rapid diagnostic tests can independently conduct safe and effective HIV testing services. *(p.44)*

Couples and partners should be offered HIV testing services with support for mutual disclosure. This applies also to couples and partners from key populations. *(p.67)*

Trans populations need access to high-quality voluntary HIV testing services (HTS). Given reluctance among trans populations in many countries to access government-sponsored HTS, it is very important that community options be available. The 2015 WHO *Consolidated guidelines on HIV testing services* recommend that a wider range of providers and models offer HTS. This includes endorsing trained lay community providers such as community outreach workers to offer all HTS, including collecting specimens, performing HIV rapid diagnostic tests, interpreting tests results and explaining the HIV status, giving pre-test information and post-test counselling, and supporting linkages to prevention, treatment and care services as needed (see *WHO policy brief on HIV testing: WHO recommends HIV testing by lay providers*).

Box 3.10

The range of HIV testing services

HIV testing services refers to the full range of services that should be provided together with HIV testing:

- counselling (pre-test information and post-test counselling)
- linkage to appropriate HIV prevention, treatment and care services and other clinical and support services
- coordination with laboratory services to support quality assurance and the delivery of correct results.

The WHO 5 Cs (Consent, Confidentiality, Counselling, Correct test results and Connection) are principles that apply to all models of HTS and in all circumstances.

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[16] Consolidated guidelines on HIV testing services. Geneva: WHO; 2015.

Box 3.11

Case example: Linking clinical and community-led services in Thailand

Sisters, a registered trans-led community organization, provides HIV, health and human-rights services to the trans woman community in Pattaya, Thailand. Sisters provides information on hormonal therapy including gender enhancement procedures as an entry point to increase uptake of HIV testing and STI screening services. The organization collaborates with owners of local nightclubs, beauty salons, live entertainment venues and other popular spots to organize mobile HTS in their spaces. HTS is also provided at the Sisters drop-in centre. Trained trans counsellors provide confidential pre- and post-test counselling, and rapid HIV testing from venous and finger-prick blood samples are administered by certified trans counsellors, a professional nurse and a lab technician. Those who test HIV positive are referred to local health-care and social-welfare facilities for care, support and treatment services.

In 2015, 154 trans women received mobile on-site HTS and 435 received community-led HTS at the Sisters drop-in centre. By making access to health information and services more convenient, Sisters has also helped greater numbers of trans women seek medical care in Sisters partner clinics.

HIV self-testing options, where trans populations have access to a self-administered rapid screening test through an NGO, community-led organization or pharmacy are increasingly available.

Box 3.12

Case example: Self-testing in China

Guangzhou Tongzhi (GZTZ), with support from the Guangzhou Centre for Disease Control and Prevention, operates HIV testing services in five cities in southern China. GZTZ also runs the website GZTZ.org. It is China's first and best-known website for trans people and men who have sex with men and the most widely used to provide health education and to conduct surveys among these communities. Since 2014, GZTZ has provided support for HIV self-testing by sending HIV self-test kits to clients and providing online support and information, pre-test information and post-test counselling, referrals for further HIV testing and diagnosis and information on where and how to seek additional support services.

In five months GZTZ sold 199 HIV self-test kits to users in Guangdong province for US$23, including a US$16 deposit refundable following submission of feedback after self-testing. Of the 199 purchasers, 174 submitted feedback online. Of these, four reported having a reactive test result and six individuals, who might not have done so otherwise, sought follow-up care at a GZTZ facility.

Source: Consolidated guidelines on HIV testing services. Geneva: WHO; 2015.

Providers of HTS have a crucial role in ensuring linkage to care for people diagnosed with an HIV infection. Prompt linkage to HIV treatment and care is ideal and should be encouraged. However, many people do not link to treatment and care. Often, people need time to accept the diagnosis and seek support from partners and families before linking to care, and others cycle in and out of care. Systematic reviews and several studies describe practices, listed in Box 3.13, that may improve linkage to treatment and care of people who have received an HIV diagnosis.

Box 3.13

Good practices in linking HIV positive clients to treatment and care

- **Integrated services**, where HIV testing, HIV prevention, diagnosis, treatment and care, TB and STI screening and other relevant services are provided together at a single facility or site
- Providing **on-site or immediate CD4 testing with same-day results**
- Providing assistance with transport, such as **transportation vouchers**, if the antiretroviral therapy site is far from the HTS site
- **Decentralized antiretroviral therapy provision** and community-based distribution of ART
- Support and involvement of **trained lay providers** who are trans community members and act as peer navigators (see Chapter 4, Section 4.2.2) to provide support and to identify and reach people lost to follow-up
- **Comprehensive home-based HIV testing**, which includes offering home assessment and home-based ART initiation. This is also referred to as self-testing
- **Intensified post-test counselling** by community health workers
- Using communication technologies, such as **mobile phones and text messaging**, which may help with disclosure, adherence and retention, particularly for adolescents and young people
- Providing **brief strengths-based case management** which:
  - emphasizes people's self-determination and strengths
  - is client-led and focuses on future outcomes
  - helps clients set and accomplish goals, establishes good working relationships among the client, the health worker and other sources of support in the community
  - provides services outside an office setting.
- **Promoting partner testing** may increase rates of HIV testing and linkage to care.
- **Intimate partner notification** by the provider, with permission, is feasible in some settings; it identifies more HIV positive people and promotes their early referral to care.

3.3.8 HIV treatment and care

2015 ART and PrEP Guidelines

Antiretroviral therapy should be initiated among all adults with HIV regardless of WHO clinical stage and at any CD4 cell count.

As a priority, ART should be initiated among all adults with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and adults with CD4 count ≤350 cells/mm^3. *(p.24)*

Antiretroviral therapy (ART) is the principal component in the recommended package of services for HIV prevention, diagnosis, treatment and care. Early and effective ART has tremendous potential for preventing HIV transmission by reducing the individual's viral load and affecting community viral load.

For people living with HIV, there is a direct connection between an inclusive and supportive environment and better adherence to ART, and subsequently a lower viral load (see Section 3.3.10). Gender identity, sex assigned at birth, and sexual orientation have no effect on the efficacy of antiretroviral therapy. It should be provided and administered to trans persons as it is for all other persons. (See WHO *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*, 2015.) Training for antiretroviral therapy providers should follow up-to-date, national and international standards. For general guidelines on training staff to provide ART to trans people and how to tailor ART service delivery to make it more accessible and acceptable to trans people, see Box 3.2. WHO guidance is regularly updated to reflect changes in eligibility criteria, preferred ART regimens and monitoring approaches, and providers are encouraged to check the WHO website regularly.

Specific considerations for trans clients and ART

Like many people, trans people may have fears and concerns about ART, in particular whether the medications can interfere with hormone therapy. Knowledge of the current community understanding of ART is imperative to address concerns, fears or misconceptions with accurate and appropriate information. Counselling should include why it is beneficial to initiate ART before feeling unwell or having symptoms. The role of adherence in maintaining a suppressed viral load to support good health, prevent treatment failure and reduce the risk of HIV transmission should be fully discussed. This should not happen exclusively after HIV is diagnosed, but regularly throughout the trans person's treatment and care. Concerns about hormone therapy in relation to ART should also be addressed directly (see Section 3.3.9).

3.3.9 HIV and hormonal therapy

Qualitative data suggest that hormone therapy is of a greater priority to trans people than HIV treatment and care.[17] HIV infection and ART are not contraindications for the use of hormone therapy.

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[17] Schneiders M. Values and preferences of transgender people: a qualitative study. Geneva: World Health Organization; 2014 (an annex to the 2014 WHO Key Populations Consolidated Guidelines). http://apps.who.int/iris/bitstream/10665/128119/1/WHO_HIV_2014.21_eng.pdf?ua=1.

In fact, integrating hormone therapy into HIV services may optimize antiretroviral adherence, and therefore it may be beneficial that the two be integrated.

Viral load should be closely monitored for potential drug interactions, particularly when other medications are added, modified or discontinued. Withholding hormone therapy is likely to cause the trans person to seek hormones from underground sources and self-administer them (see Section 3.3.4). While monitoring for drug interactions is important, it is just as critical to ensure that all health concerns are prioritized according to the client's changing health needs.

Antiretroviral drugs may interact with the hormones found in oral contraceptives (ethinyl estradiol particularly) which trans women often use for feminization, especially where safer formulations of estrogen (17-β estradiol) are unavailable or more expensive. These interactions have the potential to alter the safety and effectiveness of either drug. In particular, when ethinyl estradiol is used in combination with ARV drugs there may be an increased risk of blood clots. However, 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.

Most interactions between oral contraceptives and ARV drugs decrease the blood levels of estradiol but not of ARVs. Starting, stopping or changing ART regimens may lead to hormonal fluctuations among trans women taking gender-affirming medications; therefore, close monitoring is recommended.

There are limited data on the interactions between ARVs and other drugs that trans women use in feminizing hormone therapy, particularly anti-androgens (for example, cyproterone acetate or flutamide). The same is true for androgens (for example, dihydrotestosterone) commonly used by trans men. Currently, there are no documented drug interactions between these medications and ARVs. However, more research is needed.

Self-medication with products and doses that are not recommended is common, and health-care providers should be aware of such self-medication, alert clients to possible risks and monitor potential side-effects.

3.3.10 Prevention and management of co-infections and co-morbidities

Viral hepatitis

2014 Key Populations Consolidated Guidelines

People from key populations should have the same access to viral hepatitis B and C prevention, vaccination, screening and treatment services as other populations at risk of or living with HIV. *(p.73)*

Catch-up Hepatitis B immunization strategies should be instituted where infant immunization has not reached full coverage. *(p.74)*

When treating viral hepatitis among trans people taking hormones for gender affirmation, it is important to screen for interactions between hormone therapy and hepatitis medications. Due to the more rapid progression of hepatitis-related liver diseases in people infected with HIV, treatment for hepatitis and HIV should be prioritized in people who are co-infected.

WHO has published *Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection* (2015), *Guidelines for the screening, care and treatment of persons with hepatitis C infection* (2014) and *Guidance on prevention of viral hepatitis B and C among people who inject drugs* (2012).

Hepatitis B virus (HBV) is transmitted by contact with the blood or other body fluids of an infected person. Sexual contact and injecting drug use can also transmit the virus. Risky sexual practices and sex work are associated with HBV infection in different regions of the world. Fortunately, a cheap, safe and effective vaccine against HBV is available. People newly diagnosed with HIV should be screened for HBV and if not immune should receive the full course of HBV vaccination. For people co-infected with HBV and HIV and who have severe chronic liver disease, ART should be offered with a tenofovir (TDF) and lamivudine (3TC) or emtricitabine (FTC)-based regimen. The 2015 WHO HBV Guidelines recommend tenofovir or other HBV active antivirals with a high barrier to resistance for those with cirrhosis or high viral loads.

Hepatitis C virus (HCV) is also transmitted through contact with the blood or other body fluids of an infected person. Most HCV infections occur through the use of contaminated injection equipment among persons who inject drugs or in medical settings. HCV can also be transmitted by sexual contact, especially anal sex among HIV positive persons, although a small number of cases have also been reported through sex between HIV negative persons. There is no vaccine to prevent HCV infection, but for most people, chronic HCV can be cured with new oral treatment regimens. The current standard treatment is combination antiviral therapy of pegylated interferon and ribavirin. New WHO guidelines include inteferon-free treatment regimens. New antiviral drugs, which are more effective, safer and better-tolerated, have been developed and are known as oral directly acting antiviral agent (DAA) therapies, but these are currently only available in in a limited number of countries and at very high prices. Service-providers are encouraged to refer to the most recent WHO guidance.

People newly diagnosed with HIV should be screened for HCV. For those co-infected with HIV and HCV, prioritization of treatment should be evaluated based on the most recent WHO ARV and HCV guidance. Special consideration to the type of antiretroviral treatment for HIV should be given to ensure compatibility with the HCV antiviral treatment.

Infection with hepatitis A virus (HAV) commonly occurs when a person eats or drinks contaminated food or water. However, HAV is also found in the faeces of someone infected with the virus and can be sexually transmitted through activities such as oral–anal sex (rimming). HAV infection, unlike HBV and HCV, does not cause chronic liver disease and is rarely fatal, but it can cause debilitating symptoms and acute liver failure, which is associated with high mortality.

Attention to personal hygiene, such as careful hand-washing and the washing of genital and anal areas before sex, can decrease the risk of infection with HAV. The use of condoms or dental dams should be encouraged as they can also decrease transmission. There is no specific treatment for the virus once a person is infected. Treatment is aimed at maintaining comfort and adequate nutritional balance, including replacement of fluids lost from vomiting and diarrhoea. There is a vaccine for HAV, and a combination HAV and HBV vaccine is available.

Tuberculosis

WHO HIV and TB Recommendations

ALL KEY POPULATIONS

People from key populations should have the same access to TB prevention, screening and treatment services as other populations at risk of or living with HIV. *(2014 Key Populations Consolidated Guidelines, p.69)*

TRANS PEOPLE[18]

All trans persons living with HIV should be regularly screened for TB using a clinical algorithm.

The screen should contain all four of the following symptoms: cough, fever, night sweats and weight loss at a minimum.

All TB clients who have HIV or live in high-prevalence areas should receive the recommended treatment regimen for TB in addition to prevention, diagnosis, care, support and treatment for HIV.

HIV infection presents a serious challenge for controlling tuberculosis (TB). TB is the leading preventable cause of death among people living with HIV. Risk factors for developing TB include HIV, diabetes, injecting drug use, alcohol use, smoking, previous or current incarceration, and poverty.

To maximize every opportunity and entry point for the delivery of comprehensive health-care services, all trans persons living with HIV should be regularly screened for TB. WHO recommends the use of a simple evidence-based screening algorithm that relies on clinical symptoms (current cough, fever, weight loss or night sweats). If the client does not have any of these symptoms, they should be offered treatment for latent TB infection (e.g. with Isoniazid), while those with one or more symptoms should be investigated for TB or other diseases. Similarly, trans people entering the health system for TB treatment and care should be offered HIV testing, prevention and care services.

All clients who have TB and HIV should receive the recommended treatment regimen for TB. If they are not already receiving ART, they should do so as soon as possible, and within 8 weeks of the start of TB treatment. Trans people should be offered the same assessment, treatment and care of HIV-associated TB as that provided to the non-trans population.

National coordinating bodies at all levels of the health system are needed to ensure strong and effective collaboration between HIV programmes and TB-control programmes. The national coordination should be based on clear consensus developed through collaboration with stakeholders and those at risk and affected by HIV and TB. Of those involved in the national consensus-building, trans populations should be broadly represented. Addressing HIV and TB requires strategic planning that is not only collaborative but also systematically scaled up to deliver HIV and

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[18] Based on: WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders. Geneva: World Health Organization; 2012. (p.22)

TB care simultaneously to those at risk and affected by HIV and TB (see WHO *Policy on collaborative TB/HIV activities*).

Violence

The link between violence and HIV is well documented (see Chapter 2). Health services, including HIV interventions, serve as an entry point for identifying and responding to experiences of violence and trauma (see also the section below on trauma). Training health-care workers who provide HIV services on sexual and gender-based violence, and vice versa, is an effective way to address both HIV and risks related to violence and abuse. Those providing primary care, broader sexual-health services, and harm reduction and psychosocial support can be similarly trained.

All clinics offering services to trans people should screen for violence in order to offer relevant support. Providers should be especially aware of intimate partner violence and familial violence, or violence encountered through sex work (see Chapter 2, Section 2.2). Health-care workers who address trans people's violence-related injuries should facilitate their access to PEP, treatment and care for HIV and other STIs, ano-genital pain, unintended pregnancy and injection-related injuries. Referrals to legal services, where available and accessible, can also be made.

Box 3.14

Case example: Screening for violence against trans people: a pilot project in Mexico and Thailand

In 2007–2008, USAID implemented a pilot project that developed a screening tool for service-providers in HIV clinics to identify violence experienced by trans people and men who have sex with men. Screening was integrated into HIV clinical services, including HTS and treatment programmes, in Pattaya City, Thailand and in Puerto Vallarta, Mexico and Mexico state. In Thailand, screening also was integrated into community drop-in services, which include HTS and outreach for trans people and men who have sex with men.

In Mexico, 65% of trans people screened had experienced violence in the prior year, while in Thailand the figure was 89%. Emotional violence was most common in Thailand (78% among trans people), and sexual violence was most common in Mexico (65% among trans people). Sexual violence was more common than other physical violence in almost all groups.

The screening tool helped providers improve communication and trust with clients and identify the range of social vulnerabilities they faced. Providers recommended training on counselling to use with survivors of violence and training on sexual diversity, as well as referral services that cover all needs of trans people and men who have sex with men, such as legal services and shelters. Overall, providers saw the tool as beneficial to their work and agreed that screening should continue, provided there is institutional support, training, and adequate time and space.

Source: Egremy G, Betron M, Eckman A. Identifying violence against most-at-risk populations: a focus on MSM and transgenders. Training manual for health providers. Washington (DC): Futures Group, Health Policy Initiative, Task Order 1; 2009.

Mental and psychosocial health

2014 Key Population Consolidated Guidelines

Routine screening and management of mental-health disorders (particularly depression and psychosocial stress) should be provided for people from key populations living with HIV in order to optimize health outcomes and adherence to ART. *(p.76)*

WHO defines mental health as "a state of well-being in which the individual realizes their abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community". In order for trans people to achieve this, they need access to mental-health services that respect their gender identity and do not consider it a mental illness.

There is increasing recognition that being trans is not a mental-health disorder but an identity that requires clinical competency, sensitivity and affirmation. Greater support of trans people from individuals, family and peers, as well as their own pride in their identity, may also be predictive of resilience and better health outcomes. Health-care workers and psychosocial care-providers should encourage familial and peer support and acceptance.

Trans people experience a range of risks to their psychological well-being because of transphobia.[19] Psychotherapy can facilitate mental health and HIV risk reduction, but the trans community has a complex relationship with the field of psychotherapy. In many countries, trans people are often required to undergo evaluation by a mental-health professional in order to gain access to feminizing or masculinizing therapies and surgeries. This requirement can make clients mistrustful of their health-care providers. However, trans-competent treatment of common mental-health concerns like depression or anxiety can lead to their resolution, increased comfort with the individual's gender identity, and less HIV risk-taking.

The health-care worker should screen all clients for psychosocial conditions, including substance use (see Section 3.3.4). Psychosocial health is broad, and this tool focuses on some of the most common issues among trans people: trauma, depression and anxiety, and minority stress. Although there is no replacement for a thorough clinical evaluation, the scales and questions described in the following sections may be used as tools to facilitate dialogue between health-care workers and trans people.

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[19] Transphobia is prejudice directed at trans people because of their actual or perceived gender identity or expression. Transphobia can be structural, i.e. manifested in policies, laws and socio-economic arrangements that discriminate against trans people. It can be societal when trans people are rejected or mistreated by others. Transphobia can also be internalized, when trans people accept and reflect such prejudicial attitudes about themselves or other trans people. For more information, see Chapter 2.

Box 3.15

Case example: Approaches to overcome stigma and raise awareness of trans mental health in Australia

The Australian National LGBTI Health Alliance's MindOUT! LGBTI Mental Health and Suicide Prevention project facilitates activities to make the mental-health sector more inclusive, including providing online professional development and webinars for mental-health professionals. This includes topics that focus specifically on understanding and working therapeutically with trans and gender non-binary people, and the needs of young people who are seeking support while in the process of gender alignment or transitioning. Additionally, MindOUT! works intensively with organizations in the mental-health and suicide prevention sector to increase inclusive and accessible practices that support psychosocial well-being for LGBTI people, and to eliminate stigma associated with gender, sexuality and intersex variance which impacts their ability to access mental-health services.

www.lgbtihealth.org.au/mindout

The Australian organization beyondblue promotes good mental health, tackles stigma and discrimination, and provides support and information on anxiety, depression and suicide. To raise awareness on stigma directed against LGBTI people and the impact it has on their mental health, the organization launched the *Stop Think Respect* campaign through web-based videos and posters, making an analogy between the abuse and stigma LGBTI people face and the former stigmatization of left-handed people.

http://resources.beyondblue.org.au/prism/file?token=BL/1397

Box 3.16

Case example: Collaborating to increase access to psychological care for trans people in South Africa

The Social, Health and Empowerment Feminist Collective of Transgender Women in Africa (S.H.E.) was founded in 2010 to advocate for the rights of African trans women and is the focal point for local (provincial) programming for trans health, including HIV. The organization applied to refer its clients to the Cecilia Makhiwane Hospital's psychology unit for psychological support services, but the head of department turned S.H.E. away because the unit was stretched beyond capacity by the general public. After persistent advocacy initiatives with the South African Commission for Gender Equality, the commission's legal officer contacted the Eastern Cape Department of Health, which acknowledged the issue of trans clients' access to health services. Since 2014 S.H.E. has been able to refer clients to the psychology unit.

S.H.E. has developed good working relationships with the commission and the psychology unit and trains psychologists and social workers at the unit in how to create safe spaces for trans persons. Discussions have begun on developing a memorandum of understanding between S.H.E. and the psychology unit. S.H.E. is currently developing a health protocol for trans people in the Eastern Cape and asked the psychological unit to give input on the mental-health section of the protocol.

www.transfeminists.org

Trauma

Trans people, especially those living in poverty, commonly experience verbal, physical or emotional trauma. Anyone who indicates a traumatic experience—whether through physical violence, sexual violence or psychological victimization—should be assessed for post-traumatic stress disorder, as well as other anxiety disorders. This is true whether the trauma occurred recently or in the past. The screening tool below can evaluate a trans person, either as part of standard intake forms or as a discussion with the health-care worker. In only a few minutes a health-care provider will have additional information to determine if a person is in need of further evaluation or resources from a trans-competent provider.

Box 3.17

The Primary Care Post-Traumatic Stress Disorder Screen (PC-PTSD)

If a client answers "yes" to any three items they should be further assessed for PTSD.

In your life, have you ever had any experience that was so frightening, horrible or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
3. Were constantly on guard, watchful or easily startled?
4. Felt numb or detached from others, activities or your surroundings?

Depression and anxiety

Depression and anxiety are highly prevalent in trans populations, and often co-exist, creating intense psychological and emotional suffering. Depression is associated with poorer health outcomes, reduced adherence to ART, poor retention in care, substance use and sexual risk-taking. It is very important that facility- or community-based caregivers screen for mental-health symptoms, provide care and counselling, and refer for further help or treatment where symptoms are identified. Box 3.18 lists tools that can be used to quickly screen for depression and anxiety among trans persons during routine health visits or following trauma.

Box 3.18

Screening tools for depression and anxiety

The **Primary Care Depression Tool Kit** was designed to help primary-care providers:

- recognize and diagnose depression;
- educate the client about depression, treatment and care;
- select an appropriate approach for treating depression;
- monitor compliance and modify as needed to improve symptoms and function.

The toolkit is available at:
http://www.integration.samhsa.gov/clinical-practice/macarthur_depression_toolkit.pdf

The **Patient Health Questionnaire (PHQ-9)** is a brief assessment for depression and is available at:
http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf

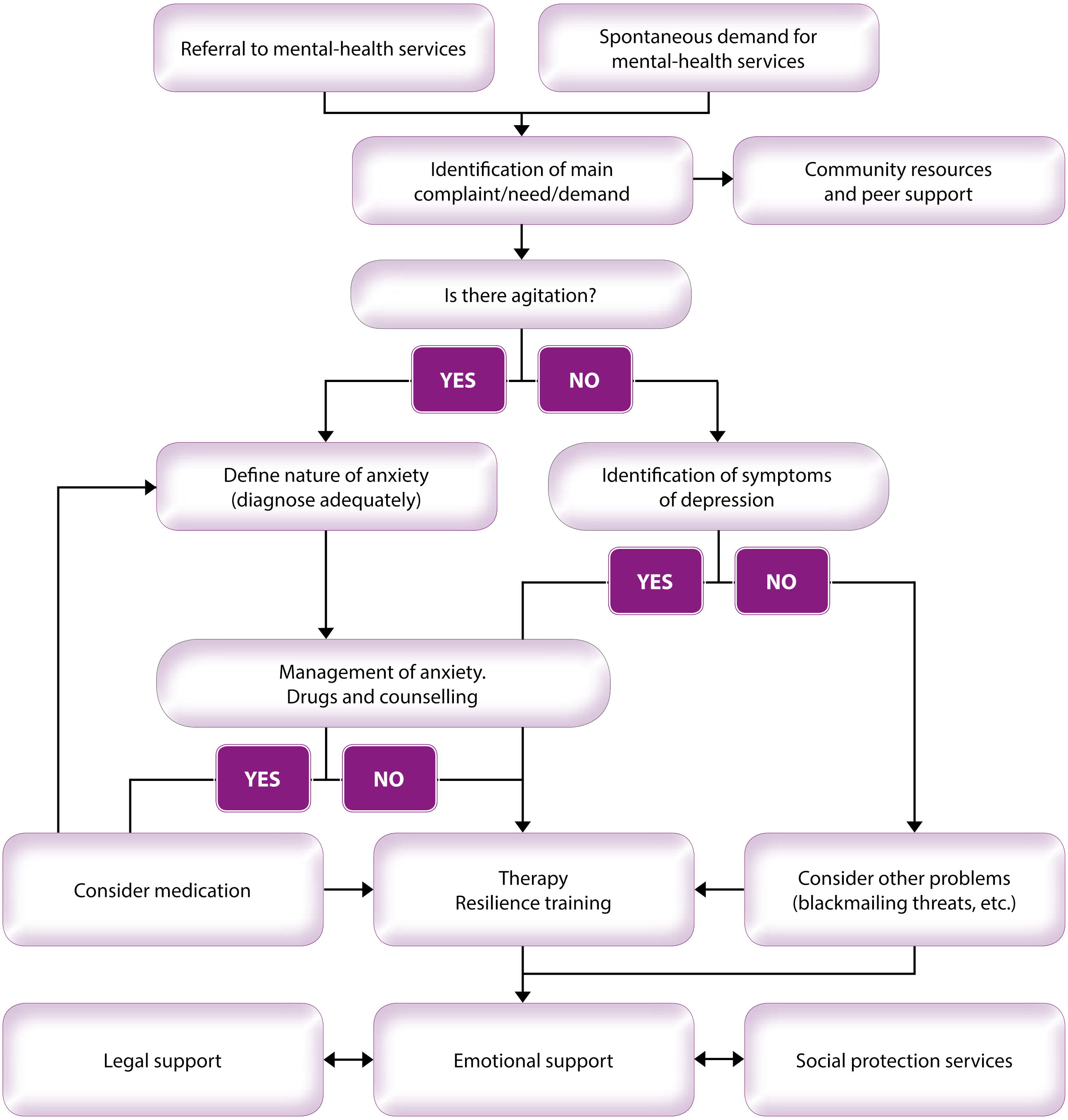
The **Generalized Anxiety Disorder (GAD-7)** is a seven-question general screening tool that identifies whether a complete assessment for anxiety is indicated. It is available at:
http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf

The **Beck Anxiety Inventory (BAI)** is a well-accepted self-report inventory to measure the severity of anxiety in adults and adolescents. It is available at:
http://www.pearsonclinical.com/psychology/products/100000251/beck-anxiety-inventory-bai.html

Minority stress

Minority stress theory suggests that higher rates of mental disorders are the result of hostile and stressful social environments that may be infused with transphobia. Minority stress is suffered in addition to the general stress experienced by everyone, and is reinforced institutionally, structurally and socially. This stress can contribute to increased HIV risk-taking and a higher lifetime prevalence of depression, anxiety, low-self esteem, self-harm, suicidal ideation and suicide attempts. Figure 3.6 shows a model that may be useful in managing and responding to minority stress in trans individuals and communities.

Figure 3.6 Management of minority stress



Source: Blueprint for the provision of comprehensive care for trans persons and their communities in the Caribbean and other Anglophone countries. Arlington (VA): John Snow, Inc.; 2014.

3.4 Resources and further reading

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International

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USA

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Latin America

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TB

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4

Service Delivery Approaches


Community mobilization and structural interventions
2 Stigma, Discrimination, Violence & Human Rights
5 Programme Management
1 Community Empowerment
3 Services
Starting, managing, monitoring and scaling up a programme
4 Service Delivery Approaches
Approaches to improving the continuum of HIV and STI prevention, diagnosis, treatment and care

What's in this chapter?

This chapter explains:

- how to deliver clinical services appropriately (Section 4.2)
- how to design and implement trans-specific behavioural interventions, and how to adapt other HIV programmes for trans populations (Section 4.3)
- trans-specific condom and lubricant programming (Section 4.4)
- community empowerment and engagement (Section 4.5)
- how to create and maximize use of safe spaces (Section 4.6)
- how to use information and communication technology for programming (Section 4.7).

The chapter also includes a list of resources and further reading (Section 4.9).

4.1 Introduction

The comprehensive package of interventions presented in this tool includes health interventions common to all trans individuals and specific to trans women. Most of these interventions are the same HIV prevention, diagnosis, treatment and care interventions as for the general population. Chapter 3 discusses the particular health concerns of trans populations and how these are addressed though clinical health-care services. However, there are often complex challenges and barriers to implementation and delivery of these services. Some of these challenges relate to the multiple concurrent factors that impact the health of trans populations, including psychosocial stressors, substance use, violence and victimization, discrimination, familial rejection, social isolation and economic hardship (see Chapter 2 for further information). Other challenges relate to the scarcity of clinical services designed specifically for trans people which could serve as models for service delivery. It is therefore often necessary to adapt behavioural interventions designed for the general population or other key populations in order to meet the unique needs of trans individuals. Programme adaptations must be executed with particular attention to the needs of the trans community[1] to ensure that services are truly appropriate, accessible and acceptable to them, as well as affordable and equitable.

Programmes need to address these challenges and barriers to provide sustainable HIV services for diagnosis, linkage, retention and adherence. Multicomponent interventions are required to respond to these complex interacting factors. In addition to sexual-health services, it is important to provide linkages to substance use treatment, psychosocial care, housing, legal and educational services. It is equally important to publicize these services at the community level in order to reach trans individuals who may feel disconnected from general health-care services within mainstream public-health systems.

This chapter presents some of these challenges and discusses approaches to overcoming them, especially by engaging the community in the delivery of services. By linking clinical services to formal and informal community-led activities, it is possible to expand the reach of HIV prevention programmes to individuals who are marginalized and underserved.

It is critical that trans community members are involved in every aspect of programme design and implementation to ensure that strategies are relevant and meaningful to them. This is particularly important when the implementing organization[2] is not trans-led or does not have significant trans representation on its staff. There is no "one size fits all" approach, but the general principles described in this section can be universally applied.

HIV prevention, diagnosis, treatment and care interventions are more effective and sustainable when conducted within an empowerment framework. This enables trans individuals and communities to address structural constraints to health, human rights and well-being; make social,

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[1] In most contexts in this tool, "community" refers to populations of trans women or men, rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, "outreach to the community" means outreach to trans people, "community-led interventions" are interventions led by trans people, and "community members" are trans people.

[2] An implementing organization is an organization delivering an intervention to trans people with a client-centred approach. It may be a governmental, non-governmental, community-based or community-led organization, and may work at a state, provincial, district or local level. Sometimes a non-governmental organization provides services through subunits at multiple locations within an urban area, and in this case, each of those subunits may also be considered an implementing organization.

economic and behavioural changes; and improve access to health services. Meaningful participation of, and partnership with, community-led organizations and networks in the planning, implementation, monitoring and evaluation of activities is fundamental to improving HIV service provision for trans people.

Trans-led and trans-focused groups, activities and services foster a sense of community, belonging and validation. Whenever possible, hiring from within the trans community sends a powerful message of affirmation. Trans people should be trained and hired to provide professional health services and training. Having trans people deliver services fosters a sense of trust within trans communities.

4.2 Clinical approaches

Different programme models can be used to provide a comprehensive continuum of HIV prevention, diagnosis, treatment and care to trans persons, depending on the context, location, estimated number of clients and available resources (see Table 4.1). It is important to consider that there is limited data on clinic-based interventions designed for trans individuals and communities compared with community-based programmes. However, establishing strong links between clinics and the communities they serve is paramount. In this objective, some approaches for trans populations may be adapted from models used to meet the needs of other key populations (see Section 4.3.2).

Table 4.1 Models of clinical service delivery sites and approaches

TYPE OF CLINIC	DESCRIPTION	ADVANTAGES	DISADVANTAGES
Standalone NGO/CBO clinic	• Full-time services in fixed location, often run by an NGO or CBO; ideal where there is a high concentration of trans people (over 500) • Dedicated staff required	• Technically efficient • May be community driven/managed • Comprehensive services may be provided; mix of clinical and educational interventions is possible • Flexible to address needs of trans people • Greater possibility for hiring trans staff, hosting trans-led health promotion programmes/activities on site • Possibility of linking to safe space (drop-in centre)[3]	• May be costly if few trans people access the clinic • In countries where only a doctor is permitted to administer hormone therapy, staffing this service may be expensive. • Possibility of stigma associated with clinic • May be difficult to sustain

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[3] A safe space (drop-in centre) is a place where trans people may gather to relax, meet other community members and hold social events, meetings or training. For more information, see Section 4.6.

TYPE OF CLINIC	DESCRIPTION	ADVANTAGES	DISADVANTAGES
Outreach/mobile clinic • can be NGO- or government-run	• Satellite or "pop-up" clinics (fixed location) or mobile vans • Part-time clinics • Operate at fixed time in fixed locations • Ideal for reaching hard-to-reach trans people and for providing services to smaller numbers of trans people • Dedicated staff or volunteers	• Satellite or "pop-up" clinics providing a select menu of services can be set up in any location and can operate effectively in small spaces, i.e. small retail spaces in shopping plazas, private rooms inside community centres • Cost-effective for reaching hard-to-reach trans people and for providing services to smaller numbers of trans people • Greater accessibility • Can increase visibility of HIV testing services, thereby normalizing testing and reducing stigma	• Provision of comprehensive services for trans people may not be possible • Quality of services may be variable • Only accessible at specific times
Private-sector clinic	• Services provided by private practitioners who develop rapport with trans community and who are acceptable to the community	• Acceptable to trans people • Confidential • Sustainable	• Comprehensive services may not be provided (e.g. educational and counselling services) • Consistent monitoring and reporting may not be possible • May not be affordable for all
Government-owned clinic/public health department	• Government clinics, including STI clinics and integrated HIV clinics	• Sustainable • Provision of technically efficient services if staff are well trained and facilities are available	• May not be acceptable and accessible to trans people • Links to CBOs services, including the ability to track referrals, may not exist • Real or perceived concerns regarding discrimination, lack of confidentiality
Hybrid partnership model of CBO working directly with government staff	• Government clinic with CBO staff working onsite, or government operated clinic within a community space • Could be fixed site or mobile	• Strong links between national programme and community-led organization possible	• Government staff need to work outside their comfort zone • Restrictions on funding may limit the number of services offered along the continuum of care
Public–private Partnerships	• Managed by private-sector entity using public funding	• Funding may be more secure but it may be subject to government procurement policies • May fill gap in service delivery in remote locations or where infrastructure is not well developed	• Dependent upon private-sector entity, i.e. corporation that has established business in a specific location and has vested interests in improving local health services • Clinics are only sustained as long as the private company is in operation

4.2.1 Creating an appropriate clinical services environment

Training clinical and support staff

In order to reduce the likelihood that trans people receive substandard care, health-care workers and other staff of facilities providing health care must be trained and sensitized about trans persons and their health needs. Health-care workers frequently report that other staff will stigmatize them if they demonstrate compassion for trans and sexual-minority clients. For this reason, training staff at all levels—from the waiting room to the exam room—empowers them to engage with all clients respectfully. This is known as trans cultural competency (Box 4.1) Adequate training will reduce stigma and discrimination and increase knowledge of trans health at every point along the HIV continuum.

Box 4.1

Ensuring trans cultural competency

Trans cultural competency is a set of skills that enables trans and non-trans individuals to work together effectively. Trans cultural competency is broadly defined as the ability to communicate and demonstrate a respectful understanding of trans people as unique individuals, on their own terms, according to their chosen gender identity,[4] preferred gender pronouns, and self-identified sexual orientation. Beyond basic etiquette, this includes understanding that trans people, like all people, identify across a spectrum of gender and sexual orientation, and do not conform to a universal standard of physical transition,[5] psychological traits, or lived experiences.

Organizations can make a commitment to trans cultural competency by providing mandatory trainings for all staff, including trans individuals on staff. The ideal scenario for trans-cultural competency trainings is to create a system that ensures all employees receive the same information in an ongoing manner. It is critical to include all staff, from community outreach workers[6] to administrative support staff, in such trainings. This ensures that each staff member whom a trans client or programme participant will encounter from the moment they walk into a clinic or service-delivery site is equipped with knowledge and understanding to address them respectfully and guarantee they receive the highest quality of care and attention.

"LGBTI" is now a common term that combines lesbian, bisexual, gay, trans and intersex people in a single category. However, it is often applied to programmes that in fact serve only one or some of these populations. When community organizations and service-providers apply the "LGBTI" label, it should be a truthful indication which implies that their programmes and services really are inclusive of all. As trans people have been widely excluded from lesbian, gay, bisexual and intersex spaces, LGBTI should only be applied where trans people are actively engaged as programme leaders, participants and beneficiaries.

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[4] Gender identity is a person's internal, deeply felt sense of being male, female or some alternative gender or combination of genders. A person's gender identity may or may not correspond with her or his sex assigned at birth.

[5] Transition refers to the process transgender people undergo to live authentically in their gender identity. This may involve changes to outward appearance, clothing, mannerisms or to the name someone uses in everyday interactions. These types of changes are sometimes called "social transitions". Transitioning may also involve medical steps that help to align a person's anatomy with their gender identity. These steps are sometimes called "medical transition" and can include feminizing or masculinizing hormone therapy, soft tissue fillers or surgeries. However, transition is not defined by medical steps taken or not taken.

[6] A community outreach worker is a trans person who conducts outreach to other trans people, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called "staff outreach workers" or simply "outreach workers"). Community outreach workers may also be known by other terms, such as "peer educators". However, the terms "peer" or "community" should not be understood or used to imply that they are less qualified or less capable than staff outreach workers.

Box 4.2

A checklist for trans-competent care

Trans-competent care means providing services, especially health-care services, to trans people in a technically competent manner and with a high degree of professionalism that reflects the provider's knowledge of gender identity, human rights and the particular situation and needs of the trans individual being served. In addition, trans-competent care is delivered in a respectful, non-judgemental and compassionate manner, in settings free of stigma and discrimination.

Further aspects of trans-competent care include:

- free or affordable services—clinical, counselling, training/workshops
- both fixed-site and outreach/mobile services—mobile care-providers and community outreach workers
- "one-stop-shop" service catering holistically for a range of health and social needs, e.g.:
  - fully equipped—all equipment and no stock-outs of commodities
  - range of services: sexual and reproductive health, HIV and STIs, drugs and alcohol, psychosocial care and support
  - point-of-care testing or quick referral for fast turnaround of results
  - counselling on all issues of concern including housing, finance, legal issues
  - healthy lifestyle promotion (diet, nutrition, exercise)
- flexible opening hours, e.g. including evening/weekends
- no appointments/short waiting times, with adequate clinic staff to ensure quick service
- service signage/branding, posters, brochures and photographs, and other visual elements that acknowledge and are relevant to trans people's lives
- "Charter of Service" for clients, clearly displayed
- confidential services:
  - private counselling and clinical examination rooms
  - providers/staff only informed on a "need to know" basis
  - young trans clients welcomed without need for parental/guardian consent[7]
  - locked storage of all client notes/records
- choice of service-providers including:
  - trans, male and female staff for gender-sensitive care
  - clinical staff, counsellors, health educators, social workers, community outreach workers
  - trans peer navigators to help clients access, understand and navigate services (see Section 4.2.2)
- relaxed consultations, with time to clearly explain issues
- voluntary procedures clearly explained for informed decision-making by clients:
  - referral for further specialist care, as required and with client consent
  - list of trans-competent resources available within the area
- provision of information, education and communication materials, e.g. brochures, posters, DVDs, presentations on different topics
- provision of condoms and lubricants by providers and via dispensers, including outdoors for after-hours accessibility.

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[7] Young trans people are those in the age range 10–24 years, in accordance with the Interagency Working Group on Key Populations *HIV and young transgender people: a technical brief* (Geneva: World Health Organization; 2015) .

Organizations of trans people are essential partners in delivering comprehensive training on human sexuality and gender expression.[8] They also can facilitate interaction with members of communities with diverse gender identities and expressions, thereby generating greater understanding of their emotional health and social needs. Where formal trans-led organizations do not exist, information about sexual health and where to access clinical and social support services can be disseminated through informal networks of peers. In addition to training, health service centres need policies and practices to prevent discrimination. Follow-up and supportive supervision should complement training in order to detect challenges early, ensure onsite support is provided, and work to solve problems collaboratively. Health-care workers have a professional obligation to care for and treat people impartially, equitably and ethically.

Box 4.3

Case example: Approaches to training health-care workers in the Caribbean

The USAID-funded Health Policy Project has developed a training manual for health-care workers, piloted in the Dominican Republic, Jamaica and Barbados, to strengthen their capacity to provide high-quality, stigma-free health services for trans persons.

The manual, *Transforming care: tools to understand and meet the health needs of transgender people in the Latin America and the Caribbean*, contains six half-day sessions on the following topics:

- gender identity and sexual diversity
- transphobia[9] and stigma
- health needs
- trans people and HIV
- deeper understanding of trans people's lives
- planning the way forward.

The manual was developed in response to a lack of training for health-care providers on trans health in the Caribbean. Providers work in environments where there are high levels of stigma and discrimination against trans persons, which creates significant barriers in their access to health services. The training provides tools to implement in their own settings to improve knowledge and reduce stigma and discrimination. In the three countries where this training was piloted, it was well received and was acknowledged to fill an important gap to improve the quality of health care for trans persons.

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[8] Gender expression is a person's ways of communicating masculinity and/or femininity externally through their physical appearance (including clothing, hair styles and the use of cosmetics), mannerisms, ways of speaking and behavioural patterns.

[9] Transphobia is prejudice directed at trans people because of their actual or perceived gender identity or expression. Transphobia can be structural, i.e. manifested in policies, laws and socio-economic arrangements that discriminate against trans people. It can be societal when trans people are rejected or mistreated by others. Transphobia can also be internalized, when trans people accept and reflect such prejudicial attitudes about themselves or other trans people. For more information, see Chapter 2.

Using appropriate language

Just as images can have a strong impact in creating environments that are welcoming and affirming for trans individuals, language used in clinical environments is just as powerful. It is critical to ensure that all client intake forms, clinical documents and health information literature includes gender-neutral or gender-inclusive language wherever appropriate. For example, on client intake forms that require individuals to indicate their sex and gender there must be separate questions for "sex at birth" and "gender". It is also important to ask individuals to indicate their preferred gender pronoun, and for all clinic staff and community health workers to be trained to ask for preferred gender pronouns and to use them accordingly.

In health facilities where electronic medical records are maintained, the information that can be recorded should not be limited in ways that prevent clients from receiving accurate and competent health services. If electronic medical records "auto-populate" anatomy, exams and recommendations according to the gender assigned at birth, this limits the ability to accurately and efficiently provide and document care. For instance, a person who was assigned male at birth, takes estrogen, had breast augmentation surgery, but has not had a legal name and gender marker change to match their female appearance will be registered in an electronic health record as a male. This registration does not allow health-care workers to accurately address the individual using their preferred name and gender or provide appropriate medical care for the anatomy that is present. See Figure 4.1 for an example of a gender-inclusive intake form.

Ensuring client safety and confidentiality

Trans people are less likely to access health services if they cannot do so safely. It is important to ensure that at every point of health-service delivery trans people feel safe and that their information is kept confidential. All staff (administrative, community health workers, nurses, doctors, lab technicians and management) should be trained, monitored and evaluated for their compliance with safety and confidentiality procedures and laws. If health records cannot be secured sufficiently to ensure that the client's information is confidential, health-care workers may consider developing special codes (e.g. unique identifier codes) to document the information adequately but protect it from being accessed for non-medical reasons. (See Chapters 2 and 5 for legal and programme management methods of addressing safety and confidentiality issues.) If possible, a system should be in place for people to anonymously report problems. Efforts should be made to ensure that trans people are not targeted or harassed by police, security personnel or others when entering or exiting the clinic. In particularly hostile climates, mobile rather than fixed service-delivery centres or safe spaces (drop-in centres) may be a safer alternative (see Table 4.1).

Figure 4.1 Example of gender-inclusive intake form for clinics and social-service agencies
NOTE: These are suggested questions—this does not represent a complete intake form.

Legal name: Name I prefer to be called (if different):

Preferred pronoun?

☐ She/her ☐ He/his ☐ They/their ☐ Other ______________________

Gender: Check as many as are appropriate:

[An alternative is to leave a blank line next to Gender, to be completed by the client as desired]

☐ Female ☐ Male ☐ Transgender
☐ Transmale/Transman/Female to Male ☐ Transfemale/Transwoman/Male to Female
☐ Genderqueer/Gender non-conforming ☐ Other ______________________

Sex assigned at birth

☐ Female ☐ Male ☐ Other ______________________

Are your current sexual partners ☐ Female ☐ Male ☐ Transgender

☐ Transmale/Transman/Female to Male ☐ Transfemale/Transwoman/Male to Female
☐ Genderqueer/Gender non-conforming ☐ Other ______________________

In the past, have your sexual partners been ☐ Female ☐ Male ☐ Transgender

☐ Transmale/Transman/Female to Male ☐ Transfemale/Transwoman/Male to Female
☐ Genderqueer/Gender non-conforming ☐ Other ______________________

Current relationship status
[An alternative is to leave a blank line next to current relationship status]

☐ Single ☐ Married ☐ Domestic Partnership/Civil Union ☐ Partnered
☐ Involved with multiple partners
☐ Separated from spouse/partner ☐ Divorced/permanently separated from spouse/partner
☐ Other ______________________

Children in home

☐ No children in home ☐ My own children live with me/us ☐ My spouse's or partner's children live with me/us ☐ Shared custody with ex-spouse or partner

Sexual orientation/identity

☐ Bisexual ☐ Gay ☐ Heterosexual/Straight ☐ Lesbian ☐ Queer

☐ Other ______________________ ☐ Not Sure

Are there any questions you have or information you would like with respect to starting a family?
☐ Yes ☐ No ☐ Don't know

Do you have any concerns related to your gender identity/expression or your sex of assignment?
☐ Yes ☐ No ☐ Don't know

Do you currently use or have you used hormones (e.g., testosterone, estrogen etc.)?
☐ Yes ☐ No ☐ Don't know

Do you need any information about hormone therapy?
☐ Yes ☐ No ☐ Don't know

Source: Based in part on Deutsch, M.B., et al., Electronic medical records and the transgender patient: recommendations from the World Professional Association for Transgender Health EMR Working Group. Journal of the American Medical Informatics Association. 2013;20(4)700–703.

Service integration

WHO recommends integrating HIV services with a range of other relevant clinical services, such as those for TB, viral hepatitis, maternal and child health, sexual and reproductive health services and drug dependence treatment. Integration of services makes it easier to provide comprehensive and consistent care and makes service accessible. It allows individuals to take care of their various health needs at the same time and in the same location. Integration of services involves not only providing related services in a single setting but also systems to share information and provide referrals across settings and among providers.

Collaboration between programmes at every level of the health system is important to the success of HIV and other related health and social services. Aspects of coordination that need consideration include mobilizing and allocating resources; training, mentoring and supervising health workers; procuring and managing drugs and other medical supplies; and monitoring and evaluation. A key goal of programme planning is to create delivery systems that best facilitate access.

Box 4.4

Case example: Clinical service integration in the USA

The Transgender Family Programme at the Community Healthcare Network clinics in New York City was established in 2004 to improve access to HIV prevention and linkages to primary health care. To understand how best to integrate comprehensive trans services into a community health clinic, the Network undertook community mapping, consultations and forums and learning from similar programmes. The programme asked clients to form a Client Advisory Board to help guide integration and implementation of services for the trans community.

Integrated services include trans care, HIV testing services (HTS), medical case management, support for treatment adherence, STI screening and treatment, prevention interventions and psychosocial and nutritional services. In addition, the programme provides risk reduction counselling, support groups, outreach, bilingual educational workshops and referrals to legal and social services.

Over 750 people have received trans-specific services. Identified benefits of integrated trans services include:

- greater sensitivity to and long-term acceptance of this population in the wider community;
- improved accessibility through convenient location of services; the provision of trans care is no longer a specialty but an integral part of primary care across the network of 12 centres;
- flexible hours as a result of larger capacity;
- increased access to a range of in-house support services.

In addition, in-depth evaluation has found significant decreases in sex work, needle-sharing and unregulated hormone injections, and increased likelihood of regular condom use.

www.chnnyc.org/services/transgender-lgbt

The majority of programmes providing health services to trans people focus on HIV and other STIs. However, trans people should receive the same high-quality health services as non-trans people for all of their health needs. Programmes should work to provide a full range of health and social services. It is important that case management strategies link participants to health clinics and HIV testing and to other programmes for legal advocacy and social support. Psychosocial services should ideally be available to provide individual, group, and family sessions for trans persons who have psychosocial needs.

Using trans-specific health services as a point of entry for HIV care

The threat and actual experience of stigma, discrimination, violence and oppression create significant barriers for trans people to access health services. In order to make services more accessible, trans-specific health issues beyond HIV can be used as a point of entry. These services could be offered at the health site or via referral to known and trusted facilities. At a minimum, information and education on trans-specific health issues should be provided, such as:

- hormone access and hormone therapy
- hormone level monitoring and assessing of hormone–medication reactions (see Chapter 3, Section 3.3.9)
- gender-identity and psychosocial counselling and support
- support groups focused on transitioning and developing networks of support
- hair removal
- male and female chest reconstruction surgery, sex reassignment surgery, and other gender-affirming[10] surgeries and procedures.

Health-care workers can use client visits for any of the above concerns as opportunities to discuss co-existing issues that may impact their health care for both trans-specific and general needs. Many of these concerns may not be directly related to health but nonetheless impact a client's ability to seek and adhere to adequate health care. These concerns commonly include:

- employment
- housing
- family and social acceptance
- legal gender recognition and identity documents
- HIV-related care
- STI services
- sexual and reproductive health care
- feminization/masculinization process
- sex work
- substance use and dependence
- violence (intimate partner, intrafamilial, domestic, institutional, structural etc.).

Health-care workers should use these opportunities to treat clients for other health issues they may be experiencing or refer them to other competent health-care workers if necessary.

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[10] Gender-affirming refers to medical procedures that enable a trans person to live more authentically in their gender identity.

Box 4.5

Case example: Delivering trans-focused HIV prevention and treatment services in India

By recruiting trans people in its Shadows and Light Project as peer supporters, the Family Planning Association of India was better able to assess trans people's needs when improving access to sexual-health and HIV services. In several locations, clinics engaged health-care providers who were sensitive to the needs of trans clients, provided hormone care, information about gender transition, laser (hair removal) services, and referrals for gender-affirming surgeries. Making use of these destigmatized services, which trans people identified as the most important to them, led to increased uptake of screening and treatment for STIs (including hepatitis and syphilis), and HIV testing, diagnosis, treatment and care.

www.fpaindia.org

Box 4.6

Case example: Raising trans awareness among health-care workers in Central America

From 2011 through 2013, AIDSTAR-One (AIDS Support and Technical Assistance Resources, Sector I, Task Order 1) implemented a series of activities targeting trans women, health-care workers, and Ministry of Health authorities in Central America. In all, 916 trans women and 109 health-care workers participated in assessments of trans health needs and the attitudes of health-care workers in the region. The results contributed to the development of a health-care worker certification, which included a three-day training, supportive supervision visits, and sensitization session in the workplace. Participating health-care workers obtained a basic knowledge about fundamental aspects of sexual health and how to address trans people's needs in a positive and respectful way. The trained health-care workers then returned to their health service centres and facilitated sensitizing activities with their peers. In El Salvador alone, a total of 42 trained health-care workers conducted sensitization sessions in 28 health facilities.

Trans women were trained as data collectors and incorporated into the assessment team. They also co-facilitated the training of health-care workers. Engaging trans persons to fulfil these important and visible roles—and paying them to do so—not only strengthened their technical capacities, but also allowed them to engage with health-care workers as professionals and peers, thus dispelling myths and negative beliefs about trans women, their capacity and their behaviour. This engagement also increased the visibility of trans persons within their own societies, identifying them as key actors in national and regional actions that affect their own well-being and interests.

4.2.2 Peer navigators

In order to reduce loss along the HIV prevention, diagnosis, treatment and care continuum (see Chapter 3, Figure 3.1), trained peer navigators can act as important mentors and guides for their peers to access and adhere to a programme. Peer navigators are community outreach workers who are knowledgeable about existing local treatment and care resources for people who are HIV positive. They may be living with HIV themselves and have first-hand experience of seeking and accessing services. Peer navigators guide new HIV programme clients from HIV counselling and testing at community-based sites to clinics which provide diagnostic screening and HIV treatment and care services. This is critical not only in contexts where all who test positive are required to register with a government clinic or hospital for ART (most treatment sites are government-run), but also for supporting case management more broadly.

Peer navigators can serve as liaisons between the public, private and community sectors. They should be aware of mobile clinics, and clinics with flexible times or after-hours services and with trans-competent staff. Peer navigators may accompany or trans individuals to providers, building upon systems of formal referrals. A strong peer navigation programme can strengthen linkages to additional services like counselling, psychosocial and legal support and ensure that clients are supported along the continuum of testing, treatment and care.

Peer navigators can have an especially important role at service-delivery sites which are not community-led. They can greet individuals when they arrive and explain the client intake process, including completing medical and client history forms etc. Where fear of judgement, discrimination and maltreatment is a major barrier for trans individuals in seeking HIV and STI services, peer navigators can answer questions and alleviate any anxiety clients may have about the clinical encounter. In this role, peer navigators are more than merely a “friendly face” for trans individuals within health clinics. They are community health professionals who are integral members of a clinic staff. Peer navigators are essential to linking communities and clinics.

Because of peer navigators’ central role in the implementation of key population programming, an investment in their professional development is also an investment in the broader network of trans individuals participating in service delivery across the HIV prevention, diagnosis, treatment and care continuum. When peer navigators are institutionally supported with continued training, career mentoring and ongoing opportunities to increase their reach, they are able to serve as linking agents in decentralized HIV service delivery models. They can also be key leads in stigma and discrimination work, monitoring and reporting, as well as becoming leaders and experts in referrals, prevention, care and support and treatment literacy.

4.3 Social and behavioural interventions

Social and behavioural interventions are interventions that operate at the societal, community, organizational or individual level to change behaviours in a way that positively impacts health. Social and community-level behavioural interventions seek to change structures and norms that influence individual behaviours, while individual-level behavioural interventions aim to address an individual’s sources of risks. For HIV prevention, individual-level interventions often include one-on-one risk reduction counselling focused on routine sexual-history taking, client-centred counselling on protective strategies such as use of condoms and lubricant, sero-adaptive strategies, pre-exposure prophylaxis (PrEP), sexual practice related to relative risk (insertive versus receptive anal sex, oral sex versus anal sex etc.), importance of health-seeking behaviours and the benefits of HIV treatment, and skills-building on negotiation with partners. See Chapter 3, Section 3.3.4 for additional information about harm reduction counselling and promotion in clinical settings.

Box 4.7

Case example: Behavioural interventions through community-led education in the USA

The Healthy Divas programme is a behavioural intervention to address the HIV care needs of trans women living with HIV in San Francisco. The programme helps them build skills to cope with transphobia and HIV stigma, become active and collaborative in their treatment planning, and proactively address challenges to adherence and in their relationships with providers.

Healthy Divas consists of six individual counselling sessions with a community facilitator and one group workshop, which take place over a three-month period. Each individual session is standardized: the facilitator uses a detailed manual specifying session content, procedures, exercises and activities. The manual helps the facilitator tailor this content to the participant's unique circumstances and address their particular concerns (such as transition, or substance use). The sessions also develop the individual's communication, coping and self-advocacy skills through role-playing, behaviour rehearsal or practice exercises. Workshop topics are generated by the participants and are also tailored to address their concerns while capitalizing on a supportive group process in which participants can share experiences and brainstorm solutions.

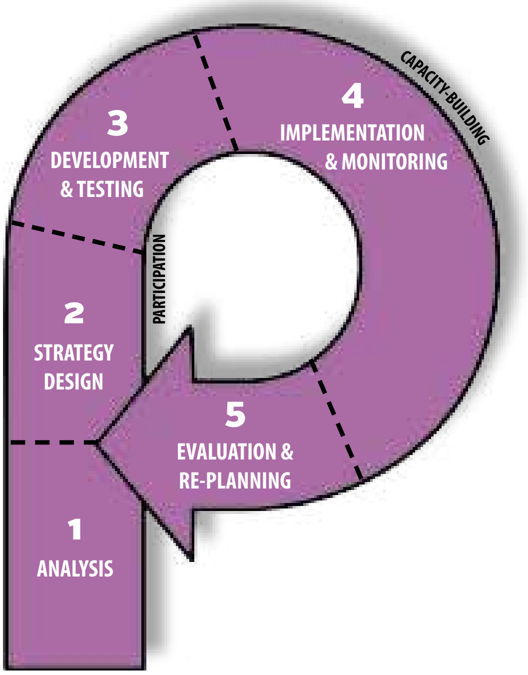
Healthy Divas was adapted from an existing programme for people living with HIV by members of a trans community advisory board and project staff, who re-wrote the content to reflect the priorities and values of the people to be served. The intervention was piloted with members of the trans community, and their feedback on both the structure and content of the intervention was incorporated into the next iteration. Programme participants are recruited through service-providers, clinics, community-based organizations, word of mouth, direct outreach and social networks. The programme is currently government-funded, and participants receive monetary incentives for participating. Feedback is gathered at the end of each session and at the end of the whole intervention for incorporation into the next round.

4.3.1 Designing trans-specific behavioural interventions

While programmes can be successfully adapted to serve immediate community needs, programmes that are wholly designed to meet the specific needs and concerns of trans people are likely to be more effective. Such programmes, whether at the community, national or regional level, are ideally designed, led and implemented by trans people themselves. Trans HIV and STI programmes, similar to other HIV interventions, are based on the principles and best practices of social and behaviour change communication (SBCC). The foundational principles guide programme design and can be used as a roadmap to link trans individuals with clinical services and other resources. One tool for developing high-quality SBCC is the P Process, a framework originally developed at the Johns

Hopkins Bloomberg School of Public Health in the USA (Figure 4.2). Each step in the P Process is based upon the principles of community participation and capacity-strengthening as requirements for effective social and behaviour change.

Figure 4.2 Steps in the P Process[11]



Step 1 Analysis

Conducting a situation or environmental analysis and an audience and communication analysis is the first step to developing a tailored programme. However, when a programme is being developed in a context where local trans experiences are already documented and where there is sufficient baseline health data or knowledge of trans health priorities, the initial analysis does not need to be lengthy. A situation analysis can be done by reviewing existing health and demographic data, and any information that exists relating to the aspect of HIV programming that the given intervention seeks to address. Situation and environmental analyses can include: a list of factors that prevent and enable the desired behaviour change; a clear and brief problem statement that sums up the issue(s) that the programme will address; and a clear and specific description of the target population who are the intended beneficiaries of the programme.

Where there is little or no data on the local trans population, formative research will be required to establish the baseline of the targeted population's health status and needs (see Community Mapping in Section 4.5.1).

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[11] *Source:* The Health Communication Partnership. The New Process: Steps in Strategic Communication; 2003. http://www.who.int/immunization/hpv/communicate/the_new_p_process_jhuccp_2003.pdf https://www.k4health.org/toolkits/hcp/strategic-approach.

Audience and communication analyses should assess the knowledge, attitudes and behaviour of intended participants. This analysis will also look at the communication and training needs of the intended participants, including community preferences for media sources, social media and social communication. Finally, the programme should conduct a participation analysis to identify stakeholders in trans health within the targeted area.

Step 2 Strategy design

Strategy design begins by outlining *programme objectives* that are "SMART": Specific, Measurable, Appropriate, Realistic, and Time-Bound. Next, the strategy design process *determines the model(s) of behaviour change* that best fit the intervention and uses the selected models to explain how and why the programme will improve health behaviour among trans people. A third step in the strategy design process is to *decide the channels of communication* (i.e. social media, interpersonal communication, group settings, mass media) that will most easily reach and change the behaviour of the specific trans population. Once SMART objectives, behaviour change models, and channels of communication have been decided, an intended output of the strategy design stage is the development of an implementation plan and work schedule that has benchmarks at regular intervals to gauge progress.

Step 3 Development and testing

This step involves gathering, creating and adapting the tools and materials that will be needed, including guidelines and toolkits, facilitation manuals for conducting workshops or discussion groups, manuals for peer counselling, or HIV and STI messages for media circulation. New materials developed for the programme, or existing materials adapted for it, must be clearly designed to address a specific aspect of the behavioural model. Before implementation, all materials should be pre-tested with the exact segment of the trans population that will be reached in order to evaluate the materials for cultural competency, accuracy, and to ensure they are tailored to local languages and socio-cultural norms.

Step 4 Implementation and monitoring

The implementation and monitoring stage puts all of the planning that occurs in the first three steps into action. At this stage, trainings should take place for managers, outreach workers and any key partners involved in implementation. Once key personnel have been trained, they will implement the programme with regular supportive supervision to ensure ongoing quality.

As implementation progresses, key participants can be mobilized to share information and results among other organizations and agencies within the network of allies and programme partners. Throughout the period of implementation, programme monitoring should occur to ensure consistency and quality of outputs and gauge milestones in achieving stated intervention goals. For additional information and resources on programme monitoring and evaluation, see Chapter 5.

Step 5 Evaluation and re-planning

Evaluation of any intervention determines how well it has met its objectives. For behavioural interventions, evaluation can identify how and why a programme was able to change behaviour, and in some cases, determine the overall impact on disease transmission of changing those behaviours. In the P-Process framework, evaluation includes measurement of outcomes and impact assessments, dissemination of programme evaluation results, and programme revision or redesign.

4.3.2 Adapting behavioural interventions developed for other populations

There is an immediate need for HIV prevention among trans populations. However, in many settings, no evidence-informed HIV prevention programmes specifically designed for trans women have been rigorously designed and evaluated. Many programmes must therefore be adapted from those designed to serve other populations, particularly men who have sex with men. When HIV prevention programmes for men who have sex with men are expanded to include services for trans women, they must be evaluated and adapted in order to adequately accommodate trans participants and clients.

Systematic adaptation can increase the cultural relevance of an evidence-based intervention. Interventions that lack cultural relevance to a subpopulation's unique needs and preferences will likely falter in achieving the desired outcomes.

To adapt a programme, community-led organizations must: (a) conduct a community needs assessment; (b) create a method for community involvement that works best for the organization; (c) hire appropriate staff if needed; (d) attend the original intervention training; (e) become familiar with the adaptation process; (f) develop a method of systematically creating changes to the curriculum and activities; (g) pre-test specific activities; (h) adapt the evaluation forms; and (i) pilot the adaptation.

One organization explains the process it followed to adapt an HIV prevention curriculum for trans youth: "We started by having everyone that was part of the [adaptation] team review the original curriculum and write down their own ideas of what they liked about it, what they thought should stay the same, what they thought should change, what they thought was missing. We then spent several meetings brainstorming key issues for trans youth. Then … we would sort of synthesize that down [to] what we thought were the really key issues in terms of health outcomes and HIV prevention for trans youth, then we talked about okay, so how do we make sure these key points are in this curriculum?" By engaging community members in each stage of planning, and conducting a thorough needs assessment, this organization was able to strategically plan a programme that directly addressed the priorities and preferences of its intended beneficiaries.

4.4 Condom and lubricant programming

2014 Key Populations Consolidated Guidelines[12]

The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and STIs. *(p.26)*

Members of key populations, including people living with HIV, should be able to experience full, pleasurable sex lives and have access to a range of reproductive options. *(p.81)*

TRANSGENDER PEOPLE

Condoms and condom-compatible lubricants are recommended for anal sex. *(p.27)*

Adequate provision of lubricants for transgender women and transgender men who have sex with men needs emphasis. *(p.27)*

Promoting condom and lubricant knowledge and use through non-judgemental, sex-positive and medically accurate communication at the individual, group and community level is essential to successful programmes with trans individuals. Condom and lubricant behaviour change communication strategies should be designed with the primary goal of motivating individuals to understand and take charge of their sexual and reproductive health. For additional information about the use and efficacy of condoms and lubricants for sexual health, see Chapter 3, Section 3.3.1.

Condom and lubricant programming should reflect a rights-based approach to sexual health that honours and protects individual choice and bodily autonomy. Effective programming recognizes the full spectrum of human sexuality, sexual orientations and gender identities and is grounded in respect for each individual's sexuality.

Sex-positive approaches to behaviour change communication are likely to be most effective. Sex-positive messaging emphasizes pleasurable, romantic and enjoyable aspects of sexual expression, removes the stigma around condoms and lubricants, and associates condoms and lubricants with the broader realm of healthy sexuality and sexual expression.

A variety of opportunities exist to promote condoms and lubricants among trans individuals, including individual, community and mass-media strategies. Condoms and lubricants may be promoted via one-to-one counselling, interpersonal communications, group activities, television, the Internet and social media. Condoms and lubricants should be available and promoted in health centres frequented by trans individuals (i.e. clinics) as well as in community spaces frequented by them (i.e. drop-in centres, entertainment venues etc.).

It is important that government condom and lubricant distribution programmes actively involve organizations of trans individuals and civil-society organizations in condom and lubricant supply forecasting, market segmentation, condom and lubricant distribution and product promotion.

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[12] Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2014.

Procurement of condoms and lubricants should follow internationally established quality assurance mechanisms. In addition, empowering organizations of trans individuals to play an active role in awareness-raising and in distributing condoms and lubricant to communities is essential to increase their accessibility and use at the community level. With direct access to the population being served, organizations of trans individuals are key distribution points for condom and lubricants, providing condom and lubricants in safe spaces (drop-in centres), through community outreach workers and as part of other health services.

It is useful for marketers and distributors of condoms to engage trans populations to design and distribute a variety of condoms and lubricant that meet the specific needs of trans women and men. Male condoms may not be acceptable for some trans women, nor female condoms for some trans men. Trans communities need to be engaged from the start in the design and marketing of condoms and lubricant, and in planning, mapping and implementing their distribution.

4.5 Community-led outreach

2014 Key Populations Consolidated Guidelines

Community-based approaches to service delivery can increase accessibility and acceptability for key populations. Outreach, mobile services, drop-in centres and venue-based approaches are useful for reaching those with limited access to, or underserved by, formal health facilities. These approaches allow for more efficient referrals between the community and health facilities, and support collaboration across all sectors engaged in health promotion. Community-based programmes can also refer to programmes that are led and delivered by members of the key population community. *(p.117)*

Community-led organizations can play important roles in reaching key populations, engaging with them, linking them to services and providing ongoing care and support. *(p.116)*

Community-led organizations play a crucial role in delivering services that best meet the needs of key populations. *(p.129)*

Community-led approaches are an essential link between the community and HIV prevention, diagnosis, treatment and care services. They empower trans people to draw on their first-hand knowledge of vulnerability and risk to problem-solve with members of their community, strengthening access to services, and making HIV prevention, diagnosis, treatment and care viable.

A community outreach worker is a trans person who conducts outreach to other trans people. Trained community members with direct experience of many of the factors that elevate risk for HIV and other STIs can discuss personal stories and address intimate issues with candour and empathy. With formal training in health education (see Section 4.5.1) community outreach workers can link others to clinical and community-based or community-led services.

Community-led approaches involve building the capacity of a community-led organization to assess the needs of the community, design high-quality services based on identified needs (starting with the most essential) and roll out these services progressively as the capabilities of the organization grow. In most localities, the social-political context, HIV incidence and risk behaviours among trans people will shape how services are designed. In more tolerant settings (for example, some urban areas), community-led organizations may be able to be more visible about their work and hold public events and group outreach sessions. In much of the world, community-led organizations must operate very discreetly to provide outreach, HTS and referrals to comprehensive care services. (For more information on organizational capacity-building of community-led organizations, see Chapter 1, Section 1.4.)

Most trans community-led organizations initially build their outreach work around one-on-one and group education activities, with referrals to safe spaces (drop-in centres) where available (Section 4.6), or to trans-competent public or private health-care providers. Some trans people may prefer to receive information online or through social media (see Section 4.7). On the other hand, one-on-one or group approaches can be particularly effective for people who are illiterate. In contexts where trans people are marginalized or disconnected from organizations and services, formal and informal support groups can foster a sense of community and alleviate social isolation and its attendant risks. Support groups, including informal social gatherings that are exclusive to trans-people, can help individuals to process trauma, understand their shared experiences and be empowered to engage in safer sexual practices. Individual counselling can also help in this regard.

Promoting sexual health and HIV prevention, diagnosis, treatment and care must extend far beyond clinical settings to be effective. In order to reach the greatest number of individuals who can potentially benefit from programmes, it is essential to bring information and services to places where trans people gather socially. Physical and virtual spaces frequented by trans individuals can be entry points for developing relevant, accessible and sustainable programmes. Sexual-health promotion in non-clinical settings is the most effective means of reaching individuals who are most disconnected from mainstream health services and therefore at greatest risk for HIV and other STIs.

Community-based entry points are often different for trans women, trans men and young trans people. Determining where those spaces are, and how they can best be used as sites for sexual-health education, peer counselling, condom and lubricant promotion and other HIV programming can therefore only be done with the meaningful participation of community members themselves. Recruiting and retaining trans people as community outreach workers ensures that programmes are not only established in the right locations, but also that they are responsive to the changing preferences and priorities of their beneficiaries.

Community outreach workers are uniquely positioned to address the complex interaction between stigma, trauma, social stressors and behavioural risk among other members of their communities. It is important for community outreach workers to address these psychosocial stressors and provide resources to help with them (see also Chapter 3, Section 3.3.10).

Community outreach workers' understanding of, and personal investment in, the welfare of their community are as essential to the success of an intervention as the services they offer. Therefore, they must be respected and engaged meaningfully. Community outreach workers are not volunteers. They should be remunerated for their work at a rate comparable to that of other staff, and should have the opportunity to progress to permanent paid positions in the implementing organization.

The following section presents steps in developing community-led outreach that can be used by programme managers of an implementing organization that does not yet benefit from an established community-led outreach approach.

Box 4.8

Case example: Community-led outreach and empowerment in the Dominican Republic

As in many other countries, Dominican trans women are disproportionately represented among sex workers, and face the converging risk factors of police abuse and harassment, limited education and economic opportunities, and discrimination within the public health-care system. Since 2004, La Comunidad de Trans-Travestis Trabajadoras Sexuales Dominicana (COTRAVETD) has worked to eliminate stigma, discrimination and marginalization of trans sex workers throughout the Dominican Republic.

Although free HIV testing is readily available, many trans women report that they do not access any other routine health services due to the criminalization of sex work and systemic discrimination of both trans women and sex workers. For those who test positive for HIV, high-quality treatment and care is not easily or regularly attainable. In order to bridge this gap, COTRAVETD developed a programme tailored to trans women sex workers in Santiago and Santo Domingo. The programme recruits and trains community health educators to go beyond distributing condoms and lubricant and information on testing. The educators also address health and well-being from a human-rights perspective and educate their peers about their legal rights to be free of discrimination in health-care settings and how to take action against police abuse. COTRAVETD also dispatches a mobile clinic to provide basic primary health care, STI and HIV testing. A central component of the programme is the referral system to a clinic offering a trans health programme that provides primary care, hormone therapy and transition counselling. To date, they have reached approximately 1,300 trans women through community outreach,[13] with a staff of eight trained community outreach workers in the field.

cotravetd.blogspot.co.uk

4.5.1 Implementing community-led outreach

There are several steps to establishing an effective community-led outreach programme:

A. Map the community and design outreach strategies with community members fully engaged in each stage of the process. This includes mapping virtual spaces used by trans communities, i.e. popular social media platforms and websites.

B. Engage and train community outreach workers, or online community outreach workers.

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[13] Community outreach is outreach to trans people in order to provide services such as education, commodities and other forms of support. Wherever possible, outreach is best done by empowered and trained community members, i.e. trans people (referred to in this tool as community outreach workers). However, non-trans people can also be effective outreach workers, especially in contexts where community members are not yet sufficiently empowered to do outreach.

C. Implement and manage outreach, including website banner ads and social media promotion.
D. Foster leadership opportunities for community outreach workers.

A. Map the community and design outreach strategies

Understanding where trans people are and how to reach them is essential. This starts with population size estimation and programmatic mapping. Population size estimation may be conducted at a regional or national level when a programme is established, but it may involve members of local trans communities and other organizations or individuals with knowledge of local communities. This process is described in Chapter 5, Section 5.3.1.

Mapping is a process to identify more precisely the number of trans people in a more localized area, as well as any places where they gather, and services that already exist that they make use of. Mapping involves the programme team, trans people and other people at locations where trans people gather. Once mapping focuses on locations within a coverage area, the participation of community members is needed to help assess the availability and quality of services and characteristics of the environment, as well as the relative risks and vulnerabilities of individual trans people.

The steps for local consultations to inform mapping are:

- Engage a core group of trans individuals to participate in mapping. They should have detailed knowledge of where trans people gather and meet, often referred to as "hot spots".
- Work with the core group to develop maps that identify these hot spots (such as bus stations, clubs, parks, saunas and other hook-up spots).
- With the core group, identify and build rapport with "key informants" in these locations, such as trans individuals, bar owners and managers of sex workers. Through group discussions with the key informants, arrive at consensus estimates of the number of trans individuals at each location.
- Work with local stakeholders to identify and map service-delivery points for core elements of the comprehensive service package, including condoms and lubricants, prevention and STI services, HTS, and clinics for treatment and care.
- Plan services, using the information from the key informant meetings. In order to maximize access to services, clinics and drop-in centres should be located near the areas with the greatest density of trans individuals and operate at the most convenient times for them. The maps can also be used for planning structural interventions against stigma and discrimination, including violence.
- Through the key informants, meet and build rapport with additional trans people who could become community outreach workers.

Box 4.9

Case example: Trans women make the case for integrated service delivery in Peru

The Peruvian Ministry of Health is developing a Focus Plan to reduce the high rates of HIV and other STIs among trans women. One of the first activities was to map trans communities. Trans women were identified and trained to develop and manage the mapping. They then went to all the places where trans women work, live and socialize and were able to produce a cohesive and comprehensive map of the health services they need and when and where to deliver them. This informed the subsequent mobile service delivery with an emphasis on community action and the engagement of trans women to ensure that services are relevant. The implementation of the mapping demonstrated that when this type of research is done by trans women, they are more likely to obtain the necessary information and evidence to develop the programme.

Ultimately, the trans women produced more than just a map of their community's needs. They shaped the technical norms for providing integrated services to trans women nationwide. Even though this started out in response to HIV, they realized they could not make an impact in that epidemic without providing integrated services, with an emphasis on primary care and requiring the state-funded health system to deliver trans-competent care.

B. Engage and train community outreach workers

Engaging community outreach workers

In the initial stages of a programme, selecting community outreach workers may be an informal process. Implementing organizations may invite trans people who have been involved in the initial mapping and planning stages to remain involved in the new programme as community outreach workers, or to identify other trans people with the potential to fulfil this role. In either case, the selection criteria listed in Box 4.10 can be considered. It is also important to observe the rapport between trans people involved in mapping and other members of their community.

As the programme matures, a more structured process for selecting new community outreach workers may be adopted:

- A community advisory group and programme staff, including current community outreach workers, define the criteria for new community outreach workers, identify potential community outreach workers, contact them to see if they are willing to serve and conduct a basic interview with them. The candidates are ranked based on the criteria listed in Box 4.10.
- The candidates are asked to take part in a social network mapping exercise, facilitated by outreach coordinators, to determine the size of their social networks of trans people.
- Current community outreach workers consult with the potential community outreach worker's contacts to see whether the candidate would be acceptable to them as a community outreach worker.
- Based on the interviews, social network mapping and consultations, the community advisory group selects the appropriate number of new community outreach workers.

- The community advisory group discusses methods for monitoring community outreach workers' performance. This can be through formal performance reviews or through informal feedback processes such as regular "check-in" meetings. Community members should be able to contact the project if they have any issues related to the community outreach worker. It is important that community outreach workers not only meet programme targets, but do so with the highest quality and skill.

Community outreach workers from subgroups at higher risk should be engaged to do outreach to their peers. This includes those engaged currently or formally engaged in sex work or injecting drug use.

Box 4.10

Suggested selection criteria for a community outreach worker

- active in the community with time to do outreach
- committed to the goals and objectives of the programme
- knowledgeable about the local context and setting
- accepted by the community
- accountable to the community as well as to the programme
- respectful of all communities of trans people
- able to maintain confidentiality
- good listening, communication and interpersonal skills
- self-confident and with potential for leadership
- potential to be a strong role model for the behaviour promoted by the programme
- willing to learn and experiment in the field
- committed to being available to other trans people if they experience violence or an emergency.

Programmes that conduct outreach through social media may also choose outreach workers based on their profile as opinion leaders within social networks and other criteria such as age, class or local sexual and gender identities that will enable them to reach distinct subgroups for the programme.

Training community outreach workers

Training curricula should be interactive. The strength of community outreach workers in bringing their own experience and initiative to their work should be emphasized. This means that training may be most effective when facilitated by trainers who are themselves trans people. Basic training for all new staff must include competency in understanding gender and sexual diversity, regardless of how the new staff themselves identify.

Training should take place regularly and may be done at several levels:

- basic training at the beginning of engagement in the programme
- advanced training sessions at least quarterly to build knowledge and skills and to reinforce positive examples of outstanding outreach
- informal mentoring by an outreach supervisor to support community outreach workers (daily)
- group discussions and mentoring with community outreach workers (weekly).

Basic training may include:

- interpersonal communication skills to build confidence and individual agency (the choice, control and power to act for oneself). This includes learning to apply tact, discretion, active listening skills, being non-judgemental and maintaining confidentiality
- awareness of gender and sexual diversity, including the basic physical and psychological stages of human sexual development
- knowledge of a range of trans issues, both health- and non-health-related
- condom gap analysis, condom negotiation, lubricants, and training on how many condoms outreach workers should take to meet their outreach needs
- social network mapping
- monitoring of programme reach
- making prevention and care referrals
- using micro-planning tools, record-keeping
- STI symptoms and disease processes, referrals and treatment of STIs, HIV and TB
- promotion of voluntary HTS
- identifying and discussing violence, providing psychosocial support
- community mobilization.

Advanced training may include:

- advanced communication and counselling skills
- leadership skills
- dealing with stigma, discrimination and harassment
- legal literacy, negotiating with police and calling upon the community for support
- violence screening and crisis intervention
- counselling for drug and alcohol use
- creating links to other services (e.g. sexual health, HIV and HTS, and other health services)
- helping people navigate systems for social benefits, e.g. health insurance, unemployment insurance etc.
- care and support through individual and group peer counselling, including for trans people living with HIV
- use of programme data to better target outreach services
- interacting with the media to promote a positive image of the community (but note the importance of maintaining the safety of trans people whose identity is revealed through media interviews and other coverage).

C. Manage outreach

Outreach happens at two levels: the community outreach worker manages their own outreach to trans people; and programme staff supervise and support the community outreach workers.

The community outreach worker uses a prevention and case management approach for each trans person, consisting of several steps that are re-assessed and repeated, as circumstances require.

- Assess the range of needs of the individual, using a standardized tool (see "Micro-planning" below).
- Develop a plan of action with the individual based on needs that can be addressed.
- Provide commodities, information and counselling to address the beneficiary's needs.
- Facilitate referrals to other services, as needed.
- Follow up referrals with support and information, as needed.
- Re-assess and evaluate the needs of the individual on a regular basis.

Micro-planning

Micro-planning gives community outreach workers the responsibility and authority to manage their own work. In this approach, community outreach workers use their knowledge of the community, and the information they record during their contacts with trans people, to prioritize and manage outreach.

Community outreach workers are trained to use tools to capture data on the vulnerability and risk of each individual they serve, and the services they deliver. Micro-planning tools are designed to be user-friendly, e.g. they are pictorial and can be used by people with low literacy skills. They may be adapted so that routine monitoring can be reported using a mobile phone, in addition to recording data on paper.

Community outreach workers record data at each encounter with the individual trans person, and aggregate them onto a weekly or monthly reporting form (unless the data have already been submitted electronically), with the assistance of a supervisor if necessary. Some of the aggregated information may be reported by the programme according to regional or national reporting requirements, but its primary purpose is to enable community outreach workers to analyse their outreach efforts and plan their outreach according to the most urgent needs of the trans people they are serving (e.g. those with the highest risk or vulnerability, or those who have not been met for a significant period of time). The community outreach worker may do this planning in the context of weekly review sessions with the supervisor.

Supervising and supporting outreach

An outreach supervisor has the responsibility to train, motivate and monitor the work of 5–20 community outreach workers. The role may be filled by a community outreach worker who has progressed into this supervisory role or by an NGO staff member until community outreach workers are trained. The outreach supervisor observes community outreach workers in their day-to-day outreach work, reviews their data on components of the service package (number of one-to-one contacts, group contacts, referrals or accompanied visits, condoms and lubricant distributed etc.), and may input the data into a computerized management information system if there is no dedicated data entry officer. The supervisor has weekly meetings with their group of community outreach workers, usually at the safe space (drop-in centre), to discuss high-priority individuals and any problems the community outreach workers may be encountering, and to provide informal training.

Remunerating community outreach workers

Community outreach workers should always be remunerated for their work. However, paying community outreach workers for each individual they persuade to come to the clinic or drop-in centre for services—rather than providing a fixed salary or stipend—may distort demand and lead to coercion. In addition to fixed remuneration, effective incentives and evaluation-based recognition can include phone credit, non-monetary gifts and leadership opportunities that are not linked directly to the number of trans people who are brought to the programme. Offering the chance to participate in national or international trainings and meetings, where possible, may also be an effective way of recognizing outstanding community outreach workers.

Table 4.2 Remuneration/compensation for community outreach workers

RESOURCE SPENT BY COMMUNITY OUTREACH WORKER	REMUNERATION	RATIONALE
Time on outreach (includes time for travel, meeting with trans people, reporting, planning further outreach)	Fixed periodic payment	Agree upon a rate that is acceptable to community outreach workers and feasible for programme sustainability. If possible, rates should be set consistently across state and national programmes.
Time on extra training	Stipend	Programmes should recognize that community outreach workers may have other work and personal obligations that cannot be fulfilled when they are in training.
Travelling between venues, for referrals, training etc.	Bus, train, taxi charges, as required	It is usually most efficient to map travel routes and fix travel allowances for groups of community outreach workers.
Mobile phone airtime	Mobile phone airtime (predetermined is usually best)	Whether using text messages or limited talk time, community outreach workers should be remunerated for on-the-job phone use.
Mobile phone batteries	Chargers, access to power and safe charging	Community outreach workers need their phones for outreach, and phone battery chargers should be made available at agreed-upon charging locations.

D. Foster leadership opportunities

Experienced community outreach workers improve the effectiveness of outreach and provide leadership in their community beyond programme services. It is important that programmes adopt an approach from the beginning that allows community outreach workers to grow as leaders. Programmes do this not only by showing respect and appreciation to community outreach workers, but also by:

- providing support through training, mentoring, constructive feedback and remuneration;
- offering opportunities for them to learn new skills and apply their experience in expanded ways through the programme and in their communities, so that they and other trans people are empowered;
- developing individual promotion plans, whether it be within the implementing organization (higher-salaried jobs within the organization) or with opportunities that the community outreach worker may want to pursue in other organizations.

Training and mentoring of community outreach workers should focus not only on outreach, but also on strengthening their leadership. Community outreach workers with leadership skills are more likely to use critical thinking and take the initiative to reach greater numbers of trans individuals. They may also support the programme in other important areas including:

- **Advocacy:** Trans community outreach workers are uniquely positioned to advocate and mobilize ground-level support to counter barriers such as police harassment, discrimination, stigma and violence. They may initially need support in this role from staff of the implementing organization who are not themselves trans people, but staff should be sensitive to the need to reinforce the community outreach worker as a leader for their community, only stepping in when needed.
- **Programme monitoring:** With experience and support, community outreach workers can participate in monitoring the programme and improving its quality. This develops naturally from the approach taken with micro-planning, where community outreach workers assume responsibility for recording, analysing and acting on data about the trans people to whom they provide services. Community outreach workers who collect monitoring data should also be provided with tools to analyse them (as with micro-planning) and the authority to make decisions based on the information collected. They should also be supported in monitoring aspects of the intervention that the community considers important, such as trends in the service quality of referral clinics. Report-back methods can be through in-person meetings, or by entering tracking information into simple web-based databases.
- **Programme management and leadership:** Community outreach workers can train and mentor other community outreach workers, and may assume other roles in a programme. As programmes mature, community outreach workers naturally seek advancement as leaders, and jobs once done by implementing organization staff may be done by trans people who began as community outreach workers. Outreach supervisors will generally work as full-time staff with a salary commensurate for implementing organization staff in similar positions—these positions will often be staffed by members of the trans community.

4.5.2 Building coalitions and alliances

In most contexts, trans-specific programming has only been recently developed, and resources and infrastructure may be limited. Forming coalitions with existing organizations and local public-health departments that provide similar services to other key populations is therefore essential. Building alliances with non-trans organizations can create opportunities to promote improved policies and practices in HIV prevention, diagnosis, treatment and care into existing public and private systems. Alliances with non-trans organizations such as civil-society organizations, non-governmental organizations (NGOs), community associations or unions representing gays, lesbians, bisexuals or sex workers can enable trans communities to widen their pool of resources. Partnerships with health departments and clinics, colleges and universities, and private businesses can help trans organizations meet the needs of their constituents while generating powerful shifts in mainstreaming and destigmatizing trans individuals and their unique health concerns.

Box 4.11

Case example: Reaching trans people in Mexico

Clinica Especializada Condesa in Mexico City offers a model for successfully providing services to hard-to-reach key populations in a large urban area. The clinic was originally planned as a centre for STIs and HIV care, but has expanded to include psychosocial counselling services, referrals to social services and care for victims of sexual violence. The clinic also provides outreach to people in prisons and is engaged in community-based health promotion.

A comprehensive care centre expressly for trans individuals has been established as a separate component of the clinic, complemented by a community outreach programme to link trans individuals to the services. The passage of a gender recognition law in Mexico City in 2009, and amendments to the city's health law in 2014 recognizing trans individuals as a distinct population with particular health concerns, helped to create an enabling environment for the centre's work. All services are provided at no cost to more than 1,000 female and male trans clients, in an environment that promotes compassion, equality, and respect for all trans individuals.

Although HIV prevalence among trans women who receive services at the clinic is 41%, the majority of clients in the new trans health centre seek clinical services for medical transitioning, and not initially for HIV-related care. Self-medication with hormones is common within this population, often leading to medical complications and sometimes to hospitalization. Clients come at the invitation of outreach workers, or via word of mouth from other users, because of promotion in the print and electronic media, or because they are already receiving other care at Clinica Condesa.

After a mental-health assessment, clients are referred to the clinic´s endocrinology unit for an assessment to initiate hormone therapy. HIV tests are offered as part of the routine lab work. Persons with positive results are linked to HIV treatment and care services. Hormone treatment is initiated once the HIV positive individual's viral load is undetectable, barring secondary health conditions. In this way, the centre serves as a gateway to public health services that normally would be difficult to access due to stigma and discrimination from some providers.

www.condesadf.mx

4.6 Safe spaces

The term "safe spaces" is widely used throughout HIV prevention programming among key populations. In trans communities, safe spaces are any location where trans individuals can gather in a place where they feel secure and are able to freely express themselves. Safe spaces can also be online (virtual) locations (see Section 4.7), but this section addresses physical safe spaces, also known as drop-in centres, which can be:

- a place where community members may discuss programmes with programme managers to improve services
- a venue for psychosocial services and support, based on community demand
- a place to provide information on events and activities relevant to the community (not just programme-related information)

- a place to strengthen community empowerment by discussing discrimination and stigma against the community and planning a response
- a distribution point for condoms and lubricants
- a place for community outreach workers to review their work and plan outreach
- a place for community trainings (of community outreach workers, but also of other trans individuals, e.g. in violence response, power analysis)
- any location where trans individuals gather to share common interests. These spaces can range from private businesses such as salons to retail outlets that are owned or patronized by trans individuals, or any other space in a community where people regularly gather.

In many contexts, safe spaces are important as they provide the only opportunity for trans people to freely express themselves in their preferred gender. In places where criminalization and hostile social environments restrict individuals from dressing and acting according to their preferred gender, safe spaces can be used as a place for people to change clothing, do their hair and alter their gender presentation in a way that is comfortable and authentic for them. Some programmes have established social gatherings for a few hours a week in private rooms of bars and restaurants, and in community centres (see Box 4.12). For some, these short gatherings may be the only time they are able to be themselves openly. Providing an affirming and secure environment, even briefly, for that opportunity can have an extremely positive impact for participants regardless of their stage of transition.

Safe spaces may be located close to programme-operated STI clinics, or even in the same building. There are practical advantages to co-locating safe spaces with clinics, such as the convenience of dealing with just one landlord, and the closer links between community activities and programme services. Nevertheless, it is important to ensure that safe spaces remain a distinct community area. In some contexts, it may be important to separate an implementing organization's office from the safe space and to ensure that community leaders have clear responsibility for managing activities at the safe space.

Box 4.12

Case example: Social safe spaces in South Africa

T-Junction gatherings began in 2004, when there were no formal trans-led organizations in South Africa, as a way to bring trans people and their partners together to socialize without experiencing prejudice or stigmatization. The meetings provided a private and affirming environment where people could experiment with new ways of presenting themselves, especially those who were not fully out as trans and did not change their appearance in public.

T-Junctions were initially potluck gatherings held once a month at the home of a trans community member. In order to include people from more diverse socio-economic backgrounds and from communities of colour, facilitators would drive participants from different suburbs to and from the gatherings. Financial support under Gender DynamiX, a trans-led organization based in Capetown, made it possible to expand the programme and increase average attendance from 5 to 20 people.

In 2010 T-junction collaborated with the Triangle Project, another organization that held monthly support group meetings. The project's support group would meet for two hours on Saturdays, facilitated by a trained counselling professional. Half an hour after the group dispersed, T-Junction would start at a nearby restaurant. Attendees of each programme were encouraged to participate in the other one as well. After some initial success, the collaboration faced financial challenges to cover costs of the T-Junction venue and assist participants with transport costs. Additionally, since the T-Junction began as an exclusively social activity, later efforts to engage participants in more structured thematic discussions around health-care issues were not appealing. However, as the gatherings continued, an increasing number of trans individuals who had previously been socially disconnected from each other developed a sense of community and began to participate in both the support group and in T-Junction's social activities. This caused a substantial trans community to coalesce and made it possible to carry trans issues into other mainstream spaces.

4.6.1 Steps in establishing safe spaces

Community consultation and mapping: A consultation provides guidance on where to locate the safe space, services to be provided, staffing and service hours. Services should be available when trans individuals most need them.

Location: The choice of location should take into consideration not only its accessibility to trans individuals but also its visibility to the public and the response from the wider (non-trans) community. Care must be taken to ensure that the space is safe from intrusion by outsiders and the police.

Lease agreements and landlords: Maintaining a fixed location for the safe space is important to prevent disruption of services. The lease drawn up with the landlord should clearly state the duration of the agreement and clarify the hours and nature of use.

Infrastructure and safety: The safe space will ideally have at least two rooms: one that can be used for one-on-one meetings or counselling, and one for community activities. The safe space should be equipped with basic equipment to handle fires and other emergencies.

Designing the space: The space should be both functional and inviting. Meeting tables and chairs may be kept to one side unless in use; couches or mattresses to sit on can make the room comfortable. Walls may be painted or decorated with art made by the community.

4.6.2 Operating safe spaces

Management: The programme should provide resources for the space. To ensure that the community feels ownership, trans individuals should have the lead role in decisions about the space and its management.

Service promotion: To ensure trans individuals are aware of the safe space and its services, it can be promoted through flyers, SMS messages and community networking.

Ground rules: These should be formulated by those using the space so that they understand what behaviour is acceptable, e.g. with regard to noise levels (this is also important so as not to disturb any neighbours) as well as drug and alcohol use.

Relationships with neighbours: The safe space managers, including the community, should make plans to manage relationships with neighbours and those in the wider community. In contexts where there are concerns about interaction between police and trans community members, the sponsoring organization or individuals overseeing the safe space should assess the policing environment in the area where the safe space is located. Where there are reported incidents of police violence or harassment (e.g. arbitrary stopping and searching of trans women on allegations of sex work, or confiscating condoms and lubricants and using them as evidence of sex work), tracking and monitoring systems may ensure the security of individuals using the safe space. For more information on documenting stigma, discrimination and violence, see Chapter 2, Sections 2.3.1 and 2.3.2.

Programme use: Growing implementing organizations may want to use the safe space for other programme activities or as offices; efforts should be made to ensure that this does not happen or that such activities are kept to a minimum. The safe space should remain open to members of the community to use informally, even if the programme is using it.

Sustainability: Safe spaces can be made financially sustainable when managed by the community. For example, programmes requiring a location can rent or negotiate for use of space on a limited basis, or during set meeting times. In some locations, trans community members generate extra income by renting their own private or commercial space to programmes.

4.7 Information and communication technology

Harnessing information and communication technologies (ICT) that are already being used by trans individuals can broaden outreach efforts and be instrumental in scaling up HIV services. Social media, SMS messaging and other ICT platforms are used by increasing numbers of people, and online spaces in particular have the power to draw together individuals from all socio-economic levels and demographic groups. The anonymity offered by virtual spaces makes users feel safer in discussing intimate topics openly, such as their sexuality, transitioning concerns and personal relationships, without fear of judgement or discrimination.

Community outreach workers are able to provide health information and HIV prevention, diagnosis, treatment and care in clinic-based and community-based programmes. Many of these "front-line" health-promotion activities can also be taken online in order to reach wider audiences and generate meaningful dialogue among supportive peers. Common platforms for trans-led ICT programmes include social media such as Facebook, Twitter, Instagram, independent blog pages and websites, podcasts, and dating and hook-up websites and smartphone applications.

While disseminating medically accurate information, individuals can also connect with each other to share experiences and seek emotional support. ICT interventions should link the virtual to the physical, i.e. they should enable linkages to HCT, treatment, care and support; referrals to STI services; and referrals to psychosocial and other health services.

ICT can be used for the full continuum of HIV prevention, diagnosis, treatment and care, and can be a tool for programme research, design, mapping and analysis as outlined in the "P Process" (Section 4.3.1). It is important to note that while the use of ICT platforms, and social media in particular, in HIV prevention programming for men who have sex with men is widely documented, ICT programming by and for trans communities is only just beginning to grow. Although many of the publication, dissemination, and live-chat strategies used by organizations of men who have sex with men can be adapted for trans communities, the nature and preference of online social media must meet the needs and interests of trans people. Trans community members who are involved in programme mapping, design, implementation and monitoring can determine the platform that will best reach their own community and generate the most positive responses.

4.7.1 Social media and social isolation

Social media can expand programmatic reach to individuals who may otherwise not access trans-specific health information, but it should not replace all face-to-face interactions. As one community outreach worker in El Salvador explains: "These are communication methods that bring with them some risk, such as people having a lot of online friends that they don't know in person, so they are still strangers, really. This can give a false expectation in people who lack self-esteem and who have trouble interacting with others in public for fear of discrimination because of their appearance or gender expression. It can sometimes give people a false sense of security. When people feel isolated and lonely, they can easily trust people who they shouldn't or may be more likely to engage in unsafe behaviour." While ICT can provide important information, emotional support provided face-to-face in a community setting is equally or more important for many individuals.

Box 4.13

Case example: Online sexual-health promotion in Thailand

Sexperts! is an online community-led outreach and support platform for trans sexual-health promotion. A "Sexpert" is a trans woman trained as a community health educator. Sexperts provide HIV, sexual-health and legal rights education in non-threatening, anonymous virtual environments. They not only address standard HIV prevention and treatment questions, but also engage community members in discussions around sex, relationships and body issues that come with transitioning and self-acceptance in one's chosen gender identity.

Sexperts! uses a Facebook group page as the main communication platform and for facilitating live chats. Any member who logs on can discuss any issue related to their sexual health and well-being with a community health educator. Since Thai trans women are typically frequent users of social media, Sexperts! maximizes the captive audience and advertises its page on other trans- and LGBTI-related social media pages. Compared to traditional peer support workshops and online peer education, this approach allows more intensive communication between community health educators and community members.

A priority for Sexperts is to openly acknowledge the pleasure of having sex. A Sexpert understands that causing a person to feel guilty about their sexual practices will sacrifice an opportunity to discuss safer sex and personal risk of HIV.

Thai Lady Boyz Sexperts! Facebook community page allows community members to chat live and anonymously with peer counsellors.

Sexperts receive training and supervision from Thai Lady Boyz and partner organizations. They are required to stay up to date with news relating to trans health. The community health educators are also equipped with authoritative sources to quickly look up information for Facebook page members upon request, and are able to provide resources to individual community members when needed. Their communications are monitored by a programme manager.

4.7.2 Quality assurance and online safety

Good-practice standards for online programmes and outreach efforts using smartphone applications ensure the safety and privacy of members and participants. Many online programmes prefer platforms such as Facebook Group pages, such as the Sexperts! profiled in Box 4.13, or independent blog pages that require users to subscribe for membership and that are monitored by group administrators. Such monitored sites can control who has access to content and who is able to engage in live chats with either community outreach workers or other community members. Consistent monitoring by community outreach workers trained in HIV prevention and sexual-health promotion is critical to ensure the accuracy and integrity of any information presented. This is particularly important where social media pages are used as they may be easily subject to unwanted advertising and unsolicited posts from outside the intended audiences. Since it is not possible to verify the identity of online community members with total accuracy, it is especially important to take safety measures when designing and implementing any form of ICT programme.

Social media pages that include live chats with community outreach workers should be moderated by community members who serve as site administrators. This can be done by only accepting members who can access the website by referral or request. Content must also be consistently monitored to ensure that members are not "trolling" to collect information about other people's identity or to gather content without permission.

Steps to ensuring online safety include:

- Personal information such as addresses and phone numbers must never be shared.
- When using social media platforms to connect with other individuals for dating or other personal reasons, exercise great caution when sharing any personal information. When meeting in person with someone through an online connection, always meet in a public place and inform a trusted friend about the time and location of the meeting.
- Precautions must be taken to restrict announcements about safe space (drop-in centre) gatherings, or other social events that are for trans community members only to social media pages that have restricted access to members only.

4.8 Conclusion

As this chapter and the case examples throughout it highlight, programmes across diverse regions have successfully forged links between clinics and communities, using innovative approaches to common strategies. In doing so, they have achieved measurable improvements in the health of local trans populations and offer models for promising practices that may be replicated in similar resource-limited regions. Providing effective HIV prevention, diagnosis, treatment and care for trans populations not only requires trans competency in clinical and community-based programmes, but depends upon strong links between programmes across all sectors. As discussed in Chapter 3, strengthening health systems through improved training and service integration enables providers to better meet the comprehensive health needs of trans individuals. At the same time, these services must be brought together with greater efforts to bring health information and services to individuals where they are, beyond clinical settings.

4.9 Resources and further reading

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5

Programme Management


Community mobilization
and structural interventions
2 Stigma,
Discrimination,
Violence &
Human Rights
5
Programme
Management
1
Community
Empowerment
3
Services
Starting, managing,
monitoring and scaling
up a programme
4
Service Delivery
Approaches
Approaches to improving
the continuum of HIV and
STI prevention, diagnosis,
treatment and care

What's in this chapter?

This chapter describes effective management systems for national and subnational programmes serving trans people in multiple locations including urban settings. This includes:

- **how management systems support effective programmes** with trans people, including for HIV and STI prevention (Section 5.1)
- **how to design, organize and implement a programme** (Section 5.2) including identifying community needs, tailoring services to meet these needs, ensuring high-quality services, mechanisms to increase acceptance and uptake, and establishing monitoring and evaluation systems
- **how to bring a programme to scale** in a staged manner (Section 5.3)
- **how to build capacity within the implementing organization** (Section 5.4).

Throughout the chapter there is a focus on programme ownership by trans people to support management and delivery of community-led programmes within trans communities.

The chapter also provides a list of **resources and further reading** (Section 5.5).

5.1 Introduction

This chapter gives guidance on strengthening management of national and subnational programmes delivered with and for trans people. To provide high-quality services to a large proportion of trans people, national-level management ensures coordinated delivery of a programme. Depending on the size of the country, additional layers of management may be needed to support local implementing organizations.[1] Delineated tasks are assigned at these different levels of management.

A management system is key to delivering a programme, as it supports and facilitates:

- design, planning and delivery of multiple activities at different levels
- definition of programme staff roles and responsibilities, management of relationships with external partners and linkages with other programmes
- operational activities underpinning programme delivery such as data collection and reporting of results, commodity procurement, quality assurance monitoring, and supervision and training of staff
- public outreach and information-sharing to create awareness and demand for services
- financial procedures and controls.

This chapter is not a comprehensive guide for strategic planning or programme management—many other resources are available to assist managers (see Section 5.5). It focuses on several management approaches and systems that are particularly relevant for trans programmes, and on the necessity of including trans people in each stage of designing, implementing, leading and monitoring programmes. Although policies and systems may not be available in all contexts to support all the aspects of programme management described here, programme implementers and policy-makers are encouraged to implement whatever is feasible and to develop and strengthen components as necessary.

5.1.1 Essential issues for designing and managing HIV and STI programmes serving trans people

Trans leadership: When a new programme is planned, trans people should be included in its design and implementation from the outset. When an existing programme with trans people is developed and refined, trans people should be increasingly engaged in its management and delivery. Initial management by a supportive non-government or government ally ideally shifts to self-management by the trans community members. The management of non-trans-led implementing organizations should be trained to maintain and repeatedly articulate a focus on community empowerment, not just on technical and service delivery aspects. Opportunities for trans staff should be developed in senior management, leadership, governance and monitoring, rather than just limited career opportunities such as community outreach[2] (see Section 5.4.3).

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[1] An implementing organization is an organization delivering an intervention to trans people with a client-centred approach. It may be a governmental, non-governmental, community-based or community-led organization, and may work at a state, provincial, district or local level. Sometimes a non-governmental organization provides services through subunits at multiple locations within an urban area, and in this case, each of those subunits may also be considered an implementing organization.

[2] Community outreach is outreach to trans people in order to provide services such as education, commodities and other forms of support. Wherever possible, outreach is best done by empowered and trained community members, i.e. trans people (referred to in this tool as community outreach workers). However, non-trans people can also be effective outreach workers, especially in contexts where community members are not yet sufficiently empowered to do outreach.

Addressing structural and societal constraints: During the programme design phase, decisions will be made on the constituent elements of the programme. Where feasible, a multifaceted programme addressing structural issues beyond direct HIV risk reduction may generate more community[3] interest and uptake and provide multiple entry-points for trans people to engage programme services. Supporting local trans communities through housing, legal aid, employment, health or immigration advice can positively impact HIV risk and management, and these interventions are valid to consider as part of an HIV and STI programme. Generating ideas for new employment and businesses opportunities for trans people may be particularly useful in encouraging community cohesion. Co-location of services, for example within a community safe space (drop-in centre)[4] for trans people (see Chapter 4, Section 4.6), can help make the programme more relevant and accessible.

Linkages and coordination with other services: At the local level, local government, such as city councils, may be receptive to partnering with community-led organizations. Consideration can be given to developing complementary services, such as government support for after-hours community outreach and client transport services delivered by non-government providers. Trans community health and social issues should be incorporated within national strategic and development planning processes via advocacy efforts. Ensuring that trans community needs are adopted within strategic planning frameworks is important for bringing services to scale and building networks for effective referral between trans and broader national development programmes. Advocacy and negotiation with government helps facilitate whole-of-government responses to trans issues such as addressing violence against trans people in a holistic manner (see Figure 5.1 on p.163).

Financial management: Managers must give attention to securing adequate financial resources, budgeting, and ensuring financial sustainability. Budgeting must occur both before the start of a programme, and over each new financial cycle, when commitments from donors, governments and other sources may be renewed. Programmes may be funded by the national or local government but delivered by community-led organizations with good links and reach within trans communities. Sponsorship, donations, charitable foundations and the private sector can also be sources of funds. Throughout the programme cycle there needs to be ongoing financial monitoring—regular accounting of income and expenditure to ensure that expenditures remain on track and do not escalate beyond budget. Financial controls are important to ensure that funds are spent appropriately on legitimate programme needs. Financial monitoring is thus an integral part of programme management to ensure sustained delivery of services.

Confidentiality and protection of personal data: Designing and managing a programme with trans people requires information on the locality of trans individuals, the size of trans communities and, ideally, unique but confidential identifiers for individual trans clients. Unique identifiers help avoid duplication of services, promote uptake of services and assess the extent of coverage, particularly where there are multiple implementing organizations. Personal data that identify locations or individuals must be handled with strict confidentiality and must be protected from access by individuals, groups or organizations hostile to trans people.

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[3] In this tool, community refers to populations of trans women or men, rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, “outreach to the community” means outreach to trans people, “community-led interventions” are interventions led by trans people, and “community members” are trans people.

[4] A safe space (drop-in centre) is a place where trans people may gather to relax, meet other community members and hold social events, meetings or training. For more information, see Chapter 4, Section 4.6.

Flexibility and continuous programme learning: The environment in which trans people live changes rapidly because of economic fluctuations and legal and social issues, as well as the use of technologies such as smart phones and the Internet. Trans people are often highly mobile, moving within a city, country or across state or national borders to follow fluctuating employment opportunities, find better services or seek a more accepting environment. Programme managers in collaboration with trans communities thus need to design flexible interventions to meet varying local demand for outreach and commodities, and to serve trans people who may not speak the local language. Provision of HIV and STI and other programmes and services for trans people should not be conditional on local registration, residency or citizenship. Given this diversity, changing context and the relative inexperience of some organizations in programming with trans people, it is important to develop management systems that enable rapid adjustments to programmes when necessary, incorporate client feedback, and disseminate lessons, innovations and trans-affirming good practices.

Box 5.1

Case example: Trans leadership for service delivery in the USA

The Center of Excellence for Transgender Health (CoE) at the University of California San Francisco (UCSF) is managed and staffed by trans people. Its goal is to improve the overall health and well-being of trans people by developing and implementing programmes in response to needs identified by the community. The CoE combines the strengths and resources of a nationally renowned training and capacity-building institution, the Pacific AIDS Education and Training Center, and an internationally recognized leader in HIV prevention research, the Center for AIDS Prevention Studies, both of which are housed at UCSF.

The CoE began as a collaborative project of researchers, coordinators from local trans community-based organizations, health- and social-services providers and trans community advocates in San Francisco. CoE created a safe and welcoming space to offer gender-affirming[5] health education and referral services to trans people in the San Francisco Bay Area at risk of acquiring HIV or who are living with HIV.

The CoE provides capacity-building and technical assistance to organizations interested in providing trans-competent[6] health services and other services to trans communities in the United States and internationally. The centre also provides primary care for trans and gender non-conforming clients and engages in research, including intervention development for HIV positive trans women of colour.

The CoE includes community perspectives through a national advisory body of nine trans-identified leaders from throughout the United States. The body's diversity and collective experience ensures that the organization's programmes address issues that are timely and relevant to the community.

www.transhealth.ucsf.edu

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[5] Gender-affirming refers to medical procedures that enable a trans person to live more authentically in their gender identity.

[6] Trans-competent refers to the provision of services, especially health-care services, to trans people in a technically competent manner and with a high degree of professionalism that reflects the provider's knowledge of gender identity, human rights and the particular situation and needs of the trans individual being served. In addition, trans-competent care is delivered in a respectful, non-judgemental and compassionate manner, in settings free of stigma and discrimination.

Box 5.2

Case example: Engaging the community in national strategic planning in Peru

The Global Fund to Fight AIDS, Tuberculosis and Malaria is supporting trans-specific civil-society participation in the country coordinating mechanism and other public-policy arenas. Trainings are offered to trans women to enable them to better understand and articulate their needs to policy-makers. Trans women activists trained through the programme are advocating for stronger legislation for gender-identity[7] and human-rights protections and for more systematic documentation of violence and abuse against them.

5.2 Planning HIV and STI and other programmes with trans communities

At the central level, it is beneficial for trans people to become engaged in high-level strategic planning processes. Trans persons can give input to national strategic plans on HIV, social protection, community strengthening and other relevant areas of development, including ensuring adequate domestic investment in trans community development and programmes.

Developing and delivering specific public-health programmes can occur in a cycle with three core components, all of which need to be driven by programme managers with community engagement and oversight from the outset:

1. **Collect and analyse strategic information** to identify issues affecting local trans communities, including collection and review by community members themselves. Ensure collection of disaggregated data to identify specific needs within different age groups, gender identities, sexual orientations, ethnic and cultural groups and different locations.
2. **Engage communities to develop and implement a series of tailored interventions** to address specific, identified issues, in partnership within local communities.
3. **Monitor and evaluate the interventions** to assess their impact and refine and improve service provision, ensuring community consultation and leadership throughout.

5.2.1 Collecting and analysing strategic information

Effective programmes respond to needs articulated by trans communities themselves. This is facilitated by ensuring meaningful and appropriate collection of data, for example with adequate disaggregation along gender, age, social and cultural lines. Researchers should adopt trans-specific and trans-sensitive approaches during their data collection. For example, care must be taken not to conflate trans people with gay men or other men who have sex with men.

Some form of initial needs assessment, situational analysis or other data collection process is useful to gauge community needs and priorities. Trans community members must be involved and conduct this initial research. With appropriate ethical, confidentiality and data safeguards, some issues affecting trans people can be quantified via routine data collection and periodic surveys, e.g. prevalence of HIV and other STIs, and incidence of harassment and violence. However, some issues of critical

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[7] Gender identity is a person's internal, deeply felt sense of being male, female or some alternative gender or combination of genders. A person's gender identity may or may not correspond with her or his sex assigned at birth.

concern to many trans people and relevant to prevention and care programmes may not be easy to measure, such as multiple impacts of marginalization and stigmatization. Programme managers thus need a variety of data sources to gauge and prioritize issues faced by trans communities. These include community-led approaches and qualitative data, such as through key informant interviews and focus group discussions. Collected data may be cross-checked (triangulated) to ensure validity. The desired information is not always available at the start of a programme and it may be necessary at first to use estimates, e.g. of the size of the local trans populations. This may vary according to setting (e.g. urban versus rural), and within different areas within a city. Initial estimates may be validated later as ongoing monitoring proceeds with further collection of quantitative and qualitative information. Programme managers should provide feedback and discuss findings with representative community members to ensure these correspond with local communities' own needs and concerns.

The rationale for a proposed programme within a trans community is thus ideally developed from local evidence, including unmet needs, community perspectives and wishes, and expected gains, in terms of reduced disease, improved health and overall well-being.

Box 5.3

Case example: Community-led data collection in Peru

IESSDEH (Institute of Studies in Health, Sexuality and Human Development) in Lima began researching the trans population with support from amfAR in 2009. The organization has performed quantitative and qualitative studies, with trans women trained to interview their peers within different community spaces, such as beauty shops and private homes. As well as data on HIV knowledge, attitudes and practices and the prevalence of HIV, information has been collected on respondents' level of education, employment and access to health care.

Findings show that many trans women prefer to treat themselves due to pervasive stigma and discrimination within the health-care sector, effectively creating a parallel and unmonitored health system. As sex work is the main source of income for many trans women in Peru, they are at high risk of HIV transmission due to infrequent condom use when clients pay more to have sex without a condom, police harassment when sex workers carry condoms, and through sexual violence. IESSDEH's research has revealed strong evidence of the negative impacts of transphobia[8] among trans people, and alarming data about the community HIV prevalence: 30% of trans women are living with HIV, as opposed to 0.4% of the general population.

Valuable lessons have been learned from this community-led research, showing that trans individuals' engagement greatly increases the quality and depth of results. Although community participation can slow the pace of research, it adds greatly to findings and helps identify factors leading to trans women's vulnerability and marginalization. Community-led research helps provide a better evidence base on which to build community development programmes that address the identified needs of trans persons. Training trans researchers also increases employment opportunities for trans people in future trans-related research.

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[8] Transphobia is prejudice directed at trans people because of their actual or perceived gender identity or expression. Transphobia can be structural, i.e. manifested in policies, laws and socio-economic arrangements that discriminate against trans people. It can be societal when trans people are rejected or mistreated by others. Transphobia can also be internalized, when trans people accept and reflect such prejudicial attitudes about themselves or other trans people. For more information, see Chapter 2.

5.2.2 Developing tailored interventions

To implement a programme that addresses trans communities' identified needs, programme planners must identify the range of services and interventions to be delivered, appropriate location(s), infrastructure requirements, expected costs and funding sources, and linkages to other programmes that will successfully facilitate implementation and programme delivery.

A "theory of change" can be a useful tool for planning a programme by identifying its logical stages and causal links. Programme *inputs and resources,* e.g. staff and commodities, are obtained to enable programme *activities* to occur. These activities in turn lead to programme *outputs*, e.g. occasions of service. Outputs in turn lead to *outcomes*, such as increased condom and lubricant use and uptake of HIV testing services. Ultimately these outcomes lead to *results*—the final impact of a programme in terms of reduced HIV, STIs, violence, discrimination etc. Developing a theory of change helps to identify and plan for the desired results of a programme, by identifying what resources are needed and how these will be used to conduct activities.[9]

The setting and structure of a programme serving trans people must be carefully designed. A standalone HIV and STI service may generate further stigma and discrimination. Integrating a programme with other interventions can ensure that the demands, needs and documented issues of trans people are addressed seamlessly as part of broader community development (see Chapter 4, Section 4.2.1). Holistic programmes can support trans people to assert agency[10] over their gender identity, sexuality, health and life, as well as addressing a range of health issues including sexual and reproductive health, drug and alcohol use, tuberculosis and psychosocial health and well-being. Broader social, economic and justice issues may also be considered as part of a comprehensive community development approach.

An important element to consider is the differing needs of trans people of different ages, including education, counselling and support for both young, pre-sexual trans people and adolescent trans people exploring and affirming their developing, nascent gender identity and sexuality.[11] Consideration is also needed of how to extend programmes to parents of young trans people in order to support and sensitize parents and promote acceptance. Design of services in terms of addressing the changing "life-course" needs of trans people is a useful way to set up a programme that is relevant, holistic and provides good coverage to the whole community (see also Chapter 3 Section 3.2.5). Ensuring tailored services for unemployed as well as self-employed trans people, including sex workers, can also help increase coverage and relevance.

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[9] For examples of theories of change, see: http://www.theoryofchange.org/what-is-theory-of-change/ http://www.aidsalliance.org/assets/000/000/717/90668-Briefing-our-theory-of-change_original.pdf?1406297651.

[10] Agency means the choice, control and power to act for oneself.

[11] Young trans people are those in the age range 10–24 years, in accordance with the Interagency Working Group on Key Populations *HIV and young transgender people: a technical brief* (Geneva: World Health Organization; 2015).

Box 5.4

Establishing comprehensive, integrated community-led services

The Global Fund to Fight AIDS, Tuberculosis and Malaria supports several trans community organizations to strengthen community-led services. Some of these have a holistic, comprehensive approach to delivering HIV interventions within broader community development frameworks:

We Are Healthy Health Centre (Centro de Salud "Somos Saludables"), El Salvador: This drop-in centre provides a safe space for trans people to socialize and discuss safer sex, family relationships and social issues. HIV information and testing services are also provided. The Centre has a monthly schedule to distribute condoms, lubricants, leaflets, legal advice and other assistance. A group of trans volunteers also accompany trans people during their visits to public hospitals to ensure greater care retention.

Project DIVA multi-country South Asian grant: Afghanistan, Bangladesh, Bhutan, India, Nepal, Sri Lanka, Pakistan: Project DIVA supports capacity-building of over 60 in-country and regional community-based organizations engaged in HIV prevention, care and support services; policy development and advocacy; partnership with local governments and health departments; research into trans issues; and creating stronger community systems. Health providers have been trained with a trans-specific health curriculum: *The time has come: enhancing HIV, STI and other sexual-health services for MSM and transgender people in Asia and the Pacific*. The training package reduces stigma in health-care settings and is being integrated into national curricula.

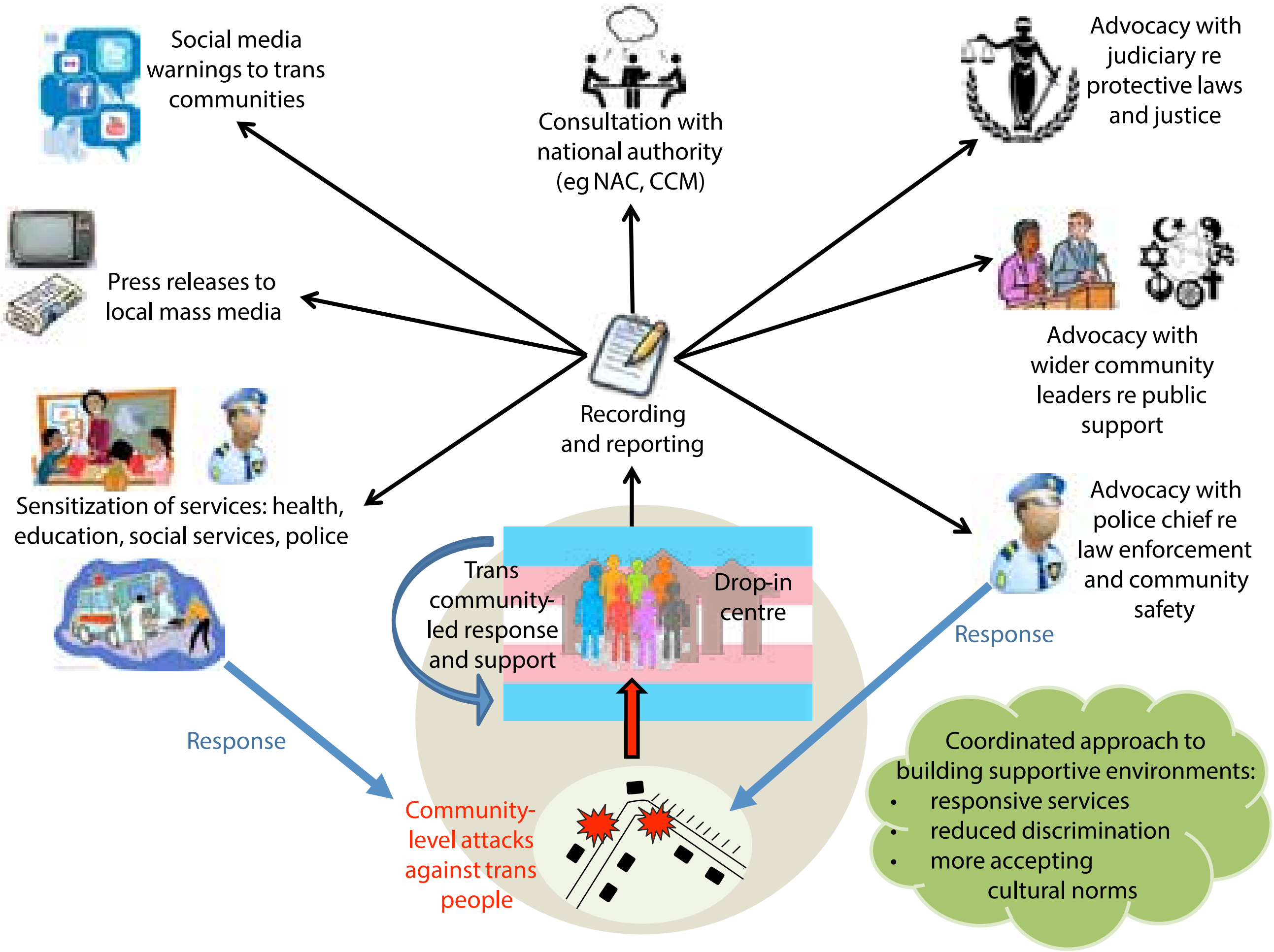
Figure 5.1 shows how an intervention addressing a specific issue—violence against trans people—requires multisectoral management and coordination (see Chapter 2 for further detail on programming addressing violence, stigma and discrimination).

Section 5.3 describes in detail how to implement services in stages to ensure that coverage is consistent and of high quality. The remainder of this section describes the process of setting programme standards, defining the management structure, increasing community acceptance and uptake of services, and ensuring consistent service delivery.

Setting programme standards

Ensuring that HIV and STI prevention, diagnosis, treatment and care programmes meet agreed standards is an essential management function. Interventions designed for other populations may need to be adapted for trans people, and existing trans programmes may need to be strengthened to reach desired quality. Care must be taken to identify specific trans communities' needs and not to conflate trans people with other groups and communities, although opportunities for overlap of services may still exist if specific tailoring and sensitisation can be maintained. Services should be delivered simply and straightforwardly, but with sufficient gender-affirming technical and professional expertise, with adequate attention to standard operating procedures and agreed treatment protocols and defined minimum standards. Training materials for providers are ideally adapted to suit trans programmes and developed nationally to maintain quality and consistency. A service charter is useful for clearly displaying the service-provider's objectives and obligations, as well clients' rights and responsibilities.

Figure 5.1 Comprehensive approach to addressing violence against trans people



Defining the management structure

Smooth programme delivery requires all programme staff to have clear roles and responsibilities across all levels of the programme. External, complementary and synergistic partnerships also need to be defined (e.g. with government, media, medical services etc.), with clear linkages and referral mechanisms supporting effective and holistic implementation.

At the national/central level, programming involves:

- setting programming standards
- ensuring programmes are implemented in prioritized areas and communities
- monitoring dashboard indicators[12] from project implementers
- delivering a country-wide evaluation plan.

Figure 5.2 illustrates a management structure of a national programme—drilling down to local, municipal and community outreach levels, showing oversight and reporting relationships within the programme, as well as external relationships managed at different levels. Key management roles are:

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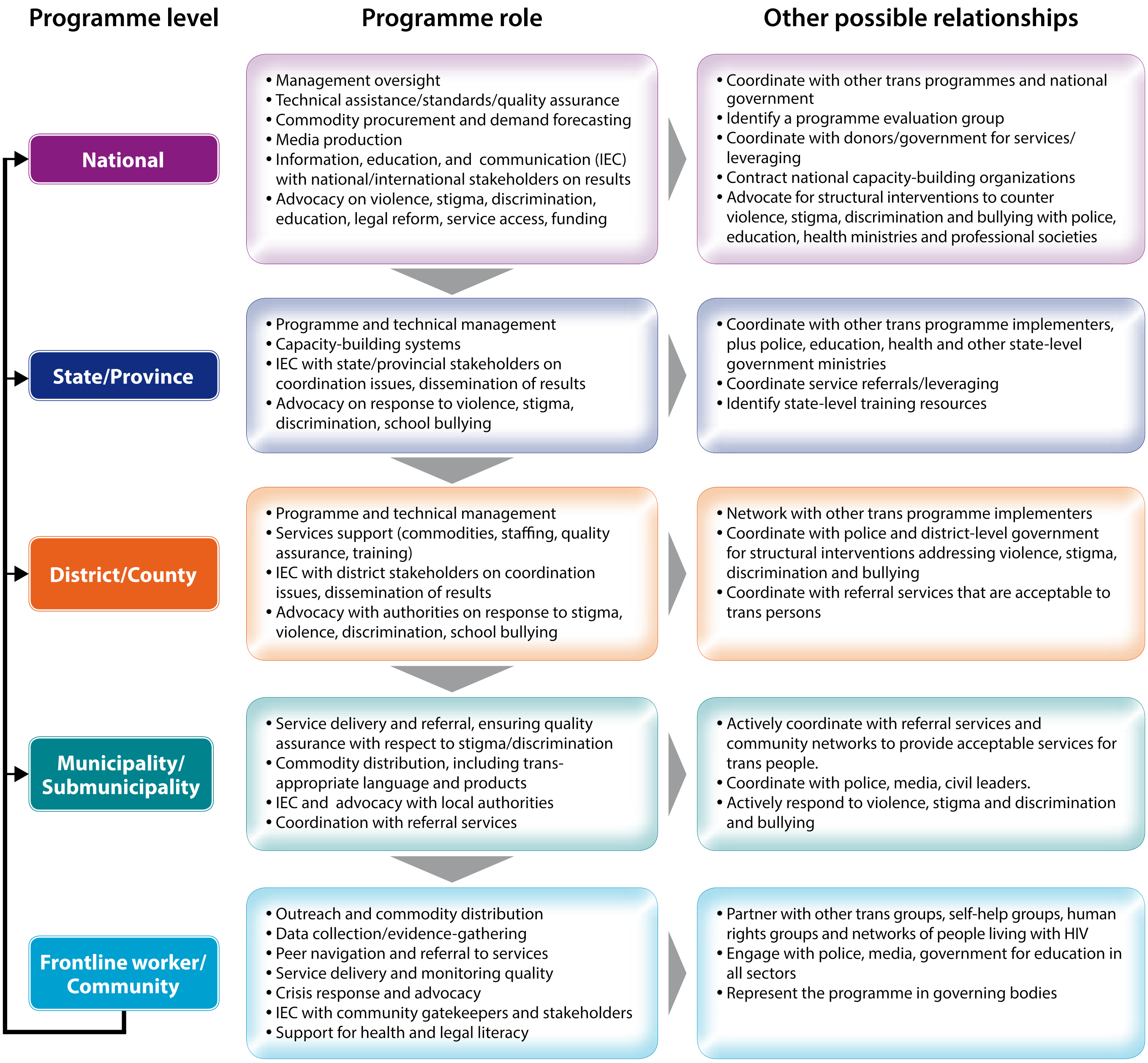
[12] Dashboard indicators are a standardized, minimum set of programme monitoring indicators, aggregated to a national level. They provide an overview of how well the programme is functioning (rather like gauges on the dashboard of a car keep the driver informed).

- **Setting milestones**[13] coupled with field oversight for monitoring both quality of services and progress towards milestones. Regularly review progress against targets to adjust strategies and tactics. Use programme experience and data to make mid-course corrections.
- **Establishing an organizational culture** that aims to:
  - – empower trans people to manage the programme
  - – empower staff at all levels to use local monitoring data to improve the programme.

Figure 5.2 Illustrative management structure for a national HIV prevention, diagnosis, treatment and care programme with trans people

Note: programme roles are not exhaustive



Programme level	Programme role	Other possible relationships
National	• Management oversight • Technical assistance/standards/quality assurance • Commodity procurement and demand forecasting • Media production • Information, education, and communication (IEC) with national/international stakeholders on results • Advocacy on violence, stigma, discrimination, education, legal reform, service access, funding	• Coordinate with other trans programmes and national government • Identify a programme evaluation group • Coordinate with donors/government for services/leveraging • Contract national capacity-building organizations • Advocate for structural interventions to counter violence, stigma, discrimination and bullying with police, education, health ministries and professional societies
State/Province	• Programme and technical management • Capacity-building systems • IEC with state/provincial stakeholders on coordination issues, dissemination of results • Advocacy on response to violence, stigma, discrimination, school bullying	• Coordinate with other trans programme implementers, plus police, education, health and other state-level government ministries • Coordinate service referrals/leveraging • Identify state-level training resources
District/County	• Programme and technical management • Services support (commodities, staffing, quality assurance, training) • IEC with district stakeholders on coordination issues, dissemination of results • Advocacy with authorities on response to stigma, violence, discrimination, school bullying	• Network with other trans programme implementers • Coordinate with police and district-level government for structural interventions addressing violence, stigma, discrimination and bullying • Coordinate with referral services that are acceptable to trans persons
Municipality/ Submunicipality	• Service delivery and referral, ensuring quality assurance with respect to stigma/discrimination • Commodity distribution, including trans-appropriate language and products • IEC and advocacy with local authorities • Coordination with referral services	• Actively coordinate with referral services and community networks to provide acceptable services for trans people. • Coordinate with police, media, civil leaders. • Actively respond to violence, stigma and discrimination and bullying
Frontline worker/ Community	• Outreach and commodity distribution • Data collection/evidence-gathering • Peer navigation and referral to services • Service delivery and monitoring quality • Crisis response and advocacy • IEC with community gatekeepers and stakeholders • Support for health and legal literacy	• Partner with other trans groups, self-help groups, human rights groups and networks of people living with HIV • Engage with police, media, government for education in all sectors • Represent the programme in governing bodies

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[13] Milestones are intermediary targets that are necessary steps towards achieving overall programme goals.

Increasing community acceptance and uptake

As services are set up, efforts are needed to promote their uptake. Benefits of a service need to be explained to key individuals and leaders within local trans communities. Such community gatekeepers influence perceptions and attitudes and can encourage uptake. Community leaders, respected service-providers, local advocates and allied organizations can all help build knowledge and acceptance of a new service, catalyse health-seeking behaviours of trans people and help them navigate health and other services. Various communication strategies can also help increase acceptance of services, including community-led referrals, publicity via social networks, other information and communication technologies, and advertising campaigns.

Encouraging uptake of newly available health services may be challenging, owing to existing stigma and discrimination and some trans people's negative perceptions of service-providers. Time, patience and sensitivity are needed to build trust within the community to increase uptake. Barriers to uptake can be addressed, including providers' knowledge, attitudes and skills regarding common trans health issues, service costs and lack of quality. Structural vulnerabilities should also be addressed, such as lack of income, punitive laws and discriminatory law-enforcement approaches.

Ensuring consistent service delivery

Once a programme is up and running, it is important to ensure continuity of service provision with uninterrupted supply of products and services. Day-to-day management can be coordinated and streamlined using continuously collected monitoring data (see Section 5.2.3). Stock control, equipment servicing, human-resource management, budgeting and financial requirements, utility and council charges must be monitored to prevent disruption to any part of the programme. Equally important, community monitoring is needed to identify any local barriers or concerns regarding the services. Strengthening treatment literacy of trans individuals living with HIV increases understanding of HIV and ART and can generate demand for improved health services within their communities.

Running a comprehensive care programme within the community does not mean taking on all responsibilities of the government health sector. Procurement of goods and commodities such as drugs, reagents and equipment is a primary responsibility of governments, for which they are accountable. Meanwhile, members of trans communities should become familiar with the procedures employed in health centres and health outlets in general so they can warn of risks of stock-outs, expiring medicines and any other threats to the functioning of the programme.

5.2.3 Monitoring and evaluating the interventions

Establishing a monitoring system

Routine collection, analysis and interpretation of data are essential operations within the programming cycle. Useful data include "occasions of service"; commodities distributed or prescribed; types of conditions diagnosed; outreach and community-led interventions, counselling and referrals. Other forms of periodic monitoring include client satisfaction surveys and "mystery client" attendance, i.e. clients who, unbeknownst to the provider, provide confidential feedback on services they received. Information can also be collected on the outcomes of persons treated (e.g. suppression of HIV viral load, cure of certain STIs). Social media can also be used by clients to share information and experiences of care and services they have received via programmes. See also the WHO *Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations.*

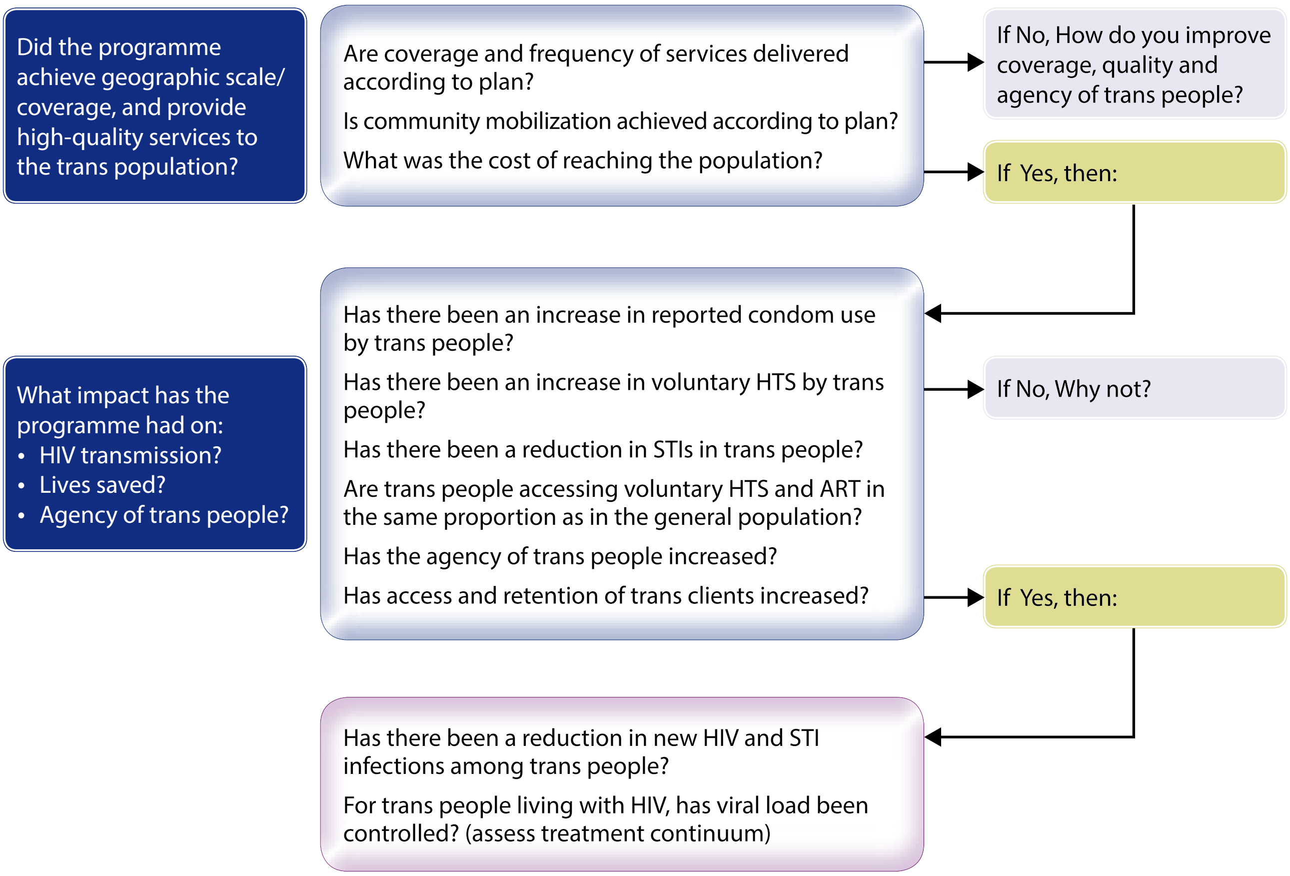
Any changes in uptake of services can be ascertained through continuous monitoring. An increase in the number of clients may signal success and acceptance within the community, leading to the need to increase procurement of commodities and possible staffing adjustments. A drop in attendance by trans people could indicate some local structural issue, prevention "fatigue" or lack of acceptance of service-providers. Measurable changes in delivery of interventions alert programme managers to the need to take actions and adjust service provision accordingly.

Members of local trans communities must have a say in service provision, including in all reviews and when adjustments are necessary. This is ideally achieved through a programme oversight committee or governing board which includes community representation to give community feedback and guidance to managers. Such oversight is an essential aspect of programme quality, ensuring that services or interventions are delivered appropriately and are aligned with community needs and expectations. Community monitoring of implementation adds insight to coverage, acceptability and appropriateness of programmes and services (see also Chapter 2, Section 2.4).

Evaluating the programme

Broadly speaking, a programme evaluation assesses first how well the implementation matched the original programme design (e.g. in terms of programme content and coverage), and second the ultimate impact of the programme, i.e. its end results. Did it prevent and manage HIV and other STIs occurring within trans communities? Did it build capacity of the implementing organizations? An illustrative, national-programme-level evaluation framework is depicted in Figure 5.3. See Section 5.5 for further guidance documents on designing evaluation programmes with trans people.

Figure 5.3 Evaluation framework for a multi-component HIV and STI programme with trans people



Key issues to consider when designing an evaluation are:

- **Effective community and ethical safeguards are in place.**
- **Clarity on the evaluation goal:** What is to be evaluated? Using the theory of change (see Section 5.2.2) can be helpful in clarifying this. For an evaluation, the results of the programme need to be identified, together with the degree of certainty that these results were achieved, in terms of both adequacy (the content, scale and reach) and plausibility (whether changes were due to the programme itself or to other factors).
- **Financing the evaluation:** Often data analysis and dissemination of results are under-budgeted. It is good to build in the estimated costs of monitoring and evaluation at the start of the programme. As a guide, about 5–10% of the total project budget should be allocated for monitoring and evaluation.
- **Data collection and triangulation:** Good collection of data is essential to accurately gauge programme impact, as well as to demonstrate to managers and funders that implementation is as planned and remains on track. Data collection methods include:
    - Surveys—ideally a baseline survey before interventions are started, with periodic follow-up, e.g. periodic, integrated biologic behavioural surveys (IBBS) and stigma index survey, which provide the best evidence of impact, provided they have sufficient power (size relevant to the trans population), and are representative and free of biases.
    - Routinely collected service statistics, e.g. enrolment data, numbers of trans people contacted, number of condoms and lubricant distributed etc. Further routine monitoring of health outcomes (e.g. HIV or STI rates) may be conducted by national HIV or STI programmes, where these exist, e.g. estimated current prevalence of health issues, or incidence of new cases per given time period. This information may help to assess the impact of the programme in terms of biological outcomes, even where these are approximate values based on models and estimates or incomplete reporting.
    - Registering financial data on programmatic costs.
    - Qualitative data, e.g. from client surveys, mystery clients or key informants.

  Trans people must be engaged in research and data collection from the outset. Building relationships between researchers and communities can be challenging. Programmes usually need to first build trust and deliver immediate services within a community before asking intimate questions or requesting biologic specimens. Since one goal of service provision is behaviour change, accurate baseline data can be difficult to obtain. Where possible, data from other sources should therefore be used to triangulate survey data. Likewise, surveys used for evaluation purposes can be used to validate other programme data, for example to:
    - estimate final programme coverage and validate earlier monitoring estimates
    - conduct population size estimates using more mathematically based approaches
    - assess levels of reported violence
    - assess legal and policy environments that may facilitate or impede access to services for trans communities (e.g. conducting mapping of laws and policies)
    - Assess levels of individual and community agency.
- **Dissemination plan:** Dissemination and feedback of results is important at all levels—from nationally down to local trans communities. Dissemination creates ownership of the results, establishes accountability and reliability and helps to further improve programme delivery and uptake.

5.3 Implementing a scaled programme

Good programmatic coverage of trans communities is essential to achieve impact at a population level. Programmes that achieve both high coverage and also wide geographic scope ("scaled programmes") require close partnerships between government, donors, non-governmental organizations (NGOs) and community-led organizations. Coverage needs to be monitored at all levels—municipal, district, state/province and national. Planning for and monitoring coverage requires estimates of total and local trans populations (denominator data). For a country-wide view, the national HIV programme or a central management agency may collect coverage information, working with all implementing organizations (see Section 5.3.2).

Implementing the programme in sequential stages helps to ensure quality and achieve wider geographic coverage. Once the physical infrastructure, e.g. the implementing organizations and service locations, has been developed in all areas, the service package (see Chapter 3, Box 3.1) is rolled out nearly simultaneously across all target geographic areas. This is preferable to piloting in one location first and rolling out to others later. It is a good idea to set up referral linkages to other providers early on for services that cannot be provided initially. As the programme matures, constant quality improvements are undertaken and further interventions and services can be added as needed. Efforts are also needed to ensure sustainability. Figure 5.4 summarizes four stages of programme implementation, described in more detail below.

5.3.1 From start-up to establishing infrastructure across the target geographic area

Key steps in starting a programme include knowing where to establish services and contracting implementing organizations to deliver these services.

Estimating the size, characteristics and distribution of trans populations

At the national planning level, reliable data are needed about the numbers and localities of trans people within each geographic area, together with information on existing services if any. Population size estimation and programmatic mapping are dual processes that inform the scale of new intervention(s), where best to locate these, funding and resource needs, setting performance targets, and assessment of programme coverage. Disaggregated data collection provides information on different cultural and age groups represented within trans communities, including young trans persons. Prioritizing locations with the largest number of trans people allows a smaller number of implementing organizations to reach a large proportion of trans people most cost-efficiently.

- **First stage: "Where in the country are there a significant number of trans people?"** Trans people exist across an entire population, but may tend to congregate in certain urban locations for mutual support, economic opportunities and safety. Information may be obtained from local key informants such as trans activists, community organizations representing trans people and service-providers, e.g. NGOs that work with them. In urban areas, interviews may also be useful with a variety of service-providers including police, health, social and education providers. Care must be taken to ensure the exercise does not provoke backlash against trans communities or individuals.
- **Second stage: "How many trans people are living in each municipality/area, and where?"** Once the general geographic area is known, more focused population size estimation may take place, such as via the PLACE method (Priorities for Local AIDS Control Efforts—see Section 5.5) or participatory site assessments, depending on the degree of involvement of

Figure 5.4 Stages of implementing a multi-component programme with trans people

	Social and Behavioural Interventions	**Commodities** (condoms and lubricants)	**Clinical Services**	**Structural Interventions**
START-UP **Identify coverage areas & establish infrastructure**	• Identify sites • Hire and train NGOs/staff • Map trans communities • Recruit and train outreach workers • Establish safe spaces (e.g. drop-in centres) and community-led HTS	• Identify source of condoms and lubricants • Establish forecasting and procurement • Estimate trans persons' condom requirements • Estimate condom gap for venues	• Map services: STI, SRH, HTS, ARV, TB, NSP, OST • Establish referral linkages and reporting • Sensitize providers on trans issues – ensure acceptable services	• Conduct environmental risk assessment. Analyse key issues: e.g. discrimination, harassment, violence • Prioritize and develop mitigation plan • Work with local police to facilitate outreach work
ROLL-OUT OF SERVICES **Improve coverage and quality**	• Micro-planning • Monthly outreach/ commodity distribution/ referrals • Training + refreshers • Review routine data for programme oversight and modification • Engage c'ty networks	• Directly distribute and track condoms to trans people through outreach • Identify additional outlets for commercial promotion • Advocate for and establish condom social marketing	• Regular referral of trans people to services (STI, SRH, HTS) • Facilitate trans persons' access to HIV care, ART • Establish community counselling and support • Monitor clinic for stigma	• Ensure trans legal literacy • Establish crisis response system • Establish monitoring systems to track and report violence • Engage stakeholders • Build capacity in advocacy
INCREASE SUSTAINABILITY **Improve systems, Social norm change**	• Social norms change in regard to condom use, service uptake and use • Address barriers to access • Consolidate client-focused services – night outreach, home testing	• Forecasting, including for local implementers • Central procurement and storage of government condoms • Condom social marketing established	• Community agency improved to access services directly • Clinical service stigma reduced • Links with networks of people living with HIV	• Trans community groups strengthened • Trans persons have increased programme role • Trans communities have increased capacity to advocate for themselves • Address barriers to access
EXPAND SCOPE **Add services**	• Train outreach workers in new services, e.g. TB verbal screening, DOTS, monitoring ART adherence	• Addition of other products/ commodities	• Expand/add clinical services	• Trans communities engage in other community priorities

trans people. Another possible method is respondent-driven sampling, a type of structured "snowball sampling" that identifies chains of individuals via personal contacts. Estimating approximate numbers of trans people in each area allows initial interventions to be focused in locations with the largest number.

Population size data are often difficult to obtain, as many trans people are unwilling to self-identify as such. In particular, trans persons who are too young to be sexually active or who are of an older generation where trans status was not well recognized are unlikely to be captured in surveys.

Implementing organizations should then map the community to assess risk behaviours, risk perceptions and barriers to access; define precise locations for interventions and services; and determine programme personnel needs. Risk level is determined by factors like barriers to health care; engaging in sex work; use of drugs; unsupervised injection of hormones or soft-tissue fillers; and the age and agency of trans people. For more information on mapping, see Chapter 4, Section 4.3.1.

Allocating responsibilities among implementing units/NGOs

When assigning implementing organizations to begin services, it is important to define distinct catchment areas for each to cover. Wherever possible, avoid overlaps in geographic areas. The size of local trans communities will determine the area of coverage for each implementing organization. If the target population is too small, it will make the intervention too costly per trans person reached; if it is too large, it may exceed the organization's management capabilities and create perverse incentives, e.g. inaccurate reporting, fake clients etc.

Hiring and training staff

A multi-component intervention with trans people requires team members with a variety of skills. The composition of a team depends on the services provided, how the services are delivered, the size of the trans community, and the geographic area being covered. Table 5.1 provides an example of an implementation team at a municipality/submunicipality level.

Table 5.1 Illustrative composition of an implementation team at the municipal/submunicipal level where trans people gather, for delivering a programme to approximately 1,000 trans people.*

POSITION (NUMBER OF STAFF)	GENERAL RESPONSIBILITY	COMMENTS/ASSUMPTIONS
Coordination and administrative personnel		
Programme coordinator (1)	Responsible for the overall implementation of the project.	
Data officer (1)	Aggregate data, generate reports and monitor data quality.	
Accountant (1)	Maintain accounts and pay local expenses of the programme.	
Medical personnel *The number and type of medical personnel needed are based on the biomedical component(s) of the programme.*		
Physician (1)	Provide clinical services offered by the programme.	Not necessary if clinical services to the community are entirely referral-based.
Nurse (1)	Provide/support clinical services offered by the programme.	Not necessary if clinical services to the community are entirely referral-based.
Clinic support staff (1)	Greet clients. Maintains reception area.	Helps clients navigate available services.
Outreach personnel		
Counsellor (1)	Identify and manage psychosocial issues, and provide support for behaviour-change processes.	Even if clinical services are not provided, a counsellor may help guide trans people on referral clinical services.
Outreach supervisors/ managers (~5)	Supervise community outreach workers on a weekly basis. Ensure outreach services are recorded and incorporated into routine monitoring systems.	
Community outreach workers (~20)[14]	Outreach to trans people, provision of commodities, referrals, follow-up and structural interventions. Support behaviour change. Support trans people in responding to stigma, discrimination and violence.	One community outreach worker works 5 days per week, 4 hours per day and can meet 2 or 3 trans people per day. Includes time needed for routine meetings with outreach supervisors/managers and monthly organization meeting. Adjust number if trans people are in close proximity or dispersed.
Office support staff (1)	Support routine office processes.	

**Staff numbers may be reduced appropriately for smaller trans communities*

Implementing organizations will include both non-trans and trans persons on staff. Trans people can occupy all positions for which they are qualified within the implementation team, including leadership positions, and wherever possible it is important that community outreach be done by trans.[15] Adequate and fair salary scales are important, with due recognition and acknowledgement

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[14] A community outreach worker is a trans person who conducts outreach to other trans people, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called "staff outreach workers" or simply "outreach workers"). Community outreach workers may also be known by other terms, such as "peer educators". However, the terms "peer" or "community" should not be understood or used to imply that they are less qualified or less capable than staff outreach workers.

[15] This is the optimal situation, but non-trans people can also be effective outreach workers, especially in contexts where community members are not yet sufficiently empowered to do outreach.

of trans staff members' skills and experience. Non-trans staff should be sensitive to the discrimination, violence and other issues trans people face. All staff should be competent discussing a broad range of issues on gender identity, human rights, sexual and reproductive health and rights in a non-judgemental manner.

Although staff members will be hired with specific roles and job descriptions, they need to be flexible in delivering services, adapting to new situations and incorporating new approaches. Since a crucial goal of effective HIV and STI programmes is to empower trans communities, non-trans staff will learn from trans people themselves, as well as serving as mentors in this process. Capacity strengthening of trans staff is important, with the intent of progressively increasing their engagement and leadership (see Section 5.4).

5.3.2 From rolling out services to improving coverage and quality

The roll-out stage is a continuous process. As services become established, the focus shifts to ensuring wide coverage of the community with programmes, and improving quality, while maintaining a human-rights-based approach to service delivery. Managers review progress against targets and adjust strategies and tactics as necessary. Mid-course corrections are based on new data, new approaches or environmental or structural changes that affect programming. The intensity and the quality of services increase as staff become more skilled in their positions. Flexibility and continuous programme learning are extremely valuable during this stage. A strong monitoring system with regular reviews is essential for successful roll-out. It also signals to funders and the government whether programming is being implemented successfully.

5.3.3 Systems improvement, social norm change and increased sustainability

Programme implementation has several complementary aims which make the programme more effective and potentially more sustainable:

- Provide services to reduce HIV and STI transmission, and treat HIV and related infections.
- Empower trans people to participate and progressively build their capacity to implement the programme.
- Address structural and institutional barriers through advocacy and policy change.

Implementation during this stage therefore involves not only providing and monitoring services, but also strengthening systems and empowering communities. Some of the earlier, intensive set-up activities may be tapered as social norms change, for example around condom and lubricant use and uptake of clinical services. Ideal characteristics of a maturing programme include:

- Community outreach is led by trans people (see Chapter 4, Section 4.5.1).
- The individual and collective agency of trans people is sufficient for them to seize opportunities and address problems themselves, e.g. with families, parents, partners, police, health systems, government and within the community.
- Trans people are engaged in planning and oversight (governance roles) at local, district and national levels, guiding service delivery and response to violence.
- Social norm change occurs among trans people, e.g. making condom and lubricant use routine.
- Health services are free of stigma and discrimination against trans people.
- Supplies of commodities (condoms, lubricants, HIV test kits etc.) are adequate, through both

social marketing and strengthened country procurement and distribution mechanisms, and trans programmes are included within state commodity tracking systems.

Once the infrastructure, community engagement and coverage have been established and the programme is functioning, it is relatively straightforward to add various further services.

5.4 Capacity-building within service-providers and implementing organizations

While an implementing organization may be trans-led, in many settings—and often in the initial stages of a programme—an organization may not have extensive experience working with and supporting trans communities. Consequently, many implementing organizations need capacity-building[16] in delivering trans programmes. Lack of experience does not mean lack of ability, and it is possible to build the capacity of both non-trans and trans staff via online or classroom training, field exposure, supervision/ mentoring and interactive problem-solving sessions.

5.4.1 Training staff

Ideally, training materials are adapted specifically for trans programmes and developed nationally to maintain quality and consistency and ensure defined minimum standards. Materials can also be tailored to meet individual capacity-building needs, with pre- and post-assessments to monitor quality of trainings.

Non-trans staff

Training goals for non-trans programme staff include:

- orienting staff to the issues experienced by trans people, ensuring correct use of names, terms and terminologies
- acquainting staff with specifics of the project (e.g. intervention elements, reporting procedures)
- building technical skills in new areas (e.g. clinical skills including hormone replacement therapy, anal, vaginal, penile and oral examinations for STIs; counselling on trans issues, specificities of working with young/adolescent trans people)
- transferring skills and responsibilities to trans community members
- See also Chapter 4, Box 4.3.

Effective acquisition of these skills may require a change in staff members' attitudes toward trans people (e.g. their attitudes on gender identity, sexuality or the morality of sex work).

Trans staff

One programme goal is to increasingly involve trans people in programme implementation and management and to build their capacity to address environmental, structural and institutional constraints that inhibit preventive and health-seeking behaviours. A training programme should focus on building the skills and hands-on experience of trans people in a wide range of roles within the organization, ranging from conducting and managing outreach and fixed-site service provision

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[16] Although this publication uses the term "capacity building", "capacity development", "organizational development" or a number of other terms would serve equally well.

to administrative and operational roles including financial management, monitoring and research, policy development and strategic planning, and full programme management and leadership. This training can be conducted in a phased approach. A mentorship programme can be established to guide and encourage individual trans persons who show particular promise, interest and commitment to the organization. More details can be found in Chapter 4, Section 4.5.1.

Although non-trans staff and trans staff may differ in their types and levels of experience and education, wherever possible training should take place jointly so that all participants can learn from one another and bridge gaps in their knowledge and skills in a collaborative manner. Some approaches for capturing programming lessons include:

- routine site visits by programme managers to learn of local innovations and transfer lessons to other sites
- regular scheduled programme reviews—bringing implementing organizations together, including opportunities for cross-sharing of ideas, experiences and solutions to issues raised
- periodic cross-site meetings of technical officers to build networks and share approaches
- formal revision of programme approaches—updating minimum standards, standard operating procedures and reporting procedures.

Box 5.5

Case example: A curriculum for community systems strengthening in India

A training curriculum on community systems strengthening for trans, *hijras*[17] and MSM (men who have sex with men) communities in India provides 15 modules on topics ranging from organizational development and financial management to identity, gender and sexuality, mental-health counselling, human and legal rights, and life-skills education. The curriculum has been used to train 200 trans, *hijra* and MSM organizations in India. The curriculum was developed by Pehchan in close consultation with community members through consultations, in order to ensure that the material reflected the training needs and priorities of the community organizations themselves.

www.allianceindia.org/our-work/pehchan

5.4.2 Establishing a supervision system

Regular, scheduled meetings between programme managers and service-providers can provide supportive supervision to foster, mentor and encourage staff. Further functions of supportive supervision include:

- motivating and training staff

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[17] *Hijras* are a distinct socio-religious and cultural group within the wider trans population in India who mostly live in close-knit clans known as *gharanas*. *Hijras* traditionally give blessings and offer songs or dances at public ceremonies such as marriages, in return for money; but changing socio-economic conditions have forced a significant proportion of them into begging and sex work for economic survival, increasing their vulnerability to HIV and other sexually transmitted infections.

- sharing guidelines
- monitoring and evaluating staff performance, including focused leadership mentoring
- managing day-to-day challenges
- facilitating organizational support.

Any necessary corrective actions can be identified early and an environment fostered for continuous improvement and independent problem-solving. Periodic team meetings enable review of monitoring data at all levels to track progress towards programme goals, including for community outreach workers, NGO staff, at state/provincial levels, and within central management. Field visits by supervising staff boost morale, provide qualitative information on implementation, and support problem-solving.

As an example, a supervision and programme review system used by a large project in India is depicted in Figure 5.5, along with the level of data that was used as part of the review. Community committee meetings and regular supervision meetings between community outreach workers and their supervisors/managers are two ways in which qualitative as well as quantitative data about the programme may be gathered. This is an important part of the community empowerment process described in Chapter 1.

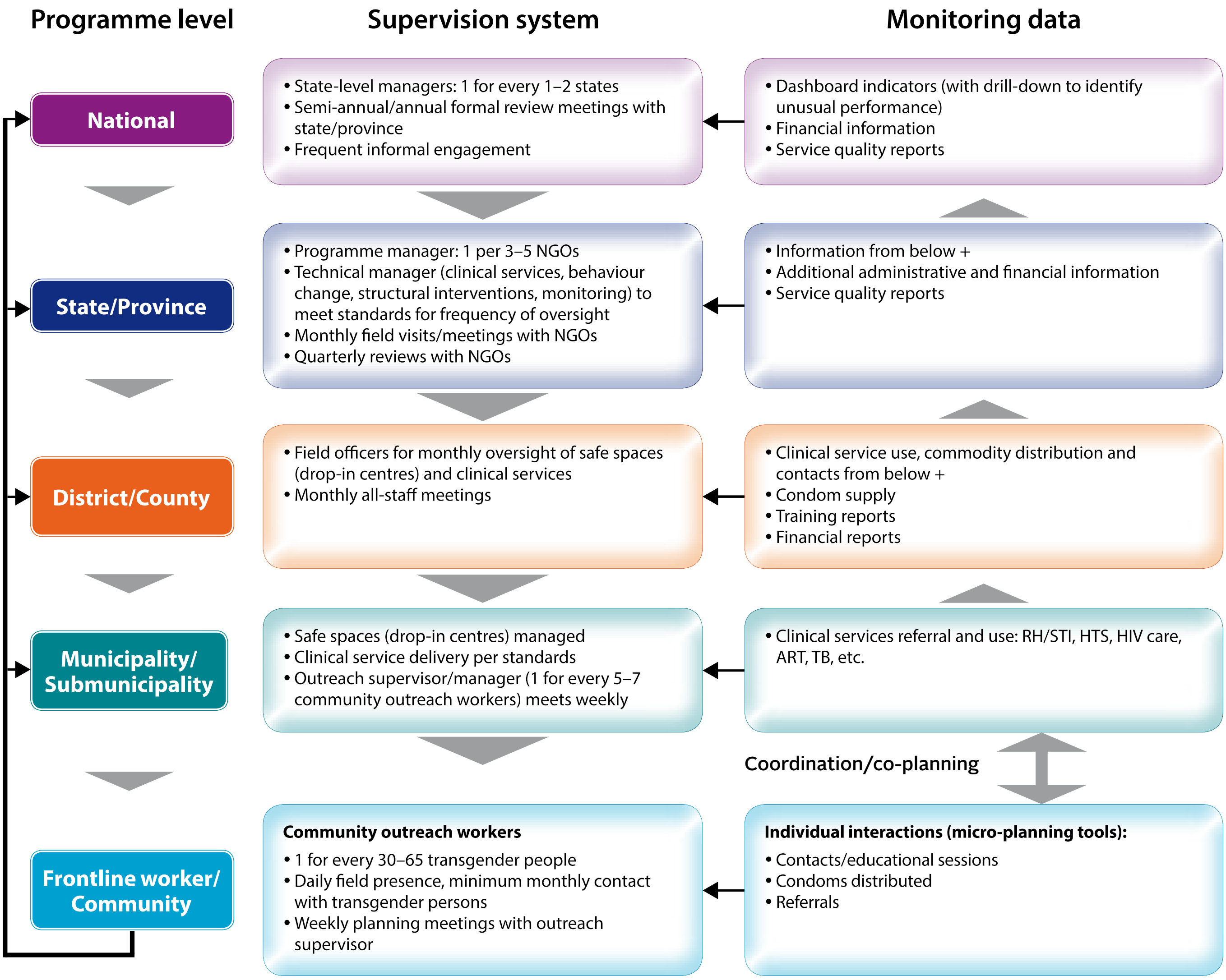
5.4.3 Staff development

There are several good practices that ensure optimal staffing and that staff are motivated and satisfied by their work. These include:

- clear job descriptions and roles and responsibilities for all positions in the programme
- clear reporting lines showing to whom each person is accountable
- team-building and a culture of mentoring, with a leadership mentoring programme for trans staff members
- clear criteria for regular performance reviews and recognition
- clear policies on leave, travel reimbursement and remuneration for work, including equitable policies for trans staff. Ideally these will be uniform across a country
- assistance and support to prevent burnout e.g. through workshops or flexible working hours etc.
- opportunities for training for different positions in the organization, such as outreach supervisor, clinic assistant, nursing, counselling, social work, office manager.

It is important to invest in developing and supporting trans and non-trans staff. Ensuring a culture of continuous learning helps to enhance performance and motivate staff to stay fresh and constantly strive to improve both their capacity and ability, and the quality of services provided. Staff who have clear career paths are more motivated to achieve and deliver results. Staff support mechanisms, such as flexible work hours and team building, increase staff retention. The best organizational leaders model commitment, passion and teamwork.

Figure 5.5 Supervision and monitoring system for a national HIV prevention, diagnosis, treatment and care programme with trans people



National

Supervision system:
- State-level managers: 1 for every 1–2 states
- Semi-annual/annual formal review meetings with state/province
- Frequent informal engagement

Monitoring data:
- Dashboard indicators (with drill-down to identify unusual performance)
- Financial information
- Service quality reports

State/Province

Supervision system:
- Programme manager: 1 per 3–5 NGOs
- Technical manager (clinical services, behaviour change, structural interventions, monitoring) to meet standards for frequency of oversight
- Monthly field visits/meetings with NGOs
- Quarterly reviews with NGOs

Monitoring data:
- Information from below +
- Additional administrative and financial information
- Service quality reports

District/County

Supervision system:
- Field officers for monthly oversight of safe spaces (drop-in centres) and clinical services
- Monthly all-staff meetings

Monitoring data:
- Clinical service use, commodity distribution and contacts from below +
- Condom supply
- Training reports
- Financial reports

Municipality/Submunicipality

Supervision system:
- Safe spaces (drop-in centres) managed
- Clinical service delivery per standards
- Outreach supervisor/manager (1 for every 5–7 community outreach workers) meets weekly

Monitoring data:
- Clinical services referral and use: RH/STI, HTS, HIV care, ART, TB, etc.

Frontline worker/Community

Community outreach workers
- 1 for every 30–65 transgender people
- Daily field presence, minimum monthly contact with transgender persons
- Weekly planning meetings with outreach supervisor

Individual interactions (micro-planning tools):
- Contacts/educational sessions
- Condoms distributed
- Referrals

5.5 Resources and further reading

Strategic planning and programme management

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Defining programme logic model, implementation components and standards

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