Interagency Coalition on AIDS and Development

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HIV Among Trans People

Introduction

Globally, trans communities are among the most heavily impacted by HIV, yet they are among the least recognized within policy, the least served by programs, and the least supported by funding at national, regional, and international levels. Available data indicate a significant HIV burden within trans communities. A series of interwoven factors contribute to vulnerability, including biological, behavioural, structural and social determinants of health. The recent UNAIDS 2016–2021 Strategy, *On the Fast-Track to End AIDS*, identifies trans people as one of the key populations requiring specific attention.

Who Are Trans People?

The terms 'trans' or 'transgender' are broad umbrella terms encompassing those whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth. This can include people whose gender expression, outward appearance, and/or anatomy does not fit into conventional expectations of male or female. They may express their genders in a variety of masculine, feminine and/or androgynous ways.

Trans people may identify differently in different cultures. Some of the commonly used terms include: transgender, trans woman (or transwoman or male-to-female transgender or MTF), trans man (or transman or female-to-male transgender or FTM), transsexual, bigender, gender fluid, genderqueer, *hijra* (India), *kathoey* (Thailand), *waria* (Indonesia).

For example, someone assigned the male sex at birth may identify as a female and live her life accordingly. She may thus identify as a transgender woman (in Anglophone communities in North America, Europe and Oceania), *une femme transsexuelle* (in Francophone communities in North America and Europe), *hijra* (in Asia) or *travesti* (in Latin America). A trans individual from a North American Indigenous community may identify themselves as two-spirited, which is an umbrella term used by many nations for various gender identities.

The differences between the terms above run deeper than translation; they refer to different realities. For instance, the feminizing techniques used by a trans woman are likely to differ depending on where she lives. *Travestis* in Brazil are more likely to inject silicone into their bodies to emphasize curves than their Canadian counterparts. The differences of the relationship between gender and sexuality from place to place is also crucial to consider. Whereas in North America trans communities tend to deliberately distinguish sex and gender from sexuality (and from homosexuality in particular), this is not the case everywhere.

While "transgender" has gained popularity in some Anglophone parts of the world as an umbrella term that brings together all trans persons, many resist this terminology, in part because it focuses too narrowly on gender. In this document, "trans" will be used as an imperfect alternative, unless the context requires a different or more specific term.

HIV in Trans Communities

Globally, trans people are identified as one of the populations most disproportionately affected by

HIV, although prevalence ranges widely between countries and regions, as well as between particular groups of trans people. Domestically, there are no national data on the number of trans people living in Canada, nor are trans people included as a distinct identity category in national data on HIV.

Worldwide HIV prevalence rates among transwomen are estimated to be 19%. Transwomen are 49 times more likely to be HIV-positive than all adults of reproductive age, a finding that remains consistent across high-income, middle-income, and low-income settings, though there is a notable lack of data from Africa, Eastern Europe and Central Asia.[1,2] Among transwomen, sex workers tend to have some of the highest HIV prevalence rates (27%), and are 4 times more likely to be HIV-positive than cisgender* female sex workers.[3] However, studies estimating HIV prevalence among transwomen tend to include an oversampling of sex workers. It is therefore difficult to generalize HIV prevalence rates to the broader community of transwomen.[4,5,6]

When available, HIV prevalence rates among transmen tend to be lower. In studies with laboratory-confirmed HIV serostatus, rates range from 0% to 4%. However, there have been so few such studies that meta-analyses have not been conducted to estimate an overall HIV prevalence rate for transmen.[7,8,9,10] Emerging data suggest that transmen who have sex with men may be at higher risk.[11]

Domestically, among participants in an Ontario study called the Trans PULSE Project, self-reported HIV prevalence was 3% for transwomen and 0.6% for transmen. However, given wide confidence intervals and the high proportion of trans people who had never been tested for HIV (46%), estimates should be interpreted with caution.[12,13] In fact, when combined with the fact that HIV surveillance data in Canada do not capture trans status, HIV prevalence among trans people in Ontario—let alone Canada—cannot currently be accurately estimated.

The lack of inclusion of trans status within much of epidemiology and surveillance data, and the relative dearth of research related to HIV within trans communities overall renders much of the community invisible. This process of erasure seems particularly acute for some segments of the trans community, including transmen, transwomen not engaged in sex work, and members of the community whose gender identity does not fit into the binary categories of male or female. It is also true for trans communities from Africa, Eastern Europe and Central Asia, where few studies have been conducted so far.

Determinants of HIV Risk Among Trans People

Several studies have identified a range of determinants of HIV risk among trans people, though the level of evidence to support the extent to which many of these determinants have an impact on HIV risk varies greatly.

The most direct factors linked to HIV risk include biological and behavioural factors, such as engaging in condomless receptive anal or genital intercourse, substance use, and needle sharing for drug use and hormone or silicone injections. The effects of hormones on genital and anal mucosal lining, and the effects of genital surgery on HIV risk remain unknown.

Some of the more contextual factors that lead to HIV risk include structural and social determinants of health, such as stigma and discrimination, violence, engagement in sex work, criminalization, the intersection of racism and transphobia, mental health problems such as depression, difficulty accessing appropriate healthcare, and lack of targeted HIV information.[14,15,16,17,18,19,20,21,22,23,24] Some of these contextual factors are discussed below.

* Cisgender refers to someone whose gender identity aligns with the sex they were assigned at birth.

- **Stigma and discrimination.** For many trans people, stigma and discrimination are among the most commonly experienced barriers to accessing healthcare and employment.
- **Violence.** Trans people face high rates of violence, often from a variety of sources. Violence can come from members of their family of origin in relation to expressing the desire to transition. It can also be experienced in the context of sex work and intimate partner violence, both of which can lead to forced sex and difficulty negotiating safer sex, leading in turn to increased HIV risk.
- **Sex work.** Difficulty finding employment because of stigma and discrimination may lead to engagement in sex work, which increases HIV risk (e.g., multiple partners, condomless receptive anal intercourse). In some cases sex work is seen as part of the cultural norm or a rite of passage for transwomen. For both transwomen and transmen, it can also be means to afford expensive hormones and sex reassignment surgery, which are often not covered by public or private health insurance.
- **Criminalization.** The criminalization of sexual and gender minorities, sex work and drug use contributes to stigma, discrimination and violence against key populations, including by state actors, and is a key barrier to an evidence-informed, rights-based response to HIV with trans communities.
- **Intersection of racism and transphobia.** In some studies, there tend to be higher rates of HIV prevalence among some racialized communities of transwomen than others. For example, in the US, they tend to be higher among African-American transwomen that among those who are White or Hispanic. Racism and transphobia interact to increase odds of HIV-related sexual risk behaviour, above and beyond the individual contributions of racism and transphobia.
- **Mental health issues.** Studies have found an association between depression and low self-esteem among trans people and participation in high-risk sexual behaviours.
- **Problematic access to healthcare.** Trans people often have limited access to healthcare and problematic encounters with healthcare providers. Obtaining gender-appropriate identification can be difficult in many contexts, and lack of gender-conforming identification can often be a barrier to healthcare services. Trans people commonly report experiencing verbal abuse, discrimination, insensitivity, and lack of knowledge from healthcare providers, as well as overemphasis on HIV. Services are often provided at the same location as they are to gay, lesbian and bisexual patients, despite these groups having quite different healthcare needs. Some trans people refuse HIV testing because of the misconception that they will be refused hormones or medically cleared for sex reassignment surgery if they are found to be HIV-positive.
- **Lack of targeted HIV information.** There is often a lack of targeted HIV information tailored to the needs of trans people. Available HIV information is often inadequate or incongruent information, usually targeted to gay men, with whom transwomen do not necessarily identify. Non-English speakers and recently arrived immigrants face additional barriers to accessing HIV information.
- **Living with HIV.** Trans people living with HIV face particular challenges. For example, little is known about the interactions between the hormones used by some trans people and antiretroviral treatments. Considering the importance of hormones for some trans people, this information is urgently needed. Furthermore, the side effects from HIV treatment can be lived differently by trans people than by non-trans persons. For example, lipodystrophy, the redistribution of body fats, can lead to a loss of fat in the cheeks. This masculinizes the facial feature, a compromise that many transwomen find challenging. Furthermore, finding comprehensive health care is rendered more complicated for trans people

living with HIV as it becomes harder to find doctors competent in both types of care.

All of these factors are strongly interwoven, such that it seems difficult to determine which among them is more important. It is also difficult to determine directionality and causality between these determinants.

These determinants tend to play out differently for different subpopulations within the transgender community. Studies suggest that determinants of HIV vulnerability (and as a result, HIV prevalence) may be more present among transwomen than transmen. For transwomen, they may be more present among those who are engaged in sex work; for transmen, among those who have sex with men. Among all trans people, they may be more present among those who engage in sexual activities within communities or network where HIV prevalence in high (e.g., men who have sex with men), and for those who are also part of Indigenous and racialized communities.

Despite the generally high HIV prevalence rates observed among some segments of the trans community, research suggests that there may be significant proportions of the trans community that are at little to no risk of HIV in a given year, since they are not sexually active nor do they share needles. Among those who are sexually active, significant risk may come from activities that are often assumed not to occur, such as receptive genital sex for transmen and insertive genital sex for transwomen.

The Global Response

The 2014 UNAIDS Gap Report identifies trans communities as a key population that is particularly vulnerable to HIV. As we have seen for example, transwomen are 49 times more likely to be living with HIV than all adults of reproductive age. Despite this heightened HIV burden, trans people are severely underserved relative to their health needs. Indeed, 61% of countries recently reported to UNAIDS that their national AIDS strategies did not address trans people.[25]

The newly released UNAIDS 2016–2021 Strategy, *On the Fast Track to end AIDS*, identifies trans people as one of the most vulnerable populations, along with men who have sex with men, sex workers, and people who inject drugs. The UNAIDS Strategy lays out goals and targets that must be reached by 2020 in order to end AIDS as a public health threat by 2030. This includes targeted efforts to ensure equitable access to comprehensive HIV services and to create an enabling environment, supportive legislation and policy, community empowerment, and strategies to address trans-specific stigma and discrimination.[26]

An increasing number of projects at local, national, regional and global levels address HIV in trans communities, including the following three case studies, described briefly as examples.

SWING (Thailand): Integrated Sexual Health Care

Service Worker IN Group (SWING) offers screening, diagnosis, and treatment for sexually transmitted infections for male and transgender sex workers, including migrants. They also offer mobile clinics, as well as educational opportunities, including English language classes and vocational training. It serves as a drop-in centre where workers can eat, use the Internet, prepare for the evening, and take part in HIV-related information games and sessions. Besides treatment and prevention services, SWING also provides access to legal services.[27]

Atlacatl (El Salvador): Ensuring Dignity of Communities

The organization Atlacatl has successfully implemented a programme called Life with Dignity (Vida Digna). Vida Digna employs the

methodology of Participatory Community Assessment, along with activities that encourage participants to examine stigma and discrimination at all levels, from the individual to the national. They help participants connect with human rights issues and provide tools to tackle stigma and discrimination through official channels. Two Vida Digna partner organizations participated in the drafting of a new law on sexual and reproductive health rights to ensure that the rights of transgender women were addressed in El Salvador. Due to the efforts of these organizations, the draft law now refers to issues such as hormone regimes and transgender women's rights to see specialist doctors—an important step in encouraging the state to address gender identity issues formally.[28]

IRGT: A Global Network of Transgender Women and HIV

For over a decade, the Global Fund to Fight AIDS, Tuberculosis, and Malaria has been one of the world's largest donors in the HIV epidemic. Through engagement with processes such as country dialogues and Country Coordinating Mechanisms (CCMs), transgender activists and organizations have helped to increase funding and programmatic focus on transgender needs related to HIV prevention and treatment. However, extensive barriers remain to sufficiently addressing transgender needs in the HIV epidemic, and little work has been done to document good practices for engaging key donors such as the Global Fund. To address this gap, the IRGT published *Most Impacted, Least Served: Ensuring Engagement of Transgender People in Global Fund Processes*, a report that offers recommendations for improving policies and fostering a more enabling environment for transgender people to participate in and engage with Global Fund processes.[29]

Conclusion

Addressing the global HIV epidemic in trans communities will require a multifaceted response. In the first place, it is crucial that we continue to produce HIV-related knowledge about different trans communities in different parts of the world.

Specifically, collecting epidemiology and surveillance data among trans populations would improve understanding of HIV prevalence and incidence within this community. Population-level health surveys and other quantitative and qualitative research methods would provide greater accuracy about factors that lead to HIV risk, including how determinants of HIV vulnerability intersect and impact specific groups within the trans community (transwomen and transmen; sex workers; Indigenous and racialized communities; urban and rural communities; HIV-positive and HIV-negative) across various regions.

As underlined by UNAIDS, this is best done in conjunction with trans communities themselves. The projects and programs highlighted in the section above reflect a movement to incorporate trans voices into contemporary policymaking and healthcare realities. Continued and enhanced trans community engagement in the development and implementation of research efforts and interventions would help to ensure that research, healthcare delivery, and HIV prevention efforts are focussed on the needs of trans communities.

Endnotes

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