



**BLUEPRINT FOR THE PROVISION  
OF COMPREHENSIVE CARE  
FOR TRANS PERSONS  
AND THEIR COMMUNITIES  
IN THE CARIBBEAN AND  
OTHER ANGLOPHONE COUNTRIES**



John Snow, Inc.



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The original working document was prepared by Walter Bockting and JoAnne Keatley. Subsequent modifications were based on the input and suggestions resulting from the technical meeting held at the headquarters of the Pan American Health Organization (PAHO) on December 19–21, 2011. A second working draft was prepared by an editorial committee whose members proposed certain substantive adjustments and changes. The members of the editorial committee were Walter Bockting, Joan Holloway, JoAnne Keatley, Angela Knutsson, Rafael Mazin, Florian Ostmann, Anita Radix, Bamby Salcedo, Chloe Schwenke, and José Zuñiga. A Spanish version was prepared by Heather Bergmann, Esther Corona, Rafael Mazin, Aysa Saleh-Ramirez, and Florian Ostmann to be used as a reference document during consultations in El Salvador, Chile, and Mexico during the year 2012, with participants from all countries of Latin America. A final Spanish edition was prepared by Lukas Berredo, Esther Corona, Florian Ostmann, Rafael Mazin, and Aysa Saleh-Ramirez.

This updated English version is based on a working document that incorporated many useful recommendations and suggestions collected during the development of the Spanish version. An updated working document in English was drafted by Esther Corona, Rafael Mazin, and Aysa Saleh-Ramirez and presented to a group of participants at a consultation held in Trinidad and Tobago on April 17–19, 2013. This version incorporates the many valuable ideas and recommendations from representatives of trans communities from several countries in the Caribbean. The final technical review was made by Esther Corona, Rafael Mazin, and Aysa Saleh-Ramirez, and edited by Stephanie Joyce and Julie Ray.

This version is intended to serve as a guide for health providers, program planners and managers, policymakers, community leaders, and other stakeholders. Many of the clinical care protocols in this document are adapted from the recommendations developed by the University of California, San Francisco (UCSF) Center of Excellence for Transgender Health, available online at [www.transhealth.ucsf.edu/protocols](http://www.transhealth.ucsf.edu/protocols). Protocols developed by PAHO and the World Health Organization (WHO) were included as well.

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## Acronyms

CESR	Covenant on Economic, Social, and Cultural Rights
DSD	disorders of sex development
DSM	Diagnostic and Statistical Manual of Mental Disorders
IAPAC	International Association for Physicians in AIDS Care
IAHCR	Inter-American Commission on Human Rights
ICD	International Classification of Diseases
LAC	Latin America and the Caribbean
LGBTI	lesbian, gay, trans, bisexual, and intersex
MARP	most-at-risk population
MSM	men who have sex with men
OAS	Organization of American States
PAHO	Pan American Health Organization
STI	sexually transmitted infection
WAS	World Association for Sexual Health
WHO	World Health Organization
WPATH	World Professional Association for Transgender Health
UN	United Nations

## Disclaimer

This document is intended to address the needs and expressed desires of members of groups and populations that differ significantly from each other in terms of personal experiences and conceptions of identity. We sought to take these differences into account when we adopted the terminology included in this document. However, our choices were also guided by the pragmatic goal of finding a conceptual basis that would enable us to make specific recommendations for expanding access to and utilization of health and social services. The terms and concepts used in this document are to be understood in light of this goal. If the terms do not adequately reflect the experiences and identities of the communities whose needs the document seeks to address, they should be interpreted in a flexible manner.

Where possible, this version includes examples and cases from the Caribbean studies and trans individuals; however, it retains many examples from Latin America because the evidence base is further developed in that region.

Many individuals played a role to the development of this document by attending consultations, providing views and experiences, and reviewing drafts. We are unable to list them all by name, but thank them for contributing to the goal to which we aspire, which is the improved health and well-being of the trans community in and beyond the LAC region.



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# 1. Preamble and Background

“Trans” is a widely employed term for people who are transgender: those whose gender identity and/or gender expression does not correspond with the social norms and expectations traditionally associated with their natal sex or the sex assigned at birth.

The trans population comprises a very diverse group of communities and individuals. From a public health perspective, this population has not been well studied or well served. Yet trans persons need health services; moreover—as all human beings—they are entitled to high-quality health care as part of their human rights. This document is an attempt to describe the health and sociocultural situation of trans persons and provide a comprehensive overview of the health care needs of this diverse population.

Trans persons have both general and specific health needs. However, historically they have had extremely limited access to competent care that appropriately addresses these needs. For a range of interconnected reasons, a large number of trans persons have difficulty accessing basic primary care, including sexual health care, that takes into account the diversity of gender identity, gender expression, anatomy, sexuality, and sexual practices found within this population. They also have difficulty accessing appropriate services for their specific needs, including both medical interventions and psychological support, to help them actualize and wholesomely live their gender identity.

In July of 2009, the Pan American Health Organization (PAHO) and the International Association for Physicians in AIDS Care (IAPAC) conducted a regional consultation that resulted in the Blueprint for the Provision of Comprehensive Care to Men who have Sex with Men in Latin America and the Caribbean (PAHO, 2010). In the process of developing that Blueprint, it became clear that a similar effort was needed for trans persons in the Latin American and Caribbean (LAC) region.

The Spanish version of this document was prepared based on a review of available research along with contributions and suggestion made during consultations held in December 2011 and April, May, and October 2012. These consultations included representatives from academia, the health sector, multi- and bilateral agencies, governmental and nongovernmental organizations, trans communities, and other stakeholders from the LAC region. We also relied on existing work by other organizations—including, among others, the World Professional Association for Trans Health (WPATH), an international organization with three decades of experience working with trans issues; and the U.S.-based Center for Transgender Care. To ensure relevance for the Caribbean, the final version of the document was translated back into English and presented to a group of stakeholders from this region during a consultation held in Port of Spain, Trinidad and Tobago on April 17–19, 2013.

This English version incorporates suggestions and recommendations made by the participants at the Trinidad meeting to ensure its cultural relevance for the Caribbean and the Anglophone readers in general. It provides guidance on improving access to competent primary and specialized care for trans persons in the LAC region: first providing an overview of the social and structural situation of trans persons; offering specific protocols for delivering medical care; and recommending steps for addressing the needs of trans persons.

While the document focuses on findings from the LAC Region of PAHO, our hope is that it will serve as a reference and guide for other countries and regions wishing to improve access to and utilization of health services by trans persons. Our intended audience includes program managers, health care professionals, medical practitioners, and other stakeholders.

We hope that this publication will form part of a growing body of national and international work intended to increase understanding of the trans community and its needs, and to meet those needs through a human rights approach that improves the well-being of trans persons and fully acknowledges their place within the global community.

## 2. Introduction

Trans persons, as all people, have needs, desires, and capacities for the emotional and intellectual expression that underlie a full and productive life. Good physical and mental health are fundamental for pursuing and fulfilling these desires and capacities, and for the ability to lead life in accordance with human dignity. Numerous international agreements, including those forged among PAHO member states; recognize the right of every person to the enjoyment of health as a universal human right.<sup>1</sup> Nevertheless, many trans people in Latin America and the Caribbean are affected by disproportionate burdens of disease, morbidity, and barriers that prevent them from realizing their optimum health, along with other human rights (see Box 1).

### Box 1. Trans Health: High Burdens, Low Access

Trans persons comprise a diverse population, but as a group they share the challenge of marginalization, which limits their access to health services. The limited studies of trans persons in the LAC region show a very high burden of health problems, even relative to other marginalized groups such as men who have sex with men (MSM):

- A study in Peru showed that 33% of the trans population (trans women) surveyed was HIV positive as compared to 18% among gay and 15% among bisexual men. Over half (51%) of trans respondents had contracted syphilis, compared to 13% of gay men, 11% of bisexual men, and 3% of the heterosexual population (Tabet et al., 2002).
- Unsupervised use of injected substances for body modification are common, with severe risks to overall health (Salazar & Villayzan, 2010). In Argentina, a majority of trans respondents reported self- or peer-administered injections of soft tissue fillers (82%) or hormones (61%) (Berkins, 2005; Loehr, 2007).
- Mental health problems, linked to social marginalization and stigma, are widespread. In a study in Chile, 87% of trans participants reported that they suffered from depression, and 50% said that they had attempted suicide. By contrast, 20% of non-trans people reported depression, while 5% reported having attempted suicide (Berredo, 2011).

Trans persons comprise a particularly disadvantaged population in terms of public health. In addition to basic health needs, shared with the general population, trans persons have needs that are unique to them. However, health care providers have traditionally neglected both the general and specific needs of this group. Trans persons also face high levels of “transphobia,”<sup>2</sup> manifested in the form of discrimination, stigmatization, violence, prosecution, and even extortion by local authorities.<sup>3</sup> Transphobia can be reflected in the quality of care (or lack of quality care) that trans individuals receive. Thus, a combination of stressors contribute directly and significantly to the vulnerability of trans persons, while also impeding their access to health care services.

1. The Member States of the World Health Organization (WHO) adopted important public health principles that are incorporated in the preamble to its Constitution. The Constitution establishes as a fundamental international principle that “the enjoyment of the highest attainable standard of health” is not only a state or condition of the individual, but “... one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition ...” The Constitution was adopted by the International Health Conference, held in New York from 19 June to 22 July 1946 and signed on 22 July 1946 by the representatives of 61 States. The International Covenant on Economic, Social, and Cultural Rights (UN), in turn, protects “...the right of everyone to the enjoyment of the highest attainable standard of physical and mental health...” (Article 12), and the Protocol of San Salvador (OAS) protects “the right to health” (Article 10). Moreover, health protection as a human right is incorporated in 18 of the 35 Constitutions of the Member States of PAHO (Bolivia, Brazil, Cuba, Chile, the Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, and Venezuela).
2. Transphobia refers to fear, hatred, or dislike for transgender people or transsexuals on the part of other individuals, including gays, lesbians, bisexuals, or heterosexuals.
3. <http://www.oas.org/es/cidh/prensa/comunicados/2012/036.asp> <http://www.oas.org/es/cidh/prensa/comunicados/2012/036A.asp>

The social and structural barriers that affect trans people are inextricably linked to health outcomes and risks. Chief of these is the stigma attached to gender nonconformity (i.e., deviations from the social norms and expectations traditionally associated with a person's sex assigned at birth). Because they are subject to high levels of stigma, trans persons are at risk of high and chronic levels of stress, which is in turn associated with (and contributes to) disproportionate rates of mental health concerns such as depression, anxiety, and suicidal ideation and behavior (*Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2011*). Stigma also underlies lack of access to competent and sensitive care for addressing the particular needs of trans persons, and often extends to those who attempt to provide such care. Thus trans persons frequently face barriers to access that include a lack of provider knowledge and cultural competence (*Barreda & Isnardi, 2003*) and a lack of access to affordable care (due to either marginalization or the exclusion of specific services from health care coverage).

These factors frequently lead to serious health consequences for trans persons and have significant implications for public health. Trans women (male to female) are disproportionately affected with HIV and sexually transmitted infections (STIs), with rates up to 40 times higher than those found in the general population (*PAHO, 2010*). Nevertheless, trans individuals have traditionally been conflated with the epidemiological category “men who have sex with men” (MSM). This not only ignores the variations of gender identity characteristic of this population, but also renders trans persons and their needs invisible to public health (*Salazar & Villayzan, 2010, p. 14*).

Despite the enduring and dehumanizing effects of social stigma, trans persons tend to be very resilient and resourceful in their efforts to protect their rights, defend their dignity, and obtain access to health services. Nonconformity with the gender identity and gender expression traditionally associated with a person's natal sex characteristics is not a psychopathology *per se*, and trans persons have vigorously resisted negative mental health categorizations. Yet the distress caused by the incongruity between gender identity and physical characteristics—also known as *gender dysphoria*—can have a strong negative impact on the health and well-being of trans persons. Providers who care for trans persons need to be aware of it.

The distress resulting from gender dysphoria can be alleviated through appropriate actions, including biomedical interventions intended align a person's physical appearance with the preferred gender identity (a process commonly referred to as *transitioning*). However, given the lack of adequate services to support the transitioning process, it is not surprising that practices such as use of self-administered hormones and injections of silicone and other soft tissue fillers (e.g., mineral, vegetable, and airplane oil) with great risk to overall health are common (*Salazar & Villayzan, 2010*).

The context of the lives of trans people—stigma and marginalization, the multiple hardships of sex work, lack of access to health care, and self-administration of hormones and silicone—are well documented and of great concern. Any future efforts to promote the health of trans people in the region must take this complex context into account.

Addressing the needs of trans persons requires a holistic approach as well as appropriate care and provision of services tailored to the trans person's needs. It is important to highlight that health services for trans persons should not strictly focus on HIV/STI services, but rather on overall well-being: providing basic services as well as support to help trans individuals overcome the particular challenges they face. In addition, the health sector as a whole should promote social solidarity, embracing diversity and rejecting expressions of hatred and intolerance. Both holistic services and an accepting attitude are essential to reduce social inequities and ensure that trans persons in and beyond the LAC region receive equal protection of their right to health and other human rights.



This document starts by introducing a conceptual framework to describe the diversity of the trans population (Section 3). Subsequent sections provide an overview of existing data on the health situation of trans persons (Section 4) and a description of health determinants and barriers to health care (Section 5). This is followed by a discussion of considerations for advocacy, public policy, training, and research relevant to the health of trans persons (Section 6). Sections 7 and 8 present a set of recommendations, including algorithms, to enable health practitioners to deliver comprehensive services to trans persons. Section 9 provides recommendations for governments, civil society, and other stakeholders, and Section 10 lists resources for those interested in trans initiatives in the LAC or other regions.

### 3. Terminology, Definitions, and Description of the Trans Population

The persons and groups who comprise the trans population differ significantly from each other in their conceptions of identity, experiences, and behavioral patterns. Besides differences within a given local context, sociocultural differences across the region greatly increase overall diversity. This diversity creates a considerable challenge to the development of a conceptual framework for addressing the needs and expressed desires of the persons concerned.

Terminology matters in such a framework. Because gender nonconforming persons (including trans) have long experienced stigma and discrimination, there is a great concern over the use of offensive, derogatory, exclusionary, and objectifying language. Even if certain expressions or categories are not meant to be offensive, their improper use can be insulting, which in itself can hamper access to and utilization of services.

Thus, the conceptual framework presented below was guided by the pragmatic goal of establishing a *lingua franca* to facilitate the development of policies and programs for trans persons. It is possible that the terms, definitions, and concepts fail to fully reflect the varied experiences and identities of the persons whose needs the document seeks to address; therefore, we hope that the terms will be interpreted in a flexible manner.

Current literature explores gender—and sex—as a conceptual continuum.

For the purpose of this document, and as agreed by the participants at the various consultations held throughout the LAC region, the term “trans” will be used as an umbrella term to refer to *persons whose gender identity and/or gender expression does not correspond with the social norms and expectations traditionally associated with their sex assigned at birth*.

It is important to emphasize that many of the gender-related concepts used in Western cultures are based on a binary interpretation that proposes sexual polarities: man-woman, male-female. However, current literature explores gender—and sex—as a conceptual continuum. In this respect, Weeks (2011) concludes that “what recent theorization of both gender and sexuality have demonstrated is that the edifice of gender can no longer plausibly be seen as an emanation of Nature, but is built on the ever-shifting needs, desires and social practices of millions of people.”

The following concepts and definitions were derived from working documents produced by the World Professional Association for Transgender Health (WPATH), the World Association for Sexual Health (WAS), and PAHO/WHO. Some terms used in the document are typically used in the LAC region; terms used in other locations or regions are likely to differ.



## Sex

Biological characteristics (genetic, endocrinal, and anatomical) used to categorize humans as members of either a male or female population. While these sets of biological characteristics are not mutually exclusive (they **naturally occur in various degrees or combinations**), in practice, they are used to differentiate humans as **supposedly opposite extremes within** a polarized binary system. Typically, a distinction is made between primary sexual characteristics (i.e. an individual's reproductive organs) and secondary sex characteristics (i.e. other, non-genital physical traits that differentiate males from females).

## Sexuality

Sexuality is a central characteristic of being human, lasting throughout life and encompassing sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors. (WHO, 2006)

## Sex assigned at birth/natal sex

Sex is assigned as male or female at birth, generally based on the appearance of the external genitalia, but also (when these are ambiguous) on other sexual characteristics such as reproductive organs or cellular determinants. Gender identity and expression coincide with the sex assigned at birth for the majority of people. However, for trans people, gender identity or expression differs from sex assigned at birth (Grumbach, Hughes, & Conte, 2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000; Coleman et al., 2011).

## Gender identity

A person's sense of being a man, a woman, or some alternative gender or combination of genders. A person's gender identity may or may not correspond with natal sex.

## Gender expressions

An individual's way of communicating gender identity through physical appearance (including clothing, hair styles, and the use of cosmetics), mannerisms, ways of speaking, and behavioral patterns.

## Gender role

The ensemble of social and behavioral norms and expectations associated with different categories of sex and gender identity in a given culture and historical period. A person's behavior may differ from the gender role or gender identity traditionally associated with sex assigned at birth, and may transcend the system of *culturally established gender roles* altogether.

## Sexual orientation

The organization of an individual's eroticism and/or emotional attachment with reference to the sex and gender of the partner involved in sexual activity. Sexual orientation may be manifested in one or a combination of sexual behaviors, thoughts, fantasies, and desires.

## Sexual identity

The overall sexual self-identity, which includes physical characteristics; how the *individual identifies as* male, female, masculine, feminine, or some combination; and the individual's sexual orientation. This encompasses a constellation of possibilities, including homosexual trans woman; heterosexual cis (i.e., non-trans) male; heterosexual trans man, and others. Sexual identity is the internal framework constructed over time that allows an individual to organize a sexual self-concept, and to perform *socially in alignment* with his or her perceived sexual capabilities.

### **Gender nonconformity or gender variance**

The extent to which a person's gender self-concept and expression differs from the social norms and expectations traditionally associated with her or his sex assigned at birth or gender identity.

#### **Transition**

The variable, individualized period of time during which individuals change from the traditional gender role associated with their natal sex, and assume the gender role of their choice. This may entail learning to live socially in the chosen gender role, or it may imply finding the gender role that is most comfortable. The transition may include physical changes (feminization or masculinization) through hormones or other medical approaches. (Coleman et al., 2011).

As noted above, the term “trans” covers a range of conceptions of identity and gender expressions. The following non-exhaustive list reflects this diversity by explaining the most common terms used to describe trans identities. Importantly, there are significant differences about the acceptability and definition of these terms across regional and cultural contexts, at the individual level, and even within trans communities over time. This means that there may be alternatives for each of the definitions that follow. Also, the meaning of these terms may not be mutually exclusive.

#### **Trans**

Adjective used in this document as an umbrella term to refer to persons whose gender identity and/or gender expression does *not* correspond with the social norms and expectations traditionally associated with their sex assigned at birth.

#### **Cisgender**

Refers to persons whose gender identity and expression *does* correspond with their sex assigned at birth. Thus the term “trans” may be contrasted with the term “cis” or “cisgender.”

### **Transgender**

Adjective to describe a diverse group of individuals whose gender identity differs to varying degrees from the sex they were assigned at birth (Bockting, 1999). The term is sometimes distinguished from the term “*transsexual*” (see the definition that follows); in this case “transgender” typically refers to persons who have not altered or do not desire to alter their natal primary sexual characteristics.

#### **Transsexual**

This term, often applied by the medical profession, describes individuals who are changing, or have changed, their primary and/or secondary sex characteristics by means of medical interventions (hormones and surgery) to masculinize or feminize the body. Generally these individuals also permanently change their gender role. (Coleman et al., 2011).

#### **Travesti**

In some Latin American countries this term is used as a synonym for “transgender women,” referring to persons assigned male at birth who go to great length feminizing their body and appearance and prefer female pronouns, without typically considering themselves women or desiring to alter their natal primary sexual characteristics through genital surgery (Kulick 1998). In other Latin American countries the term refers to transvestites. However, its use has declined, and it is not a precise term. We use it in this document to reflect participants' specific input, or to align with the wording used by researchers.

#### **Transvestites or cross dressers**

Terms used to refer to persons who wear clothes and adopt other forms of gender expression culturally associated with the other sex. Cross dressing may be the initial stage of transition, but not all cross dressers experience discomfort with their sex. Many persons periodically wear clothing and adopt a gender expression associated with the

other sex as part of performances, though their gender identity generally corresponds with their sex assigned at birth. These persons are also referred to as *drag queens* (in the case of men assuming a female role), and *drag kings* (in the case of women assuming a male role).

### Trans woman

Term used to refer to trans persons who identify as female (i.e., persons who were assigned male at birth and identify as women). We use the term “travesti” as well in this document, because it is used in literature and personal accounts to describe trans women in the LAC region.

### Trans man

Term used to refer to trans persons who identify as male (i.e., persons who were assigned female at birth and identify as men).

### Female-to-male (FtM)

“Adjective to describe individuals assigned female at birth who are changing, or have changed, their gender identity and gender expression from birth-assigned female to a more masculine body or role” (Coleman *et al.*, 2011).

### Male-to-female (MtF)

“Adjective to describe individuals assigned male at birth who are changing, or have changed, their gender identity and gender expression from birth-assigned male to a more feminine body or role” (Coleman *et al.*, 2011).

### Genderqueer and other labels

Other identity labels may be used by individuals whose gender identity and/or expression does not conform to a binary, mutually exclusive understanding of gender in terms of man or woman, male or female (Bockting, 2008). These may comprise terms such as queer and trans queer, and may include individuals whose identify as both man and woman (*bigender*, *pangender*, *omnigender*), as a third or other gender (*intergender*), or as without gender (*genderless*, *agender*, or *neutral*).

### Intersex

Persons whose congenital, physiological sex characteristics are ambiguous; this group shares certain concerns with the trans community but is not the same. The existence of these variations challenges the binary model used in sex assignment (see Sidebar 1).

### Alternative/third genders

Among some aboriginal and native peoples, gender systems may not be binary; some cultures include additional categories, such as *muxes* among Zapotecs in Mexico, or *tidawinas* among Warao in Venezuela. These groups may live, dress, interact, and work in roles different from those associated with their sex assigned at birth.

### Complexity and cultural influence on trans populations:

The terms and definitions above underscore an important point about the complexity of trans people and their communities. A person’s *physical sex*, *gender identity*, *gender expression*, and *sexual orientation* constitute four distinct individual characteristics. They are conceptually independent of each other and can occur in any combination.

There is a widespread cultural assumption, for example, of the coincidence of male sex, male gender identity, masculine gender expression, and sexual attraction to women; and the coincidence of female sex, gender identity, gender expression, and attraction to men. In reality, however, these four characteristics may exist in a vast range of possible combinations. Thus any person, regardless of natal sex, may identify as a woman while adopting “masculine” forms of gender expression, or as a man while adopting “feminine” gender expressions. In addition, nonconforming gender identity or gender expression is not intrinsically linked to a specific sexual orientation. A person may be attracted to individuals of a different gender, the same gender, or more than one gender.

Local and regional cultures add an additional layer of complexity. Across cultures, the predominant models of self-conception and social interaction accommodate individual gender identity,



gender expression, and sexual orientation in different ways and to varying degrees. In the LAC region, gender identity and sexual orientation appear to be closely intertwined. Qualitative research in Brazil (*Kulick, 1998*) and Mexico (*Prieur, 1998*) revealed that the nuances of sex with men were major theme in the lives and discourse of travestis (trans women). Participants in this research indicated that sexual behavior, rather than genital anatomy, signified gender. Thus, to affirm a travesti's femininity, the male partner would have to assume the insertive role in anal intercourse. This is what travestis typically require of their primary and casual non-paying male partners, in contrast to exchange partners (i.e., partners who offer money or other goods in exchange for sex), with whom they are more versatile (*Kulick, 1998*).

These distinctions extend to the terms used to describe different types of partners. In the LAC region, primary male partners may be referred to as *cacheros* (*Schifter, 1999*), *maridos* (or *bofes*, *homens*, *machos*, (*Kulick, 1998*), *mayates* (beetles) (*Prieur, 1998*) or *chacales* (jackals). Casual non-paying partners may be referred to as *vicios* (a vice) (*Kulick, 1998*) or *cachuchazo* (a free indulgence). Exchange partners may be referred to as *mariconas* (those who enjoy being anally penetrated) (*Kulick, 1998*). The close link between gender identity and sexuality (top/bottom, referred to in Spanish as *activo/pasivo*) can be contrasted with alternative models of relationships between gay men who are more similar in gender identity and expression.

## Sidebar 1. Trans versus Intersexual

The term “trans” and the linked concepts defined above should be distinguished from the concept of intersexuality, which refers to variations in physical sex characteristics that occur independently of a person's gender identity. More specifically, the term “intersex” is used to refer to persons whose congenital sex characteristics are ambiguous. In the medical literature, the term “disorders of sex development” (DSD) is used to refer to the different (chromosomal, gonadal, or anatomical) forms that such a condition may take. We use the term DSD here; however, critics of the term “disorder” stress that intersex conditions are natural variations and advocate for more descriptive concepts such as difference, divergence, or variation of sex development.

Differences in sex development do not equate to a person being trans. While both trans persons and those with DSD need specific medical care and treatment for psychological distress if needed, the nature and origins of these problems are very different for those with DSD.

There is substantial medical literature on the medical management of patients who have a DSD, much of it produced by experts in pediatric endocrinology and urology, with input from specialized mental health professionals, especially in the area of gender. The gender-relevant medical histories of people who have a DSD are often complex and may include a number of uncommon, inborn genetic, endocrine, and gonadal/genital characteristics. There may also have been hormonal, surgical, and other medical treatments, some performed before the age of consent, designed to create a physical appearance which the person may not desire or agree with. These may contribute to gender dysphoria, though of a different nature from that experienced by trans persons. The distinct situation of persons with differences in sex development is reflected in the Diagnostic and Statistical Manual of Mental Disorders (DSM) category of “gender dysphoria” that provides a specific subcategory for gender dysphoria in persons with DSD.

The interested reader is referred to existing publications (*Cohen-Kettenis & Pfäfflin, 2003; Meyer-Bahlburg, 2002, 2008*). Recent international consensus conferences have focused on evidence-based care guidelines (including gender concerns and genital surgery) for DSD in general (*Hughes et al., 2006*) and specifically for congenital adrenal hyperplasia (*Joint LWPEs/ESPE CAH Working Group et al., 2002; Speiser et al., 2010*). Others have examined the research needs for DSD in general (*Meyer-Bahlburg & Blizzard, 2004*) and for selected syndromes such as 46, XXY (*Simpson et al., 2003*).

As in Latin America, males in the English-speaking Caribbean are expected to be “macho” and the role of inserter in oral or anal sex is considered to be “less degrading” than being a receiver. Expressions like “back-door man”, “buccaneer” or “anal pirate” are employed to refer to males who penetrate other men’s or trans women’s anuses. The partner who is anally penetrated is called a “battyman” (“batty” referring to the butt) or “tranny boy” or “tranny fag.” Some words, such as battyman or “pantyman,” may refer to both gay men and trans woman. A trans woman may also be called “shemale” and “tranny,” which are also derogatory expressions.

## 4. The Health Situation of Trans Persons in Latin America and the Caribbean

### 4.1. Relevant health indicators and existing data

Over the past 15 years, an expanding body of research has documented the health status and diversity of trans people in North America (*IOM, 2011*). A needs assessment prepared by Kobrak on transgender women and HIV prevention in New York City provides insights on Latina trans women in the United States (*Kobrak, draft document*). Unfortunately, far less is known about the characteristics and health of trans people in the LAC region. Initial reports mainly focused on HIV; documentation on the broader health status and disparities of trans people in the LAC region is only now becoming available (*Lobato et al., 2007; Loehr, 2007; PAHO & UNAIDS, 2008; Salazar & Villayzan, 2010*). Documentation and advocacy also tend to be much further advanced in Latin American than in the Caribbean region. A major limitation is that the studies focus almost exclusively on trans women, with a persistent dearth of data on the health of trans men.

**Interviewer:** And what did you say was the life expectancy of a trans woman?

**Argentine trans woman:** from 30 to 35 years

*Interviews conducted by JoAnne Keatley,  
International AIDS Conference,  
Vienna, Austria, 2010*

Available research indicates that trans people experience a number of major health concerns that are inextricable from the effects of social marginalization and identity concerns. In the LAC region, as in most parts of the world, trans people are among the most marginalized groups, with very limited access to competent general care and trans-specific prevention and care. The main concerns documented to date combine health and social concerns, including:

- Disproportionately high levels of exposure to verbal, emotional, and physical violence, including deadly assaults
- High levels of mental health problems associated with external causes
- Disproportionate rates of HIV and other STIs
- High levels of substance use, including alcohol
- Negative consequences resulting from self-administered substances for body modification, as well as complications from poorly performed sex reassignment interventions

“In Trinidad violence against trans is brutal. The police might tell you to come off the street and go home. They lock you up for obscene vocabulary or whatever excuse they find and you have to pay a fine. But the army is the worst. They hit you and they are brutal and strike you with whatever they have in their hands if they see you on the street because they don't have the right to lock you up, so they beat you.”

- Sexual and reproductive health concerns
- Social exclusion
- Inequitable access to quality health services

#### 4.1.1 Violence

Exposure to very high, often fatal levels of physical violence ranks among the most immediate threats to the health of trans persons. An analysis conducted by the Trans Murder Monitoring Project<sup>4</sup> showed that globally, 1,123 trans persons were reported as victims of homicide between January 2008 and December 2012. Of these recorded cases, 864 cases or 77% occurred in the LAC region and 40% (452 cases) in Brazil alone; 10% of the murders occurred in the Caribbean region.<sup>5</sup> In Honduras, for example, six murders were reported during a 60-day period between November 2010 and January 2011, and the bodies of several victims were set on fire. In August, 2013 in Jamaica, a 16-year-old trans person went to a party dressed as a woman. He was recognized by a woman, who announced that this person was a biological male. He was beaten by a mob, stabbed, and shot to death. Then his body was run over by a car and dumped into bushes.

Statistical differences, both between LAC and other regions and among individual countries within LAC, may reflect variations in reporting procedures and in explicit recording of acts of violence against trans persons. Nevertheless, the available figures speak clearly of the pervasive risks to life and physical integrity that trans persons face across the region, especially since the actual rates of violence can generally be expected to significantly exceed the number of recorded cases. Lack of sensitization and awareness, stigma, and discrimination frequently affect the way crimes are recorded in police and judicial records, resulting in misrepresentation of the victim's identity (including social identity) and the motivations behind the assault. Available data suggest that hate crimes, i.e., acts of violence motivated by transphobia, constitute a large proportion of known cases.<sup>6</sup> Moreover, mass media often characterizes hate crimes as "crimes of passion," which minimizes social responsibility, increases impunity for offenders, and limits access to justice.

#### 4.1.2 Mental health

Being a trans person does not in itself constitute a pathological condition of any kind (see Section 5). However, trans people frequently must cope with discriminatory and hostile environments as part of daily life. The stress caused by discrimination and exclusion, combined with gender dysphoria, can have a strong, lifelong negative impact on the emotional and mental health of trans persons. Restlessness, anxiety, and depression are widespread among trans persons, and suicidal ideation occurs with worrisome frequency. Of 7,000 trans persons who responded to a 2010 survey conducted by the National Center for Transgender Equality and the National Gay and Lesbian Task Force, a staggering 41% said that they had attempted to commit suicide at some point in their lives (*Grant et al., 2010*). Similarly, 50% of trans participants in a study conducted in Chile (Berredo, 2011) reported having attempted suicide, and 87.5% said that they suffered from depression. Responses among non-trans people are very different: 5% report having attempted suicide, and 20% report depression.

Because of their nonconformity with cultural expectations, trans people often have to live in secrecy and isolation, and this itself can be a factor in anxiety and depression. Concerns about acceptance can lead to great distress and suffering. For many trans persons, the fear of being unable to have a partner and en-

4. This project was launched in 2009 as a collaboration between Transgender Europe (TGEU) and the online magazine Liminalis - A Journal for Sex/Gender Emancipation and Resistance.

5. [http://www.transrespect-transphobia.org/uploads/images/maps/TvT-TMM-Map-2008-12\\_EN.png](http://www.transrespect-transphobia.org/uploads/images/maps/TvT-TMM-Map-2008-12_EN.png)

6. <http://www.aidsalliance.org/Newsdetails.aspx?id=543>  
<http://www.hrw.org/news/2006/02/20/guatemala-transgender-people-face-deadly-attacks>



joy a loving relationship can be overwhelming. All of these factors can undermine self-esteem—a characteristic of critical importance to good mental health—and can make trans persons extremely vulnerable to mental health problems.

#### 4.1.3. HIV and other STIs

Epidemiological data on the health of trans persons, particularly trans men, are very scarce in the LAC region. One factor in the scant data is that trans women are often subsumed under the epidemiological category of MSM. This practice not only fails to recognize the identity of trans women as a distinct group, but also renders invisible the specific vulnerability of this population.

However, existing data clearly show that among trans women, HIV and other STIs pose very severe health threats. HIV prevalence may be up to 40 times higher among trans women than among the general population, and up to twice the prevalence among MSM (*Universidad de Valle de Guatemala, 2010a/b; Hernández et al., 2010; Tabet et al., 2002*). Other studies (*ATTA-REDLACTRANS, 2007; Asociación Silueta X, 2012; Asociación Panambi, 2011; Bolivia Red Trébol, 2012*) report HIV prevalence rates that range from 26% to 35%—compared to between 2.5% and 18% in MSM. Sex work is a significant risk factor for trans women: studies revealed prevalence rates from 28% to 63% (*Grandi et al., 2000; Sotelo, 2008; dos Ramos Farías et al., 2011; Toibaro et al., 2009; Lobato et al., 2007, Rodríguez Madera & Toro-Alfonso, 2003; 2005*).

Prevalence rates for syphilis show similar patterns. Studies report rates of active or past syphilis infections ranging from 1% to 13% for MSM, but ranging from 6% to 51% for trans women. (*Universidad de Valle de Guatemala, 2010a/b; Hernández et al., 2010; Tabet et al., 2002*). Among trans women engaged in sex work, rates show much less variance, ranging from 42 to 50% (*Grandi et al., 2000; dos Ramos Farías et al., 2011; Toibaro et al., 2009*).

There are limited data on the prevalence of infection with hepatitis B virus, human papilloma virus (HPV), and herpes simplex virus (HSV) among trans persons. Three studies assessed the prevalence of HSV2 among trans women in El Salvador, Nicaragua, and Peru, reporting rates between 71 and 81 percent (*Hernández et al., 2010; Universidad de Valle de Guatemala, 2010a/b; Silva-Santisteban et al., 2011*). A study in Argentina revealed a hepatitis B rate of 42% for trans women engaged in sex work (*dos Ramos Farías et al., 2011*). The same study reported a much lower corresponding rate of 22% for cis men engaged in sex work, which shows that the vulnerability of trans persons may not be strictly attributed to sex work. Of the female trans sex workers included in the study, 97 percent tested positive for HPV.

The HIV risk for trans men, particularly gay-oriented trans men, is associated with unprotected sex with HIV-positive partners. In a study of trans men's sexuality and sexual behavior, 14 of 17 interviewees reported having non-trans gay men as their sexual partners (*Rowniak et al., 2011*). Use of testosterone may increase libido, and this can have an impact on sexual behavior. HIV transmission may occur through unprotected vaginal (called “frontal” by trans men) or rectal (“rear”) sex practices where HIV infection is present.

#### 4.1.4. Substance use

Systematic studies on addiction and substance use among trans people are scarce. However, available studies suggest very frequent use of alcohol and other substances among trans persons engaged in sex work. One study (*Toibaro et al., 2009*) reported significantly higher substance use among HIV-positive trans women engaged in sex work than among other HIV-positive persons. Some personal communications with this particular group underscore that substance use is not associated with a compulsive desire to “party,” but with a need to endure the hardships of sex work (rude or repulsive clients, abusive treatment, threats, and violence).

Another frequently reported situation is that to “operate” in a bar or similar establishment, trans sex

workers are required to drink and encourage clients to drink, thereby generating business for the owners. To counter the numbing effects of alcohol, trans sex workers often resort to cocaine or other stimulants.

Substance use has been clearly linked with increased risk. Alcohol and other substances may reduce the capacity to negotiate

the terms of a sexual encounter, thus augmenting the vulnerability and risk of infection with HIV and other pathogens. However, substance use can also be a coping mechanism for isolation, loneliness, and a generally hostile and adverse environment—hence the difficulty of addressing this risk factor in the context of trans people (as, indeed, in the context of other marginalized groups).

“In the Caribbean we use alcohol and cocaine to escape from our problems. But many times it is the clients who encourage us to use drugs with them and if we agree, we get paid more for doing it. Just as it happens with condoms: if you don't use a condom, you get more money.”

—A trans woman sex worker from Trinidad.

#### 4.1.5. Negative effects of body modifications

Trans persons may use various methods to change their physical appearance to correspond with their gender identity. One of the most common procedures is the use of hormones to feminize the body (estrogens and antiandrogens) or to masculinize it (androgens). While it is true that these hormones can affect some of the desired changes, their use is not without risks and potentially serious side effects (see Box 2). Thus the use of hormones as part of the transition process urgently requires assessment and support from qualified physicians who prescribe these drugs and monitor their effects.

#### Box 2. Potential Side Effects of Hormone-driven Body Modifications

Trans persons should seek a physician's supervision to address and prevent the side effects of hormones used to enhance their gender identity. Hormones used for feminization can lead to side effects including: thromboembolic disease, liver dysfunction, development of hypertension, gallstones, migraines, fluid retention, and other conditions related to the use of high doses of estrogen such as alterations in the production of prolactin, insulin resistance, and development of hormone-dependent tumors. Unsupervised use of masculinizing hormones can lead to side effects of varying seriousness, including liver dysfunction, erythrocytosis, hypertension, acne, increased body fat, calcium deposits, development or worsening of sleep apnea, and development of androgen-dependent tumors and cardiovascular disease (*Hembree et al., 2009*).

Aside from hormone administration and surgery, many trans persons resort to the injection of soft tissue fillers (most commonly liquid silicone) to modify parts of their bodies. Available information suggests that trans women use soft tissue fillers to alter the shape of their breasts, buttocks, legs, lips, or cheeks, whereas trans men may resort to injections to modify their upper arms and chest. In a study of a sample of 16-25 young trans women, 29% indicated that they had injected liquid silicone at some point in their lives (*Garofalo et al., 2006*). These fillers are frequently administered by unlicensed practitioners under unhygienic conditions. Chemical, bacterial, or fungal contamination of fillers may occur, and often results in serious medical complications.

The fillers themselves are also potentially toxic. Injecting industrial silicone (polydimethylsiloxane) or oils of paraffin directly to subcutaneous tissue or cheekbones can result in life-threatening consequences, including pulmonary embolism, which is fatal in around 25% of all cases (*De March Ronsoni et al., 2000*). Complications associated with the practice of injecting liquid silicone or mineral oil include

local ulceration, cellulitis, product migration, scarring, abscesses, and infection; systemic problems include pulmonary embolism, granulomatous hepatitis, and acute renal failure.

#### 4.1.6. Other health issues

Other health issues identified by trans persons from Latin American and Caribbean countries, particularly those who work on the streets, include various problems associated with the hardships of street life (Mazin, R. *personal communication*, 2011). Mentioned issues include:

- Dermatological problems (rashes, pruritus, pustules, parasitic infestations) resulting from use of garments made of synthetic fibers and padding, excessive sweating, and lack of access to basic hygiene services
- Dental problems
- Sleep disruption and other sleep-related problems
- Eating disorders including anorexia, bulimia, and malnutrition
- Injuries, including results of sexual violence
- Physical and psychological results of bullying, harassment, and transphobia.<sup>7</sup>

In conclusion, what we know about the health and well-being of trans people in the LAC region comes from a relatively

### Sidebar 2. The Trans Population: Multiple Communities, Multiple Risks

A component of the complexity of understanding and reaching trans populations is their great diversity, with different terms, behaviors, and expectations within each subgroup. Both researchers and public health officials should understand these differences when targeting the trans population for outreach and services.

For example, several qualitative studies in Brazil examined the characteristics, identities, relationships, sexual behaviors, and sociocultural context of travestis or trans women. Roberto & Garcia (2009) found that the primary feminine identities assimilated by travestis were the submissive woman, the puta (“whore”), and the super-seductive woman (hyperfemininity). Masculine identities included the viado (“queer”), the malandro (“rascal”), and the bandito (“bandit”).

Almost all of these trans women were of low socioeconomic class, had faced intense discrimination since childhood and adolescence, lacked education, and had difficulties finding employment. These factors made sex work one of the few options for survival. By contrast, transsexuals (Benedetti, 2005), cross dressers (Primo, Pereira, & Freitas, 2000), and drag queens (Vencato, 2005) seemed to be identities more common among the middle and upper classes. Travestis seem to conform more strongly to the identity of the puta (whore) than female sex workers, in part as a way to affirm their femininity. This gender-affirmation strategy may lead them to take the receptive role in relationships with male primary partners, though they remain sexually versatile with male clients.

According to Kulick (1998), travestis do not want their primary partners so much for sexual pleasure, which they obtain instead from their exchange or casual partners: “They don’t get sex from their men—what they get, instead, is gender,” Kulick found. Kulick’s ethnographic study showed limited condom use with primary partners (condoms being associated with paid work). It also revealed widespread misconceptions among travestis about HIV, AIDS, other health conditions (for example that one can tell whether someone carries an infection just by looking at him). These beliefs suggest significant misperception of risk that, by extension, represent obstacles to adequate health care.

7. Transphobia and homophobia are pervasive in the LAC region.

small number of studies focused on trans sex workers and vulnerability to HIV. Yet the context of the lives of trans people—violence, stigma, and marginalization, the multiple hardships of sex work, lack of access to health care, and self-administration of hormones and silicone—are well documented and of great concern. Any future efforts to promote the health of trans people in the region must take this complex context into account.

## 4.2. Gaps in strategic information

Numerous challenges limit the quality and quantity of data on trans populations. Data weaknesses include restricted access to the population; diversity of the population (see Sidebar 2); lack of cohesive community networks; disagreements about terminology (which affects community trust and, in turn, researchers’ effectiveness, e.g., referring to trans women as “male transsexuals” or “MSM” alienates potential subjects); and researchers’ use of definitions (see Section 3 on terminology and definitions) that artificially circumscribe the pool of available research subjects (e.g., describing transsexual people as only those who have previously undergone genital reconstruction). The UCSF Center of Excellence for Transgender Health offers recommendations for data collection that can be accessed at <http://tranhealth.ucsf.edu/pdf/data-recommendation-2page.pdf>.

Though research on trans health is scarce in the LAC region, we were able to examine a number of published studies from Bolivia, Brazil, Costa Rica, Ecuador, Mexico, Paraguay, and Puerto Rico. In addition, needs assessment studies have been conducted in Argentina and Peru and there is an award-winning trans health initiative in Cuba. These sources seem to confirm many of the hardships found among trans populations in the United States, but the studies from LAC reported even fewer interventions and health services available. As mentioned, studies have focused on trans women so little is known about the health of trans men. Much remains unknown or anecdotal. The limited qualitative data need rigorous quantification to establish a body of evidence that can be used to allocate resources for addressing disparities in trans persons’ health and access to care. Some of the main gaps in knowledge are:

- Size and demographics (age, residence, ethnicity, education, religious affiliation, occupation, etc.) of trans populations in the region
- Systematic and comprehensive epidemiology of health issues and concerns
- Prevalence of behavioral risks
- Predictors of risk and resilience
  - Effective prevention interventions
  - Access to appropriate care services
  - Structural risk factors and effective ways to address them

Recently, the Institute of Medicine (IOM) of the National Academy of Sciences in the U.S. released a report on lesbian, gay, bisexual, and transgender (LGBT) health (*IOM, 2011*), specifically outlining the gaps in research on trans health. The report focuses on the United States, but is explicit about the need to consider trans health in light of the sociocultural context, and many of the research questions and needs described in the report are universally applicable and can be a resource for future efforts, including international collaborations and those in the LAC region, to improve health and quality of life of trans people (see Section 10).



## 5. Determinants of Health and Sociocultural, Legal, and Structural Barriers to Comprehensive Care

### 5.1. Stigma and its consequences

The experiences of trans persons, their health and well-being, and their access to and utilization of health care services cannot be understood without considering the sociocultural context in which they live (see Box 3). Universally, a major influence on the health of trans persons is the stigma attached to gender variance and gender nonconformity. In patriarchal cultures, which endow masculinity with a high value, persons who violate gender boundaries tend to be seen with disdain. In some ways, this parallels the stigma attached to homosexuality; research has shown that much of that stigma affecting MSM is based on gender role nonconformity, whether in terms of gender role behavior (masculinity or femininity) or related sexual roles (in some cultural settings, being a bottom—not being a top—constitutes being gay). The high visibility of trans persons exposes them to acute levels of gender-related stigma and discrimination. In this sense, homophobia and transphobia are expressions of intense sexism, perhaps because MSM and trans persons are seen as “transgressors” who “relinquish” the most advantageous (heterosexual) social position and thus deserve to be ostracized. Discrimination against trans women can also take place within lesbian, gay, bisexual, trans, and intersex (LGBTI) communities.

#### Box 3. Social Values and Trans Health

The minority stress model (*Brooks, 1981; Meyer, 1995, 2003*) provides a theoretical framework for understanding how the psychological effects of stigma add to other life stressors and render trans individuals extra vulnerable to adverse health outcomes. This model describes the relationship between the values of the dominant and minority groups in a given context. Minorities whose behavior, values, appearance, and actions differ from those of the dominant group experience constant stress arising from a hostile environment. In sexual minorities such as trans persons, chronic stress arises from the experience of homophobia, stigma (including self-stigma), isolation, and secrecy; this stress in turn influences health outcomes, very often with negative impacts (*Dentato 2012*).

Poverty creates a vicious cycle that perpetuates the health impact of stigma in many ways. It limits access to health care services, including urgently needed care. Poverty also restricts employment and lifestyle opportunities to options, such as illegal sex work, that may increase health risks, including violence, while reinforcing stigma and its accompanying deprivation. Additional factors—family rejection, school harassment and drop-out, and housing and employment discrimination—also exert severe impacts on the health and well-being of trans individuals (*Kulick, 1998; Loehr, 2007; Prieur, 1998*).

“She had to work that night because she didn’t have anywhere to sleep. In three months, she lost everything she had in her hotel. In Argentina, there are only shelters for men and women, and if we go to a shelter for men, they ask us to dress like men. The women’s shelters don’t accept us. The options are the state or the church. And neither of the two acts responsibly toward (trans) people. And this happens all over Latin America.”

—Recounted to JoAnne Keatley by an Argentine trans woman, International AIDS Conference, Vienna, Austria, 2010.

For example, a study in Buenos Aires showed that trans women are frequently denied housing, and may pay exorbitantly high rent for substandard housing without access to their own kitchen (49%) or bathroom (48%) (Loehr, 2007).

The trans community is often most visible in the street, with particular impact on young trans people. Trans youth face a potentially destructive dynamic: Rejection by family and peers contributes to their risk of becoming homeless and needing to find ways to survive on the street. Dropping out of school interrupts education and employment discrimination further limits the ability of trans individuals to find work and establish healthy social support systems. Employment discrimination and homelessness increase vulnerability to participation in sex work as a way of earning a living (Schifter, 1999).

### 5.1.1. Sex work and risks for trans persons

The combination of poverty, stigma, and social rejection, violence, and exclusion often makes sex work the most common means of survival for trans people. Studies among groups of trans women in several LAC countries reveal that between 33% and 75% of respondents engaged in sex work (Sotelo, 2008; Silva-Santisteban et al., 2011; Hernández et al., 2010; Universidad de Valle de Guatemala, 2010a/b, Rodríguez Madera, 2009). For trans women, an attraction of sex work is that it provides a space where they find acceptance among peers and are desired by clients, which strengthens their damaged self-esteem (Salazar & Villayzan, 2010).

However, sex work is hazardous, particularly where laws governing sexual behavior exist. Among trans women, sex work, alcohol and substance use, and soft tissue filler injections have been identified as factors with severe impacts on vulnerability to HIV and other STIs. As mentioned, poverty should also be considered a risk factor. Research in North America has shown that trans sex workers are at the bottom of the prostitution hierarchy, receiving the lowest level of payment and the greatest level of abuse compared to female and male sex workers (Boles & Elifson, 1994). Substance use appears to be a common way to cope with these hardships (e.g., Kulick, 1998; Prieur, 1998; Schifter, 1999). A study in São Paulo ( $n = 53$ ) revealed that trans sex workers were young, with little education and low socioeconomic status, and compared to male and female non-trans sex workers were at higher risk for STIs. This was borne out by the trans sex workers' greater number of years in sex work, higher number of daily sexual partners, history of ulcerative STIs, greater frequency of anal sex and use of non-injectable substances (especially crack), and history of incarceration.

Risk avoidance behavior is limited among trans sex workers. It has been documented that trans women can face the same difficulties in the negotiation of condom use as biological women in Western contexts. Also, their strategies for gender affirmation can sometimes lead them to not use condoms (Rodríguez Madera & Toro-Alfonso, 2005). Condom use is rarely consistent and varies with type of partners. Rates of condom use, ranging from 40% to 98% with commercial partners, decrease to between 37% and 78% with non-commercial partners. For interactions with stable partners, condom use is as low as 22% to 46% (Silva-Santisteban et al., 2011; Grandi et al., 2000; Centro de Estudios de la Sexualidad & Movimiento Unificado de Minorías Sexuales, 2009; Hernández et al., 2010; Universidad de Valle de Guatemala, 2010a/b).

Trans sex workers also face environmental risks. In Mexico City, Infante and colleagues (2009) found that trans sex workers were heavily stigmatized (including by members of the gay community), and had poor access to health services (in part due to fear of discrimination or lack of confidentiality). Use of alcohol and other substances was common. Compared to male sex workers, trans sex workers were found to work in a more violent environment. Conflicts among trans sex workers and their peers were common, some stemming from envy and competition, compromising the potential of peer support.

Respondents in this study said that the limited access to trans-specific services led them to self-administer hormones and silicone injections. However, self-treatment is risky. Trans women are vulnerable to



HIV transmission through unsafe injection of drugs (with reported rates ranging from 19% to 86%) or substances for body modification (*Toibaro et al., 2009; Hernández et al., 2010; Centro de Estudios de la Sexualidad & Movimiento Unificado de Minorías Sexuales, 2009; Universidad de Valle de Guatemala, 2010a/b*). According to several trans women in the Caribbean, access to self-administered hormones sometimes requires international travel; e.g., a person in Belize may need to go to Mexico.

While the risks to trans people from sex work and substance use have been documented across the globe, it is noteworthy that many of the samples in European countries consist in large part of trans immigrants from Latin America (e.g., *Gattari, Rezza, Zaccarelli, Valenzi, & Tirelli, 1991; Gattari, Spizzichino, Valenzi, Zaccarelli, & Rezza, 1992*). Reports from Brazil (*Kulick, 1998*) and Argentina (*Loehr, 2007*) document the migration of trans sex workers to Europe, facilitated by trans “madames” (called *cafetinas* in Brazil, and *regentas, tías, or madrotas* in Spanish-speaking countries) who often serve as a parent figure). The madames arrange travel (tickets, visa, contacts) and places to work, for which the trans sex worker will have to repay at high interest. Trans sex workers from the region reported that they hoped to eventually return to their native country with enough money to be able to buy a house and car and possibly become a madame themselves.

### 5.1.2. The stigma of psychopathologization

The current DSM and the International Classification of Diseases (ICD) retain a formal classification of gender identity disorder as a mental disorder (*American Psychiatric Association, 2000; Vance et al., 2010; World Health Organization, 2007*). However, there is controversy in North America, Western Europe, and the LAC region over this diagnosis. Aran and colleagues (2009) and Ventura & Schramm (2009) point out that the diagnosis might undermine trans individuals’ autonomy, and advocate for public policies that do not depend on having a diagnosis or having had sex reassignment surgery. Being labeled with a disorder confers a permanent, indelible stigma upon a person whose whole existence is considered as an expression of psychopathology.

Hence the preference among many authors for the term “gender dysphoria,” which they define as a transitory condition originating in the lack of agreement between gender identity and primary and secondary sexual characteristics. An advantage of the term is that it refers to a state of psychological distress that can be remedied. This classification may offer a route to health care coverage without imposing a permanent label. Nevertheless, some individuals consider it a stigmatizing term, and do not want it recorded in medical manuals or documents. The World Professional Association for Transgender Health (WPATH), an international organization that promotes evidence-based strategies to improve the well-being of trans persons, advocates for health and policy approaches—including eliminating negative labeling—that remove the stigma attached to the trans lifestyle (see Box 4).

#### Box 4. WPATH De-Psychopathologization Statement

“The WPATH Board of Directors strongly urges the de-psychopathologization of gender variance worldwide. The expression of gender characteristics, including identities that are not stereotypically associated with one’s assigned sex at birth is a common and culturally-diverse human phenomenon which should not be judged as inherently pathological or negative. The psychopathologization of gender characteristics and identities reinforces or can prompt stigma, making prejudice and discrimination more likely, rendering transgender and transsexual people more vulnerable to social and legal marginalization and exclusion, and increasing risks to mental and physical well-being. WPATH urges governmental and medical professional organizations to review their policies and practices to eliminate stigma toward gender-variant people.”<sup>8</sup>

8. [http://www.wpath.org/announcements\\_detail.cfm?pk\\_announcement=17](http://www.wpath.org/announcements_detail.cfm?pk_announcement=17)

Appropriate, informed mental health services could offer critical support to trans individuals. However, unless mental health professionals acquire the knowledge and skills to address the specific needs of this population, their services may take ineffective and stigmatizing approaches, which can then affect the person’s access to mental health services. As one participant in a study with Puerto Rican trans women stated: “About mental health... I have decided not to seek the services because I tell you... all doctors, all psychologists and people who deal with this area believe that my situation and my problem is sexual orientation. They always say the same thing: “Oh, your problem is this, your problem is that.” And I said: “you are the one who has identity problems. You have a professional degree and have studied a lot but you do not know what you have in your hands...” (Rodríguez Madera, 2009).

## 5.2. Sociocultural, legal, and structural barriers to health care

The stigma attached to gender variance appears to be the overarching sociocultural barrier for trans persons. Stigma affects virtually every aspect of the social, legal, and policy structures that govern trans persons’ access to both essential services and basic human rights. Trans communities are often fragmented, and lack visibility within the legal and policy spheres; this forms a structural barrier to social acceptance and inclusion within services.

Human rights and anti-discrimination legislation that protect trans people from stigma and discrimination are needed to address the structural factors that impede service accessibility. Rueda (2012) points out that people who do not express socially expected feminine or masculine behavior (i.e., culturally assigned behavior based on their genitals and other anatomical features) do not receive adequate protection from the state and society (in Salinas Hernández, Héctor Miguel, 2012).

Many factors contribute to the exclusion of trans persons from health care services. A study by Barreda & Isnardi (2003) in Argentina indicated that trans individuals may consider hospitals and other health centers as insensitive or extremely discriminatory, places to be visited only when they are in extreme need. This causes many travestis to avoid health care altogether, so that they fail to receive preventive care or early intervention.

Documentation poses another obstacle. Trans people may struggle with changing their identity documents to reflect their gender identity, which varies from the sex noted on their birth certificate. For one thing, legal recognition of a person’s gender identity reflects appropriate legal acknowledgment, but this recognition also has important health implications in terms of reducing the mental distress that trans people experience. Legal recognition, embodied in appropriate identity documents, helps to ensure that health care providers treat trans persons in a respectful manner and in alignment with their gender identity. Legal status is also critical to decreasing health risks from sex work and facilitating integration into other kinds of work.

The current reality, as reported by trans respondents from the LAC region, is far from the ideal. Travestis seeking health services may be passed around to different staff members because providers are uncomfortable treating them (Loehr, 2007). Physicians may not understand why travestis may inject silicone, why they engage in sex work, or why they abuse substances. The structure of health care services, in itself can comprise a barrier (see interview below). Inpatient health care is often segregated by gender, so that travestis may be assigned to the men’s ward, which poses challenges. Additionally, medical staff do not often acknowledge the gender identity of travestis. In an interview, one trans woman said: “Once I was in a waiting room and they called me by my masculine name and surname...I almost died of shame...I didn’t get up, I waited until they called someone else and then I left.”

“Our vulnerability or risk practices are not a condition per se of trans people; they are the result of political, economic, and social contexts.”

—Mexican trans woman, interviewed by JoAnne Keatley, 2010, International AIDS Conference

**Interviewer:** In your opinion, what is the greatest barrier that the trans community faces regarding health care treatment?

**Peruvian trans woman:** Our lifestyle is totally different from the majority. We can't go to an appointment at 10 or 11 in the morning when we've gone to bed at 6 in the morning. I think that that's a part of it. Also, there's a little bit of not being a citizen or having documents; they've told me that my whole life. I believed that. So, I don't have rights to health care, I don't have rights to a dignified life, I don't have rights to work, I don't have any rights. So, changing beliefs based on experiences we've had, for older people who are more vulnerable, because they are poor, they don't have access to education, they're illiterate, they're indigenous, they're indigenous Americans. So, it's complicated.

—Interview by JoAnne Keatley, International AIDS Conference, Vienna, Austria, 2010

### 5.3. The role of educational systems

The right to education is protected by Article 13 of the UN Covenant on Economic, Social and Cultural Rights<sup>9</sup> (CESR, adopted in 1966) and Article 13 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights<sup>10</sup> (*Protocol of San Salvador, 1988*). While these and other international agreements recognize the right of all persons to education that seeks to support the dignity and full development of the human personality, the reality, once again, is different.

There are limited hard data on educational achievements by trans persons, but available research suggests that few reach higher levels of basic education, let alone graduate or postgraduate studies. A study in Buenos Aires reports a high proportion (64.4%) of trans people without higher education (*Jones, 2006*), while a similar study in Córdoba showed that 82.3% of transgender respondents had attended only secondary or middle school (*Iosa, 2012*). Studies in Colombia, Chile, and Mexico showed that between 73% and 83% of trans people interviewed had not completed higher education (*Brigeiro, 2010, Barrientos, 2012, Sivori, 2008*).

Many factors contribute to this disadvantageous situation, but anecdotal evidence suggests that the chief factors in school drop-out are stigma, bullying, and the educational system's unpreparedness to accommodate sexual and gender diversity. It is well known that higher levels of education are associated with better utilization of health care services, improved understanding of self-care and prevention practices, and greater likelihood of adopting health-seeking behaviors in general. It is thus urgent that educational systems play a role in

“Bullying makes you feel less than a normal person... at first the bullying was verbal. They would call me and my best friend “faggot, battyman.” This was always coming from men because homophobia starts at a young age. Girls were kind of supportive. The teachers on the other hand didn't know how to deal with the situation. I remember a religion teacher citing and reading in class scripture in connection with my situation just to judge me. I think teachers also need tools to manage this bullying in schools just as doctors need to understand the needs of trans persons.”

—Caribbean trans woman

9. <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>

10. <http://www.oas.org/juridico/english/treaties/a-52.html>

improving the educational environment by combating stigma, discrimination, and bullying, measures that would contribute to reducing school drop-out by trans persons (as well as other minority groups). It is equally important to address human rights in education by ensuring that curricula address gender issues and diversity, and the negative outcomes of bigotry and sexism, including homophobia and transphobia.

#### 5.4. The role of health systems

In the LAC region, as elsewhere in the world, health systems are intended to deliver services and supplies to respond to the health needs of various populations. LAC countries are signatories or member states of the CESR, which describes the essential aspects of health care (see Box 5).<sup>11</sup>

Countries in the region have made significant investments in their health care systems and have achieved noteworthy advances in many areas. Currently many resources in the LAC region are justifiably deployed for the care of children and pregnant women. Yet little investment is made in the care of adult men, let alone of MSM or trans populations. As a result, adults in general tend to approach health care services only when they are quite sick, have had an accident, or experience some other kind of medical urgency.

#### Box 5. CESR and Health Systems

The CESR outlines four essential components of health systems and services:

**Availability:** Health facilities, goods, and services must be available in sufficient quantity within the Member State. Although the CESCR allows some flexibility in regards to the nature of the facilities, goods, and services, it remains firm in that they must include not only the traditional underlying determinants of health, but also those that create new obstacles for the realization of the right to health.

**Accessibility:** Health facilities, goods, and services must be physically and economically accessible to everyone, including trans populations, without discrimination on the basis of race, religion, physical status, sexual orientation, or any other characteristic. In addition, accessibility includes the right to seek, receive, and impart information and ideas concerning health issues, and the exercise and enjoyment of such a right must not be encumbered by discrimination on the basis of any of the aforementioned grounds.

**Acceptability:** Health facilities, goods, and services must be mindful of medical ethics, respectful of the culture of individuals, minorities, and communities as a whole, and sensitive to gender requirements.

**Quality:** Health facilities, goods, and services must be of good quality, as well as scientifically and medically appropriate.

Access to health care is especially critical for trans people because it is often the pathway to affirming their sense of self. Without the medical technologies to manifest their identities, the fulfillment of the individual and social role of many trans persons is seriously jeopardized. And given the absence or weakness of specific policies, strategies, or services for gender-diverse populations in general, trans persons often prefer to use private or clandestine services, or self-medication—or to stay out of health services altogether. For example, in a 2010 interview an Argentine trans woman said, “...in some places in Argentina there is hormone therapy. The thing is that the state doesn’t want to put medical care or endocrinologists, services that are for the improvement of the trans community, in their budget; the state doesn’t want to invest in that. What we do is speak to the schools of Medicine, to academies, with

11. <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>



doctors who don't close their doors on us and who risk their careers for our lives...[So 99% of trans women self-medicate.]”

This woman also described deliberate refusal of services by public-system providers: “What medical services do is tell you they can't see you, but that this man can see you in private, and he will charge you at his office.” (*JoAnne Keatley interviews, 2010*).

Exclusion from health care also affects access to urgent concerns, including HIV. A Peruvian trans woman described research showing that trans people were not receiving needed HIV treatment, despite the presence and wide coverage of antiretroviral (ARV) programs. “In research on people living with HIV and AIDS, for example, in poor cities, we found that coverage of [ARVs] for those needs was above 95%. There was a only small amount of people not receiving them. So, among those, a few already had the virus and were still not receiving them. Not surprisingly, we found that a factor associated to this was trans identity, right? So, for us that's a reflection that trans persons don't access the health care system, [not just for] HIV services, but in general, right?”

Thus, the principal mandate of health systems—maintaining the highest possible standards of care throughout programs and services—remains unfulfilled for this population.

One solution would be to create specialized services for trans clients. However, in resource-limited settings, this is challenging. Another possibility would be to establish alternative care facilities that serve as health service models, with certification by sexual and gender diversity organizations that endorse such premises as “free from stigma and discrimination.” Examples of these include the *Centros Amigables para la Diversidad* (Friendly Centers for Sexual Diversity) in Argentina and *Ovejas Negras* (Black Sheep) in Uruguay.

Another alternative could be to take a rights-based approach in accordance with internationally accepted standards. Such an approach would support the development of policies and strategies, along with provider training and sensitization, to meet the needs of sexual and gender minorities in accordance with international consensus on each person's right to health.<sup>12</sup> This approach takes into account the findings of the CESR that ally access to high-quality health care with related human rights.

### **5.5. Interpersonal factors (including social isolation and power in relationships)**

Like all human beings, trans people usually desire wider social relationships and would like to have committed relationships. However, socialization is often an arduous and frustrating process. Therefore, their social circle may be limited and restricted to their peer group. It can be very disturbing for trans people to realize not only that will they find limited general social acceptability, but limited access to serious sexual relationships, because such relationships entail social disapproval, stigma, and discrimination for potential partners as well. This perceived shortage of partners has negative impacts on interpersonal relationships—for example, compromising negotiations for condom use and other risk-reduction strategies. In addition, trans persons and their sexual partners may be reluctant disclose their trans identity or relationship with a trans person to health providers. This nondisclosure, in turn, may compromise the provider's ability to deliver optimal care.

The stigma affecting trans family members affects other family members as well. Thus it is common that relatives of trans people set distance from and avoid contact with (the trans person) that may negatively affect their social image. This may explain the reason why many trans youths are expelled from their homes and end up living in the streets.

12. In General Comment 14, the United Nations Committee on Economic, Social, and Cultural Rights analyzes the content, scope, and obligations of the Member States deriving from Article 12 of the International Covenant on Economic, Social, and Cultural Rights (The right to enjoyment of the highest attainable standard of health). The Committee establishes that the right to the highest attainable standard of health is closely related to and dependent on the exercise of other human rights such as life, non-discrimination, equality, freedom from inhumane or degrading treatment, the right to association, assembly, and movement, food, housing, employment, and education. This general comment is available at: [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=E%2FC.12%2F2000%2F4&Lang=en](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2FC.12%2F2000%2F4&Lang=en)

It is noteworthy, however, that family perceptions may change as the trans person grows in economic power and is able to contribute to household expenses. One trans woman said, “I knew that my mom was having money problems and I sent her some money. At first, she did not want to receive it but I think the need forced her to accept it. I also started to take care of the expenses of my nephews, the sons of my sister who is not married.”

Another interviewee recalled, “Over time, the relationship with my mom has changed and I even took her on a trip to the beach and other places. We talked about things and I love when she calls me ‘my cute kitten.’ Before, she hated me, but she now says I’m her favorite daughter. We do not live together but I take care of her and the family. My two brothers still don’t talk to me, but I do not care.”

By contrast, unemployed or low-income trans people likely face higher levels of rejection, abuse, and discrimination.

## 5.6. Individual-level factors

Stigma attached to gender variance can be internalized, leading to shame, low self-esteem, loneliness, and social isolation. This internalization of shame can also lead to compulsive sexual behavior, including compulsive features of “validation sex”<sup>13</sup> (Bockting, Robinson, & Rosser, 1998; Nuttbrock et al., 2009; Kulick, 1998). Internalized transphobia, defined as discomfort with one’s own transgender identity that results from internalizing (accepting) society’s binary gender norms and expectations (Bockting, 2003), may be expressed through an over-emphasis on “passing” as the desired gender identity. Internalized negative social notions may contribute to social alienation, the adoption of traditional gender ideologies that contribute to risk behaviors, substance abuse, and other forms of suboptimal self-care. In addition, internalized transphobia may compromise peer relations and support (Kulick, 1998).

## 5.7. Trans persons deprived of liberty

Reports of unlawful detention and mistreatment of trans persons by public authorities give rise to serious concerns.<sup>14</sup> Deprivation of liberty, whether as a result of arrest or sentencing, is a common experience among trans persons across the LAC region. A study among 455 trans persons in Argentina for example, found that 89.7% of the participants had been detained in the past (Sotelo 2008). Within the legal systems of many countries, sex work and drug use constitute crimes that can lead to incarceration. The legal codes of some countries furthermore provide for the possibility of “offences against public decency” that easily lend themselves to arbitrary and discriminatory interpretations. Some Caribbean countries still have laws that criminalize same-sex relations. Even laws that are not implemented (such as old laws that have not been repealed) fuel discrimination, exclusion, and homophobic actions.

Trans persons who are deprived of liberty are likely to face severe health risks. Inadequate policy protection governing the incarceration of this population increases their vulnerability significantly while decreasing their access to appropriate health care. Thus, the situation of incarcerated trans persons requires specific attention to ensure the preservation of their mental and physical health and human rights while in prison.

### 5.7.1. Vulnerability under conditions of detention and imprisonment

Incarcerated trans persons tend to be disproportionately affected by prison health care systems, which often provide insufficient and lower-quality care relative to that available to persons living in freedom. Incarceration may increase the vulnerability of trans persons in various ways. The risks that trans people face include mental distress, exposure to physical violence and sexual abuse, and lack of means to prevent the transmission of HIV and other STIs. These risks are compounded by the psychological vulnerability that affects many trans persons as a result of the social and structural challenges concomitant with gender nonconformity.

13. Seeking sexual relationships to support their self-concept of gender identity—an important aspect of trans behavior, especially female trans persons.

14. <http://www.oas.org/es/cidh/prensa/comunicados/2012/036A.asp>



As a general imperative, therefore, and to support the preservation of both mental health and non-discriminatory practices, being incarcerated must not undermine a person's ability to live in accordance with her or his gender identity. For trans persons, this may involve aspects of gender expression, including clothing, hairstyles, and the use of makeup, that can conflict with prison regulations that are based on a person's biological sex or legal gender. Prison regulations should be revised accordingly to respond to a person's gender identity, rather than biological sex or legal gender.

Housing regulations concerning trans persons should be guided by the goal of ensuring physical and emotional integrity and reducing the risk of stigmatization while avoiding unnecessary isolation. Depending on the context, safety concerns require separate housing sections for trans persons and other vulnerable groups. Such a measure should, however, take into account the potential harmful psychological effects of living in isolation, and should not be enforced against the will of the persons concerned. Equally, care must be taken to ensure that separate accommodation does not undermine access to social services and programs that are otherwise available within the institution.

Incarcerated trans persons have been known to face alarming levels of vulnerability to contracting HIV. For example, a study among 82 trans persons in a São Paulo prison found that 78% tested positive for HIV (compared to 17% among the prison population at large). Time spent in prison (> 6 years) and the number of sexual partners in the last year (> 10) were significantly associated with HIV infection (*Varella et al., 1996*).

Inadequate policy protection governing the incarceration of trans persons increases their vulnerability significantly while decreasing their access to appropriate health care. Thus, the situation of incarcerated trans persons requires specific attention to ensure the preservation of their mental and physical health and human rights while in prison.

Socio-economic dynamics within prisons can be conducive to forms of sexual interaction among inmates and between inmates and prison staff that increase the risk of transmission. The São Paulo study showed that incarcerated trans inmates tended to have two options: play the feminine role in a relationship with another inmate in exchange for protection from other inmates, or (continue) sex work in the prison environment. Anecdotal evidence also suggests that trans persons may be induced to engage in sex with prison guards in exchange for privileges such as family visits. In addressing these and other factors of vulnerability to HIV, it is absolutely crucial that prevention measures are not hampered by incarceration. Prison populations should have access to condoms as well as confidential testing and counseling services. In addition, as noted, housing regulations should aim at minimizing risks of involuntary or exploitative sexual interactions. At the same time, it is crucial that regulations respond to individual vulnerabilities. In some cases, prison regulations demand that members of most-at-risk populations (MARPs) be housed together with HIV-positive persons, in isolation from the wider prison population. Such provisions, supposedly intended to control the HIV epidemic, are unduly stigmatizing.

### 5.7.2 Access to health care under conditions of detention and imprisonment

Detention and incarceration, however temporary, must not undermine access to general health services or lead to delays or interruptions in treatment. Prisoners' access to appropriate and timely treatment and care for HIV is of particular concern. HIV treatment and care should be fully integrated into the primary health care services provided in penal institutions. This means that there should be

qualified on-site counseling and that public health systems should ensure the availability of pharmaceutical drugs within prisons without requiring patients to travel to specialized clinics to register for a treatment program.

The specific needs of trans persons related to gender affirmation are often dismissed as purely “cosmetic” concerns with no relationship to health. It is important that trans persons who are in the process of receiving hormonal treatment continue to have access to hormones, including supervision by appropriately trained medical staff, and medical care to address the potential health effects of hormone therapy (see Section 7.9). Equally, persons who have undergone surgical modification of their bodies should have access to adequate care. Persons who have not undergone hormonal treatment or surgical modifications, but seek to do so while incarcerated, should be able to access such procedures through health services provided by prisons.

WPATH has produced a comprehensive document on health care for trans persons, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (Coleman et al., 2010), which includes a section describing care for those who live in institutional environments (see Section 10).<sup>15</sup>

## 6. Advocacy, Public Policy, Training, and Research

### 6.1. Strategies for advocacy

Advocacy and public policy are key to combating social stigma, improving access to care, and promoting human rights for the trans population in the LAC region. Building this advocacy requires the creation of partnerships among trans communities, providers, scientists, policy-makers, and other stakeholders to promote change. Freire’s (1970) theories on adult pedagogy, pedagogy of the oppressed, and the role of the learner may guide community involvement and empowerment to achieve these aims (see *Bockting, Rosser, & Coleman, 1999* for an example of how this has been applied in the United States).

#### 6.1.1 Community involvement and empowerment

Peer support, community-building, and empowerment enable trans individuals to establish coalitions with other stigmatized communities to advocate for their interests and rights. Indeed, in Latin America and the Caribbean, several organizations and networks have been formed. These organizations empower trans individuals and their communities to become involved in advocacy—for example, by taking part in needs assessments, offering prevention interventions, developing approaches to improve access to care, and promoting human rights to combat stigma and address other structural barriers to the health and well-being of trans people.

#### 6.1.2 Partnerships

Because the infrastructure available within the trans community can be limited, the establishment of partnerships with allies is crucial (*Bockting, Rosser, & Coleman, 1999*). These partnerships may include other trans community organizations, gay, lesbian, or bisexual communities and organizations, health departments, health centers, and universities. Far from diluting the identity of any one community, coalition-building based on mutual agendas can be a powerful change agent.

For example, in the town of Manacapuru in the State of Amazonas, Brazil, government officials, health professionals, and the community developed a “constructionist-emancipatory” framework to control HIV and STIs (*Benzaken, Garcia, Gomes, Pedrosa, & Paiva, 2007*). Trans sex workers became involved as peer educators, which legitimized them as citizens and health agents. The results included an increase in condom sales and use, reduction in bacterial STIs, and stabilization of the incidence of HIV and syph-

15. Essentially the document calls for the availability of all types of medically necessary care, including mental health care, in an environment that is monitored to ensure inmate safety and respectful care by staff and providers. This document is online at [http://www.wpath.org/site\\_page.cfm?pk\\_association\\_webpage\\_menu=1351&pk\\_association\\_webpage=4655](http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=4655) (accessed July 2, 2014).

ilis. Another example is the *Projeto Venha Informar-sesobre o Virus da AIDS (PROVIVA)* (Come and Learn about the AIDS Virus) project in Rio de Janeiro, Brazil. In this project, public health researchers worked extensively with representatives of the target population (which included trans persons among other high-risk residents of *favelas* or slums) to establish a community HIV and AIDS surveillance and monitoring system and develop, implement, and evaluate a community-based HIV and AIDS prevention and intervention program for male transvestite sex workers (*Inciardi, Surratt, & McCoy, 1997*).

In addition to development of local, national, and regional networks, trans activists cite the critical need for global networking and enhancement of the visibility of the trans community at international meetings. At the International AIDS Conference in Vienna, 2010, a Peruvian interviewee pointed out that unless trans people are strongly represented in international fora, strategies to address their challenges and include them in the global community will fail. “I have seen in international conferences...a huge representation of MSM in comparison to trans people...Why don’t we have the opportunity to talk about our issues? We are all expecting that there will be some strategies...so that we can get in touch with each other regularly and we can form a global trans group.”

## 6.2. Human rights and public policy in the LAC region

Countries in the LAC region have made varying degrees of progress in reducing the structural barriers that affect trans persons. However, there are national and international laws and programs that can be used to model developing policies.

### 6.2.1 Human rights instruments as a groundwork for legislation

In recent years, the human rights of gender nonconforming persons, including trans persons, have received increasing attention within the international legal community. On 17 June 2011, for the first time in its history, the UN Human Rights Council adopted a resolution calling for a study “to document discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity, in all regions of the world, and how international human rights law can be used to end violence and related human rights violations based on sexual orientation and gender identity.”<sup>16</sup>

The resulting report was presented to the Council in December 2011.<sup>17</sup> Further affirming its concern with the issue, on March 7, 2012, the Council held its first session dedicated specifically to discrimination and violence based on sexual orientation and gender identity. In his opening remarks, UN Secretary-General Ban Ki-moon highlighted the unequivocal protection of sexual orientation and gender identity under the principles of international law.<sup>18</sup> A number of other agreements provide a range of protection measures.

Within the LAC region, the Organization of American States (OAS) has been taking measures since 2008 to ensure that member states protect LGBTI persons from discrimination on the basis of gender identity, gender expression, and sexual orientation. The OAS resolution “Human Rights, Sexual Orientation, and Gender Identity” (AG/RES. 2600, 2010) reaffirmed that the UN’s Universal Declaration of Human Rights (1948) protects the rights of all human beings without distinction on the basis of sex, which includes “discrimination against persons because of their sexual orientation and gender identity.” Signatories resolved “to condemn acts of violence and human rights violations committed against persons because of their sexual orientation and gender identity.” In addition, they agreed “to take all necessary measures to ensure that acts of violence and related human rights violations are not committed against persons because of their sexual orientation and gender identity, and to ensure that the victims are given access to justice on an equal footing with other persons.” Finally, they promised “to

16. <http://daccess-dds-ny.un.org/doc/RESOLUTION/GEN/G11/148/79/PDF/G11/14879.pdf?OpenElement>

17. [http://www2.ohchr.org/english/bodies/hrcouncil/docs/19session/A.HRC.19.41\\_en.pdf](http://www2.ohchr.org/english/bodies/hrcouncil/docs/19session/A.HRC.19.41_en.pdf)

18. [http://www.un.org/apps/news/infocus/speeches/search\\_full.asp?statID=1475](http://www.un.org/apps/news/infocus/speeches/search_full.asp?statID=1475)

consider ways to combat discrimination against persons because of their sexual orientation and gender identity,” and to provide “adequate protection for human rights defenders who work on issues related to acts of violence, discrimination, and human rights violations committed against persons because of their sexual orientation and gender identity.”<sup>19</sup>

The resolution “Human Rights, Sexual Orientation, and Gender Identity” (AG/RES. 2653, 2011) extends protection for gender nonconforming groups by asking the Inter-American Commission on Human Rights to “pay particular attention to its work plan titled ‘Rights of LGBTBI People’ and...prepare a hemispheric study on the subject; and to urge member states to participate in the report.”<sup>20</sup> This resolution also asks the IACHR and the Inter-American Juridical Committee “to prepare a study on the legal implications and conceptual and terminological developments as regards sexual orientation, gender identity, and gender expression, and to instruct the Committee on Juridical and Political Affairs to include on its agenda the examination of the results of the requested studies, with the participation of interested civil society organizations.”<sup>21</sup>

The following is a non-exhaustive list of human rights treaties and declarations that can guide the formulation of policies and laws to protect trans persons:

- **United Nations System for the Protection of Human Rights**

- Universal Declaration of Human Rights
- International Covenant on Civil and Political Rights<sup>22</sup>
- International Covenant on Economic, Social, and Cultural Rights<sup>23</sup>
- Convention on the Rights of the Child<sup>24</sup>

- **Inter-American System for the Protection of the Human Rights**

- American Declaration of the Rights and Duties of Man<sup>25</sup>
- American Convention on Human Rights<sup>26</sup>
- Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights, or Protocol of San Salvador<sup>27</sup>
- The Yogyakarta principles on sexual orientation and sexual identity.<sup>28</sup>

At the national level, Ecuador (in 2008) and Bolivia (2009) were the first countries in the region to establish constitutional protection for gender identity.<sup>29</sup> In Brazil, the federal government passed a decree in 2010 that led to the establishment of the National Council for Combating Discrimination (Conselho Nacional de Combate à Discriminação), with the purpose of formulating and proposing guidelines for government actions aimed at combating discrimination and promoting and defending the rights of lesbians, gays, bisexuals, transvestites, and transsexuals.<sup>30</sup>

19. <http://www.oas.org/consejo/sp/AG/Documentos/AG05138E06.doc>

20. [http://www.oas.org/en/41ga/docs/AG05445E02.doc#\\_Toc295241220](http://www.oas.org/en/41ga/docs/AG05445E02.doc#_Toc295241220)

21. [http://www.oas.org/en/41ga/docs/AG05445E02.doc#\\_Toc295241220](http://www.oas.org/en/41ga/docs/AG05445E02.doc#_Toc295241220)

22. Entered into force on 23 March 1976 and ratified by Argentina, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, the United States of America, Uruguay, and Venezuela.

23. Entered into force on 3 January 1976 and ratified by Argentina, Barbados, Bolivia, Brazil, , Canada, Chile, Colombia, Costa Rica, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

24. Entered into force on 2 September 1990 and ratified by Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, Venezuela.

25. 199 OAS res. XXX. OEA/Ser.L.V/182 doc. 6 rev.1, p.17 (1992).

26. Entered into force on 18 July 1978 and ratified by Argentina, Barbados, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Trinidad and Tobago,

27. Entered into force on 16 November 1999 and ratified by Argentina, Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Panama, Paraguay, Peru, Suriname, and Uruguay.

28. [http://www.yogyakartaprinciples.org/principles\\_en.htm](http://www.yogyakartaprinciples.org/principles_en.htm)

29. Uruguay, and Venezuela.

30. Constitución de la Republica del Ecuador, Article 11; Constitución Política del Estado, Article 14.



## 6.2.2 Legal recognition of gender identity

Multiple, complex, and often structurally determined risks affect the health of trans people, as described in Section 5. Thus the ability of trans persons to change legal documents to correspond with their gender identity has to be considered a public health imperative. The lack of legal documents that adequately reflect their gender identity exacerbates the marginalization of trans people and, for many, presents a serious psychological obstacle to seeking health or legal services. Likewise, in the labor market, employers frequently reject applicants whose gender expression do not correspond to their legal identity, or refuse to treat them in accordance with their variant gender identity. As a consequence, trans persons are often left with sex work as the only option for income. Thus, legal identity regulations have a direct impact on the vulnerability of trans persons, in that they provide structural safeguards that facilitate access to appropriate health care and safe employment.

Some countries in the region, such as Uruguay (2009), have recently started to introduce policies that allow trans persons to change their legal name and gender marker to reflect their identity. In contrast to legal regulations in other countries, this change does not depend on having undergone sterilization or reconstructive genital surgery and, above the age of 12, does not require parental consent.<sup>31</sup> Similar regulations have been adopted in Mexico City<sup>32</sup> and Cuba (*Centro Nacional de Educación Sexual, 2008*).

In 2012, the Senate in Argentina passed an unopposed law declaring that Argentinians over age 18 may decide the gender specified in their National Identity Document even if it does not correspond with their natal sex. That is, trans women (who were born biologically male) may choose to tick the box corresponding the female gender without undergoing surgery or hormonal treatment for gender reassignment. The same process happens with trans men (who were born biologically female). The law also provides that the procedures for updating “gender identity” will be free and will not require judicial intervention. Thus, people who wish to do so can change their birth certificate, driver’s license, passport, or any other document that states a gender they do not feel identified with. The law also stipulates that any surgery or medical treatments should be free.

Other countries in Latin America are currently in the process of reforming their gender identity laws. Unfortunately, this is not the case for Caribbean countries.

## 6.2.3 The medical rationale for public coverage of trans-specific care services

The availability of trans-specific services in the LAC region varies. Yet it is critical to recognize the role of health care interventions aimed at reducing gender dysphoria and ensuring healthy and adequate sex reassignment as a medical necessity (*Coleman et al., 2011*). Health policy-makers, care providers, or employers can play a critical role in advocating for this coverage.

### WPATH Identity Recognition Statement

“No person should have to undergo surgery or accept sterilization as a condition of identity recognition. If a sex marker is required on an identity document, that marker could recognize the person’s lived gender, regardless of reproductive capacity. The WPATH Board of Directors urges governments and other authoritative bodies to move to eliminate requirements for identity recognition that require surgical procedures”<sup>33</sup>

31. Presidential decree No. 7.388, passed on December 9, 2010. ([http://www.planalto.gov.br/ccivil\\_03/\\_Ato2007-2010/2010/Decreto/D7388.htm](http://www.planalto.gov.br/ccivil_03/_Ato2007-2010/2010/Decreto/D7388.htm))

32. <http://sip.parlamento.gub.uy/leyes/ AccesoTextoLey.asp?Ley=18620>

33. [http://trans.ilga.org/trans/welcome\\_to\\_the\\_ilga\\_trans\\_secretariat/news/mexico\\_mexico\\_city\\_extends\\_official\\_rights\\_to\\_transgender\\_individuals](http://trans.ilga.org/trans/welcome_to_the_ilga_trans_secretariat/news/mexico_mexico_city_extends_official_rights_to_transgender_individuals), <http://www.equipopueblo.org.mx/descargas/folletospdf/LGBTTLweb.pdf>

34. The same standards are recommended for the interaction of public officers with trans persons. In 2008, prior to the International AIDS Conference in Mexico City, as an initiative of the National Center for AIDS (CENSIDA), migration and customs authorities as well as security guards at the international airport were trained on how to behave and talk with trans women arriving at the conference; they were taught to call them “Señorita” or “Señora” (Miss or Mrs.) rather than Señor (Mr.), even though their passport might show a male name or picture that did not match their gender identity or appearance.

35. [http://www.wpath.org/announcements\\_detail.cfm?pk\\_announcement=18](http://www.wpath.org/announcements_detail.cfm?pk_announcement=18)



Several countries have begun to offer these services. In Brazil, the 4<sup>th</sup> Regional Federal Court ruled in 2007 that sex reassignment surgery should be covered under a constitutional clause that guarantees medical care as basic human right (*Letellier, 2007*). The Ministry of Health decided to offer sex reassignment surgery at no cost to transsexuals who are psychologically evaluated and diagnosed by public health officials (*Nichols, 2007*).

In Cuba, the National Center for Sex Education (CENESEX) has successfully advocated for access to quality trans care (see *Gorry, 2010*, for a detailed account). In 2001, the National Strategy for Comprehensive Attention to Transsexual People was launched, fulfilling the constitutional promise of health care. This strategy covered the development of integrated clinical and mental health care for gender minorities; set research priorities in trans health; designed public education and communication strategies; outlined sensitivity training programs; and proposed legal mechanisms to protect the social and civil rights of transsexual people. These goals are being accomplished through inter-sectoral cooperation among the Ministries of Health and the Interior, the Supreme Court, and the Attorney General's office, in concert with social and political organizations, labor unions, and neighborhood block associations, with coordination by the National Commission for Comprehensive Attention to Transsexual People (established in 2005). In 2008, a resolution was issued by the Ministry of Public Health mandating comprehensive health services for transsexual people in Cuba, including the establishment of a trans-specific health care specialty clinic. Care is guided by the World Professional Associations Standards of Care (*Coleman et al., 2011*).

In the Caribbean, PAHO, the Caribbean Community (CARICOM), and the Pan Caribbean Partnership against HIV/AIDS (PANCAP) can lead the development of a region-appropriate policy or blueprint for integrating the spectrum of trans-specific health issues. They can also help individual countries to adapt regional documents and develop national strategies. The ongoing Sexual and Reproductive Health Policy initiatives among the Caribbean countries may serve as a platform for these actions.

### **6.3. Education and training of health and social service providers**

Providing health care to trans persons requires a specific set of skills and appropriate attitudes and behaviors. These will distinguish between high-quality and substandard quality services. Having knowledge about specific health conditions is not enough. Cultural competency should be integrated into pre- and in-service training for members of the health care force, including social services staff. Opportunities should be identified for integrating such contents into existing curricula, along with in-service professional development to prepare providers to work successfully with trans youth and adults.

A guiding principle for any training must be the development of accepting attitudes and a climate of respect, empathy, and solidarity.

### 6.3.1. Development of clinical skills and cultural competence

Lack of education and training among health care providers is a primary factor limiting access to culturally competent as well as trans-specific health care. To meet cultural competence standards, staff and providers in any health care setting should be trained and required to be sensitive and respectful to patients who have diverse gender identities and expressions. This training could be part of any orientation or in-service sensitivity education. Specific attention should be paid to using preferred names and pronouns to communicate respect for the patient's gender identification. Asking in a way that does not "out" the patient in front of other patients is better than assuming. Primary care providers should be aware of the basics of trans-specific care even if they are not experts in providing such care. The WPATH Standards of Care (Coleman *et al.*, 2011), available at [www.wpath.org](http://www.wpath.org), provide a helpful introduction.

In the U.S. and its territories, trans issues have been incorporated within the curricula of medical school and other health professional education, either within sections on developing cultural competence in working with minority populations or within human sexuality courses. The American Psychological Association's Task Force on Gender Variance and Transgender Issues (APA, 2008) recently recommended that education accreditation requirements include trans health content. We were not able to find any documentation of specific training opportunities in Latin America and the Caribbean.

Cultural competence training will go a long way toward improving access and reducing ignorance and discrimination that trans people often report. However, becoming competent in providing trans-specific care requires advanced training. In the U.S., such training is provided as electives in certain residency programs (e.g., University of Minnesota Family Medicine and Community Health), through continuing education (e.g., provided by the World Professional Association for Transgender Health or the Gay and Lesbian Medical Association), in postdoctoral training programs (e.g., at the University of Minnesota), and through capacity building (e.g., by the Center of Excellence for Transgender Health at the University of California, San Francisco). Although competency training may be conducted in Latin America and the Caribbean, we were not able to find any documentation or resources.

However, we did identify some policies geared toward improving cultural competence in health care settings. In Buenos Aires, all staff members, nurses, and physicians in municipal health centers must refer to trans individuals by their self-assigned gender and name. Also in Buenos Aires, the High Heels Group of AIDS Coordination worked to improve services for travestis at Muniz public hospital (described in *Loehr*, 2007). This hospital specializes in infectious diseases and has a long history of working in HIV. Because of their experience with marginalized populations, providers were less averse to working with trans women compared to other hospitals. The High Heels Group promoted cultural competency and access to care; worked with the Secretary of Health to create information materials for trans women that reflected their female gender role; distributed condoms; and facilitated appointments with various specialists in the hospital. Additionally, they offered weekly workshops to discuss a range of topics, including HIV/STIs, gender, and identity documents. Peer education, advocacy, and support were important components of this program.

The Center of Excellence for Transgender Health at the University of California, San Francisco ([transhealth.ucsf.edu](http://transhealth.ucsf.edu)) provides capacity building for working with trans communities. Recently, the Center has embarked on a project to adapt and implement guidelines for trans care in a number of international settings, including Peru. Capacity building needs are numerous. Consultations should prioritize those organizations that are most receptive and ready to provide or improve the provision of comprehensive health care to trans populations in the region. In addition, we recommend that capacity building make extensive use of community involvement and partnerships, not only to ensure that the care is sanctioned by the community, but also to provide employment opportunities for members of the target population.

The Western Hemisphere Region Office of the International Planned Parenthood Federation (IPPF) has developed a tool kit for assessing agency readiness (i.e., health care systems and services) for working with sexually diverse populations, including trans persons. The tool kit can be downloaded at [www.ippfwhr.org](http://www.ippfwhr.org).

### 6.3.2. Continuing education

Continuing education on trans health in Latin America and the Caribbean has been limited. The World Professional Association for Transgender Health (WPATH) is well equipped to provide continuing education through its biennial international symposium. WPATH organizes region-specific events during the international symposium and provides continuing education throughout the year via its online distance-education provider network ([www.wpath.org](http://www.wpath.org)). WPATH's approach could serve as a model for continuing education in Latin America and the Caribbean region.

## 6.4. Research

As noted in Section 4, research on trans health is extremely limited but essential both for documenting trans health needs and justifying funding to promote trans health. During the regional and subregional consultations in 2011 and 2012, stakeholders who worked on this document mentioned a number of research topics including the use and side effects of silicone and other soft tissue fillers; the possible interaction between ARV treatment and hormone therapy; injection use practices; abuse of alcohol and other substances; and the actual dimensions of physical violence endured by the trans population.

### 6.4.1. Evidence-based and promising approaches

Evidence-based HIV prevention interventions specifically designed for trans individuals are very limited. In the U.S., a seminar on trans people's risk for HIV in the context of their overall health resulted in improved attitudes and reduced risk behavior at three-month follow-up (*Bockting, Robinson, Forberg, & Scheltema, 2005*). A series of workshops offered in a transgender resource and neighborhood space showed promising results in reducing HIV risk behaviors, depression, and perceived barriers to substance addiction treatment (*Nemoto et al., 2005*). To varying degrees, these interventions also attempted to address HIV risk co-factors, such as substance use and sex work. With the exception of initiatives implemented by a few clinics that specialize in the treatment of gender dysphoria (*Lobato, 2007*), programs and interventions in the LAC region that address the health needs of trans persons other than HIV prevention could not be identified.

Further, a major limitation of many NGOs and federal, state, and municipal government agencies that offer assistance as part of HIV/STI prevention efforts is that they often do not adequately address the larger concerns of marginalization, sex work, violence, and discrimination encountered by many trans persons. There is also a need to analyze policies and address challenges that result from their application (or lack of application).

In Argentina, the Buenos Aires AIDS Foundation developed the Hair Salon training program (*Loehr, 2007*) to provide alternative employment opportunities beyond sex work for trans women. For a period of six months, four days per week, students are trained to dress hair by volunteer teachers. On the fifth day, a workshop is offered, covering a range of topics from gender, HIV, discrimination, substance use, values, civil rights, and legal advocacy. A social psychologist works with participants on issues of living together (to improve peer support), and other speakers from various disciplines are brought in to address other relevant topics. Students may not miss more than four classes if they are to graduate; upon graduation, they receive a diploma and a party to recognize and celebrate their achievement. Internships in hair salons are also provided. A stipend of 200 Argentinian pesos per month to compensate trans women for their time was seen as key to the program's viability and success. In addition to hair-dressing, students learn such skills as keeping a regular schedule and being on time, working in a team, establishing and maintaining a clientele, and providing leadership. At any given time, there are 40–50

participants in the program, though only about half graduate.

It is important to emphasize that training options should not be limited to professional occupations related to entertainment or personal beauty. Work training for trans should extend to any other field. There are examples of trans people working in health services as counselors, laboratory technicians, pharmaceutical or pharmacy assistants, among other occupations. Thanks to their tenacity, many trans people have managed to complete a university degree and successfully perform as lawyers, doctors, surgeons, psychologists, public health professionals, and various other professions. It is important to ensure that opportunities for training and professionalization become available to trans people as a rule, rather than as an exception.

## 7. Comprehensive Care, Prevention, and Support

*The recommendations in this section are based on the care protocols developed by the UCSF Center of Excellence for Transgender Health, available at [www.transhealth.ucsf.edu/protocols](http://www.transhealth.ucsf.edu/protocols).*

### 7.1. Infrastructure and settings; coordination of care

The spectrum of trans persons encompasses persons of all shapes, sizes, ages, races, sexual orientations, socio-economic positions, and educational backgrounds. They may have bodies that do not match their gender identity or presentation (see Section 3), or they may have had (or want to have) medical treatments to modify their bodies to affirm their gender. Typically, treatments consist of cross-sex hormone administration (see Section 7.9.2) and reconstructive surgery (see Section 7.9.4). Many trans people do not identify with the terms “transgender” or “transsexual” (as described in Section 3); providers should not assume that all trans people have the same attitudes, behaviors, beliefs, experience, or understanding of their identity and experience.

Very few physicians and other health care providers currently in practice received training on the needs of trans clients during their formal education. It is thus no surprise that practitioners may experience discomfort when meeting clients whose gender identity or expression does not correspond with their sex assigned at birth. Further, practitioners may have acquired misinformation that may prevent them from providing optimal care to trans clients.

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

1. Honor the client’s preferred gender identity and use the name, pronouns, and terminology that the client prefers.
2. Do not treat a trans client as if s/he is nothing more than her or his body. A trans person’s body may have characteristics that do not conform to the client’s gender identity. It is therefore important to note that the anatomy of trans people does not necessarily define them, though the client may require treatments that are typically provided for persons of the other sex. Providers should respect the client’s gender identity, and treat the body as if it belongs to them, rather than defines them.

It is possible to act on these principles when the physician knows that the client is trans. If the client intake form asks questions about the client’s current gender identity and their sex assigned at birth (see the next section and algorithm on Reception and First Encounter or *Client Intake*), it is easier to determine a client’s trans status. Without such a mechanism, the physician must rely either on the client’s self-disclosure during conversation or on the discovery, during physical exam, that the client has a gender-incongruent anatomy.

Once aware that a client is trans, the provider should refrain from defining the person on the basis of natal sex, and give weight instead to the client’s gender identity and preferred name and pronouns.



The most important principle to apply in general prevention and screening is to provide care for the anatomy that is present, regardless of the client’s self-description or identification, gender expression, or legal status; and always to provide that care in a respectful and affirming manner that recognizes and honors the client’s self-description or self-identification.

Cultural competence in serving trans people in health care applies across all settings, from primary to specialty to emergency care. The goal is for every health care setting to be competent and respectful when treating trans persons. There are several settings, however, where the quality and sensitivity of care is especially important for trans individuals, their families, and their communities.

The first is the *primary care setting*—the front line of client care and up to now, the site of a substantial proportion of the negative experiences that trans people have reported. Thus there is much room for improvement in the primary care setting; the goal is that trans clients will have positive experiences consulting with their general or family physician. The primary care setting also provides opportunities for delivery of components of specific health care; for example, trained family physicians can easily provide and monitor hormone therapy (*Dahl, Feldman, Goldberg, & Jaber, 2006*).

Unfortunately—for numerous reasons discussed earlier in this document—many trans individuals avoid care until a crisis or emergency arises. Thus the emergency room is another important setting to consider.

Specialty care centers that are of particular importance include substance addiction treatment programs, behavioral health, obstetrics and gynecology, urology, endocrinology, and plastic and reconstructive surgery. Dental care offices are another setting where providers can both provide appropriate services and foster health-seeking behaviors.

A culturally competent clinical environment includes appropriate restroom facilities to accommodate clients with a variety of gender identities and expressions—clinics should offer a gender neutral, unisex, or private family restroom. Clinics that mount posters with trans or LGBT content or references in the clinic can help trans clients and their families to feel more welcome and safe. Clinic forms and charts should allow for more than two genders, a preferred or nickname in addition to legal name, and—importantly—a space to indicate the name to use during telephone calls, correspondence, and when calling people from the waiting room. This is important because trans individuals frequently prefer a name that is different from their legal name (e.g., Rubi instead of Juan), yet this name might be confidential, and the client may not want it used in correspondence. So forms and computer systems need to allow for noting specific preferences. Ways of handling these matters should be openly discussed and negotiated with the client.

Coordination of care is critical for any client population, especially for multidisciplinary trans-specific care. A referral network or directory of trans-friendly and competent providers should be established and maintained. Regular communication among providers is essential, whether in person, over the phone, via the electronic medical record, or through exchange of records and progress notes through regular mail. In addition, providers who see a “critical mass” of trans clients in a given area could be encouraged to hold monthly meetings or establish online, secure forums. Providers might use these venues to discuss and resolve challenges they encounter in providing comprehensive care for this community.

## **7.2. Reception, first encounter, and first clinical evaluation**

A trans person’s first encounter with a health care service provider should be easy, comfortable, and friendly. For this reason, the attitude of security guards is critically important, as they are among the “first-line” staff of a given service, and an attitude or behavior perceived as hostile or disrespectful to trans persons may prevent them from utilizing the service. Security guards and other staff, including cleaning personnel, need to be trained to demonstrate respect and consideration to all potential users of services. The training should also include the basics on human sexuality, sexual health, and gender issues.



The “second line” (sometimes, in fact, the first) are the receptionists, who will interact with clients in a more personal way, since they have to obtain information relevant to the provision of services, including certain screening procedures. Receptionists are the “face” of a service, and they need to be trained to develop skills to address clients with tact, empathy, respect, patience, confidentiality, and warmth. As with guards and other administrative staff, the training of receptionists should include the basics of sexual health, human sexuality, and gender issues. Receptionists must develop cultural competency to deal with diversity and a sense of respect for individual desires, needs, and aspiration. Receptionists should never act in a way that makes the client feel demeaned or humiliated, such as using her/his legal (instead of preferred) name; not creating a climate of trust and confidence; or disclosing confidential information. In some places, it might be useful to employ assistants who are trans persons themselves. These assistants may help to collect personal data, provide general information about how the service works, and motivate users to take advantage of certain interventions (e.g., hepatitis B vaccine, HIV testing, anal screening, support groups), and can provide peer education and support. Once the client’s needs have been identified, the receptionist and/or assistant should help the her/him navigate the service by making it clear what steps are recommended for the optimal utilization of the health care service.

Usually, the first step is a clinical evaluation that should include basic questions about gender identity, expression, and sexual health as part of the medical and sexual history. After having established the preferred name and pronouns, providers can ask how the client identifies in terms of gender. If an answer is given, the provider can ask the client to clarify what that means in his or her life. Follow-up questions may include whether client lives full-time in the preferred gender role, for how long, use of hormones, and any trans-related surgeries. However, care should be taken to ask what is relevant and not lose track of the client’s main concern.

Trans individuals may be sexually active with men, women, other trans individuals, or all of the above; the provider should not make assumptions, but recognize that gender identity and sexual behavior are distinct categories, and ask about the person’s sexual behavior. This question is preferred over asking whether the client is homo-, bi-, or heterosexual. Follow-up questions can include specific sexual practices; again, without assumptions about a particular identity or gender role being associated with a particular sexual practice or role.

### 7.2.1. Client registration

Identifying a trans client is easiest if intake forms have a place for trans clients to identify themselves to the physician and office staff in a safe and confidential manner and the staff is trained to handle the information tactfully and respectfully.

The ideal client intake form (see Box 6) has both a “gender question” and an “assigned-sex-at-birth question” such as those shown below, and an optional “preferred name and pronoun” question. Asking both a gender and a sex question instead of just one (either sex or gender), and offering many choices, allows for specific disclosure of a person’s history and also validates current

#### Box 6. Sample Client Intake Form

##### 1. What is your current gender identity? (Check ALL that apply)

- Male  Female
- Transgender female/trans woman/MTF
- Transgender male/trans man/FTM
- Transvestite (cross-dresser)
- Genderqueer
- Additional category (please specify): \_\_\_\_\_

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

- Male  Female

##### 3. What name and pronouns do you prefer? \_\_\_\_\_

gender identity. Many trans persons do not currently identify as transgender or transsexual for a variety of reasons. Some believe it is part of their past and not a present identification, others may not identify with “trans” terms due to cultural beliefs, social networks, or linguistic norms in various geographic areas.

Trans clients may reveal themselves to the physician only in the examination room, and only then because they are forced to do so because of their medical history. Physicians will not always be able to recognize a trans client without her/his self-disclosure, but during examination a physician may discover that a client’s body does not conform to his/her self-declared sex, or to the sex the physician expected to find. In the first interaction with a trans client, physicians should be careful to treat the person respectfully to help overcome any previous negative experiences in health care settings.

The physician should assess clients for immediate health needs and address illness or medical problems as needed. Check for allergies, past medical history, specialists being seen, and chronic and episodic medication usage, including any cross-sex hormone medication and its source (prescription, street dealers, sharing with others; duration of use; and any complications). Request and register information on frequency of condom use as well as use of alcohol and other substances. Take a detailed family history, with special attention to cardiovascular disease, diabetes, and cancer, especially of the breast, prostate, or reproductive organs. Assess whether the client has experienced violence, self-harm, or injuries at home. Psychosocial issues that may be addressed in an initial exam are discussed in the General Prevention and Screening Section. Review health care maintenance, including immunizations, TB screening, HIV screening, STIs screening, and safety, and provide safer sex counseling.

### **Sidebar 3. Sensitivity, Tact and Respect: Key Considerations for Addressing Trans (And Any) Persons in Health Care Services**

During all stages of the trans clients visit—from registration through consultation and follow-up—clinical staff should show courtesy and sensitivity. Rather than make assumptions, health and social service employees should routinely ask what the client’s sex assigned at birth (or natal sex) is (male, female, or other), as well as how the client identifies in terms of gender identity (woman, man, trans woman, trans man, trans person, cross-dresser, other), and if necessary ask an additional open question to invite the client to briefly describe his/her gender identity and related relevant information. However, the provider should take care not to inquire beyond what is necessary to competently address the client’s presenting health concerns.

The most important recommendation is to be mindful about the person’s identity and specific needs. Staff should respect the client’s desires, and when calling the client’s name, use the name for which the client has indicated preference. Empathy, sensitivity, tact, and respect are necessary skills that every provider should develop and practice when interacting with any client but in particular trans persons. Disclosure of a natal sex different to what the provider had assumed may be momentarily disconcerting. In such situations, providers should remain calm and respectful of the person’s body and self-declared identity. Providers should avoid expressions of surprise or interjections because these can be interpreted as insults. Confidentiality is critical for trans clients, and providers must respect it. Trans clients may not return for follow-up care if they do not feel respected or safe.

## 7.2.2. Physical exam

Physical exams must focus on the anatomy that is present, rather than the trans person's perceived or affirmed gender. However, the service user should always be referred to and treated socially as their preferred gender. For example, if breast tissue is present, perform routine breast/chest exams, but if the client identifies as male, relate to him as a man. In post-operative trans women, prostate exams are still required. If the uterus and cervix are present in a trans man, pelvic exams and Pap smears may need to be done regularly.

These exams must be done with sensitivity toward the client's affirmed gender. Always address a male-identified client with masculine pronouns and his preferred name, even when performing a vaginal exam; always address a female-identified client with feminine pronouns and her preferred name, even during a prostate exam. Ask the person if s/he would like to have someone else present during the exam, and to specify the gender of that person. Physicians should allow clients to negotiate what constitutes the exam. Physical exams are necessary elements of certain consultations. However, it is critical for the physician to ensure that the trans client understands and fully consents to the exam. Trans clients may have extreme discomfort with their bodies, and they may find some elements of a physical exam traumatic.

Physicians at Vancouver Coastal Health recommend a client-centered approach focused on the specific needs and characteristics of these clients. Feldman and Goldberg, in their publication *Transgender primary medical care: Suggested guidelines for clinicians in British Columbia* (2006), include several recommendations:

- **Establish trust:** “Unless there is an immediate medical need, delay sensitive elements of the exam, particularly breast, genital, and rectal exams, until a strong clinician-client rapport has developed. Sensitive exams can be managed in a variety of ways, depending on client preference; some clients prefer the exam to be done as quickly as possible, while others require a slow pace or even slight sedation. Discuss with clients when, where, and how you might need to touch them. When the purpose of the exam is explained clearly, most clients will understand.”
- **Expect the presence of specific conditions:** “You will see a range of development in clients undergoing hormone therapy. Trans men may have beard growth, clitoromegaly, acne, and androgenic alopecia; those who have bound their breasts for numerous years may have rash or yeast infection of the skin under the breasts. Trans women may have feminine breast shape and size, often with relatively underdeveloped nipples; breasts may appear fibrocystic if there have been silicone injections...

### Box 7. Forensic Medical Examination of Trans Persons

The only indication for conducting a forensic physical exam of trans persons should be for the investigation of sexual assault when they report the crime. Under this specific circumstance, it must be borne in mind that the victim experiences shock, humiliation, fear, disbelief, and anxiety. The physical examination must thus be conducted with enormous tact and respect for the person and only after obtaining the victim's consent.

In some places, there is a persistent malpractice consisting of subjecting trans persons to invasive exams of the genital, perianal, and anal zones for the supposed purpose of assessing their gender identity. This is based on the assumption that vaginal/anal “virginity” is requisite to verify that a person is “actually” trans and not gay, lesbian, or heterosexual. In fact, these exams provide no relevant information concerning a person's gender identity and are very painful and humiliating for the person who has to endure them.

There may be minimal body hair, with variable facial hair... Testicles may be small and soft; defects or hernias at the external inguinal ring may be present due to the practice of “tucking” the testicles up near (or into) the inguinal canal. Particularly in the absence of hormone therapy, findings suggestive of intersex conditions should be further evaluated.”

- **Expect a range of post-operative findings:** “Physical findings in post-operative clients will depend on the types of surgeries which have been done, the quality of the surgical work, the impact of post-operative complications, and any revisions that have been performed after the initial surgery.

Providers conducting forensic exams (see Box 7) should also abide by these recommendations.

### 7.2.3. Protocol for general prevention

Most medical problems that arise in the trans client are not secondary to cross-sex hormone use. Again, the most important principles in general prevention and screening are:

- Providing care for the anatomy that is present, regardless of the client’s self-description or identification
- Treating the client respectfully, in a way that recognizes and accepts the client’s self-description or identification. The protocol recommended below emphasizes of special considerations for treating trans clients.

#### a) Diet and lifestyle

- *Trans men* who have not had top surgery may intentionally carry extra weight to obscure breast and hip appearance. Some trans men with larger breasts may be hesitant to exercise, because of physical discomfort or reluctance to wear tight-fitting athletic apparel. Conversely, some trans men may not realize that taking testosterone imposes increased metabolic demands. Clients who are having difficulty gaining weight or muscle mass, or who present with fatigue or anxiety, should be screened for deficits in dietary protein, calorie intake, and vitamins or micronutrients. Intake should be adjusted to age and activity levels.
- *Trans women* may have eating disorders such as anorexia, or may intentionally take in fewer calories than necessary to maintain a slight build. Some trans women might feel that exercise is a more masculine activity, and therefore avoid it. Remind trans women that exercise does not have to entail bodybuilding, and that many non-trans women exercise regularly.
- *Trans persons* should not self-medicate, but should consume vitamins and other nutritional supplements according to the instructions of health professionals. This principle applies to any type of medication.

#### b) Vaccinations

Assess whether vaccinations are up to date. Most recommended vaccinations are not sex-specific, and therefore are the same as for any client. Both trans women and trans men who have sex with men may have increased risk of hepatitis A and meningococcal C. Discuss vaccinations, when these are available.

#### c) Mental health

Screen for depression, anxiety, bipolar disorder, and history of trauma. Refer, if needed, to a mental health provider who is capable of assessing and treating trans people without denying their gender identity (See Section 7.5).

#### d) Substance use

Assess substance use by inquiring about use of alcohol, tobacco, over-the-counter medications,

and medications prescribed by licensed practitioners over the short, medium, and long term (i.e., during the past 6 months, 12 months, 5 years). Screen for past and present use of other substances (street drugs) in the past 12 months, asking about type, frequency, quantity, and route of administration. Ask about utilization of substances, including alternative medications, to enhance sexual performance. Pay special attention to combined use of different substances, particularly those that can have synergic effects (e.g., benzodiazepines and alcohol), undesirable combined effects, or unwanted side effects (e.g., sildenafil and amyl nitrite, the substance present in “poppers”). If the person is taking antiretrovirals (ARVs), pay attention to the use of substances that may reduce their effect. Persons seen at emergency rooms, particularly victims of violence, may show symptoms of alcoholic intoxication, drug overdose, or withdrawal. These situations must be treated according to existing guidelines. If needed, refer client to a trans-competent chemical dependency program.

e) **Soft tissue filler injections**

Some trans women seek or have a history of using injections of medical or industrial-grade silicone oil, lubricant oils, caulk sealants, baby oil, or other substances into their hips, buttocks, thighs, breasts, lips, or face. These injections may have been given by unscrupulous practitioners and may have happened abroad. Additionally, laypersons may hold “pumping parties” where trans women are injected with these substances, using insufficiently sterile techniques. The risks associated with these procedures include local and systemic infection, embolization, painful granuloma formation, and a systemic inflammatory syndrome that can be fatal. Trans women should be screened for previous use of soft tissue filler injections, or the risk of such use, and counseled appropriately. Complications resulting from prior injections may require cosmetic surgery to repair excessive damage.

f) **Sexual health**

Take a sexual history: inquire about past and current sexual contacts; the cumulative number of contacts; gender(s) and number of partners during the past year. Check for sexual orientation changes; ask if the client is aware that sexual orientation may change as gender presentation changes, or as hormonal changes occur. Also check use and frequency of contraception, condoms, and barriers; STI history; sexual abuse history; potentially risky sex practices (e.g., bondage, sadomasochism, auto-erotic asphyxia). Self-destructive behaviors may indicate a need for mental health referral (see Section 7.5).

g) **Diabetes mellitus**

Trans people who have not used cross-sex hormones require the same screening criteria as persons of their natal sex.

- *Trans women currently taking estrogen:* consider an annual fasting glucose test, especially if there is a family history of diabetes and/or > 12 pounds weight gain. Consider glucose tolerance testing and/or A1C test if there is evidence of impaired glucose tolerance without diabetes. Treat diabetes according to guidelines for non-trans clients; if medications are indicated, include an insulin sensitizing agent. Consider decreasing estrogen if glucose is difficult to control or the client is unable to lose weight.
- *Trans men currently taking testosterone:* screen and treat as with non-trans clients. Consider screening (by client history) for polycystic ovarian syndrome (PCOS); diabetes screening is indicated if PCOS is present.

h) **Cardiovascular disease**

Trans people who have not used cross-sex hormones require the same screening criteria as persons of their natal sex. Aggressively screen and treat for known cardiovascular risk factors.



Consider daily aspirin therapy in clients at high risk for coronary artery disease (CAD).

- *Trans women currently taking estrogen:*
  - *CAD/cerebro-vascular disease:* Closely monitor for cardiac events or symptoms, especially during the first one to two years of hormone therapy; in clients at high risk (including pre-existing CAD) use transdermal estrogen, reduce estrogen dose, and omit progestin from the regimen.
  - *Hypertension:* Monitor blood pressure every one-to-three months; consider using spironolactone as part of antihypertensive regimen.
  - *Lipids:* Follow current guidelines.
- *Trans men not currently taking testosterone:* screen and treat hyperlipidemia as with non-trans clients.
- *Trans men currently taking testosterone:* Treat the same as trans women taking estrogen, except with respect to lipids. Conduct an annual fasting lipid profile. If hyperlipidemia is present, avoid supraphysiologic testosterone levels; daily topical or weekly intramuscular testosterone regimens are preferable to biweekly IM injection.

i) **Pulmonary screening**

Screen for asthma, chronic obstructive pulmonary disease, and tuberculosis (TB). Encourage smoking cessation. Presence of these conditions may preclude surgical interventions.

j) **Cancer**

Screen trans people who have not used cross-sex hormones or had gender-affirming surgery using the same criteria and risk parameters as for persons of their natal sex.

- *Trans women, past or current hormone use:* Breast-screening practices (for example mammography) in clients, assessing risk factors on a case-by-case basis and according to current-evidence-based algorithms.
  - *Prostate:* Use a digital rectal exam to evaluate the prostate in all trans women and follow up-to-date algorithms on the use of PSA.
    - Pap smears in neovaginas are not indicated; the neovagina is lined with keratinized epithelium and cannot be evaluated with a Pap smear. Perform periodic visual inspection with a speculum, looking for genital warts, erosions, and other lesions. If an STI is suspected, do a culture swab instead of polymerase chain reaction (PCR). Neovaginal walls are usually skin, not mucosa; when it is mucosa, it is urethral or colon mucosa.

Follow standard screening recommendations for other cancers.

- *Trans men, past or current hormone use:*
  - *Breast cancer:* Annual chest wall/axillary exam; follow breast cancer practices as for natal females (not needed following chest reconstruction, but consider if only a reduction was performed).
  - *Cervical cancer:* For any trans man with a cervix, do Pap smear and other screening procedures according to national standards.
  - *Uterine cancer:* Evaluate spontaneous vaginal bleeding in the absence of a mitigating factor (missed testosterone doses, excessive testosterone dosing leading to increased estrogen levels, weight changes, thyroid disorders, and so on) as for post-menopausal natal females. Consider hysterectomy if fertility is not an issue, client is > 40 years, and health will not be adversely affected by surgery.

Follow standard screening recommendations for other cancers.

#### k) **Musculoskeletal health**

Trans people who have not used cross-sex hormones require the same screening criteria as persons of their natal sex.

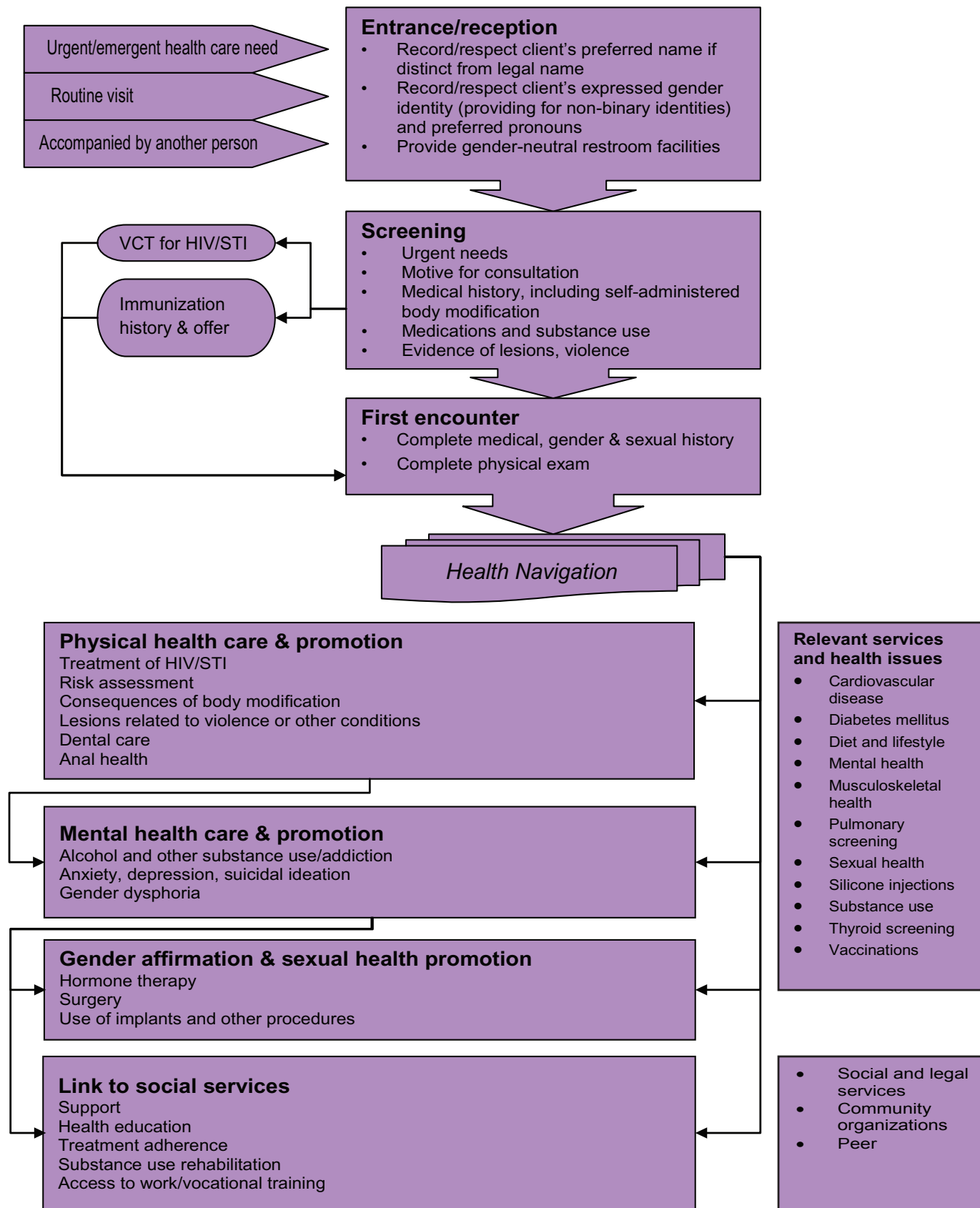
All trans clients who take cross-sex hormones and/or have had or anticipate gonadectomy are advised to take supplemental calcium and vitamin D in accordance with current osteoporosis prevention guidelines. Note that this may be applied to trans men at ages younger than the typical starting age for osteoporosis prevention treatment, because the effect of testosterone on bone density is not known.

- *Trans women currently taking estrogen:* Exercise may help maintain muscle tone.
- *Trans women, pre-orchietomy, regardless of hormone use:* To prevent osteoporosis, recommend calcium and vitamin D supplements.
- *Trans women, post-orchietomy:* To prevent osteoporosis, maintain estrogen therapy or consider current recommendations for primary prevention of osteoporosis; consider bone density screening for agonadal clients who have been off estrogen for longer than five years.
- *Trans men currently taking testosterone:* To avoid tendon rupture in trans men involved in strength training, advise increasing the weight load gradually, with an emphasis on repetitions rather than weight. Emphasize stretching.
- *Trans men taking testosterone > 5–10 years, no oophorectomy:* To prevent osteoporosis, consider bone density screening if over age 50, earlier if additional risk factors are present. Recommend supplemental calcium and vitamin D in accordance with current osteoporosis prevention guidelines.
- *Trans men, past or present testosterone use, post-oophorectomy:* continue testosterone therapy to reduce risk of bone density loss; if contraindications to testosterone therapy, consider current recommendations for primary prevention of osteoporosis. Consider bone density screening if over age 60 and taking testosterone for less than 5–10 years; if taking testosterone for more than 5–10 years, consider screening at age 50+, earlier in the case of additional risk factors for osteoporosis. Recommend supplemental calcium and vitamin D in accordance with current osteoporosis prevention guidelines. Note that younger men may need osteoporosis prevention treatment because of the unknown effect of testosterone on bone density.

#### l) **Thyroid screening**

Maintain high vigilance for thyroid disorders and screen appropriately. Use of cross-sex hormone replacement with or without gonadectomy may cause overall endocrine imbalances. Figure 1 shows an algorithm for the initial encounter with the trans client.

**Figure 1. Flow Chart for Treatment of Trans Clients**



### 7.3. The oral health practitioner's office as a point of entry into the health system

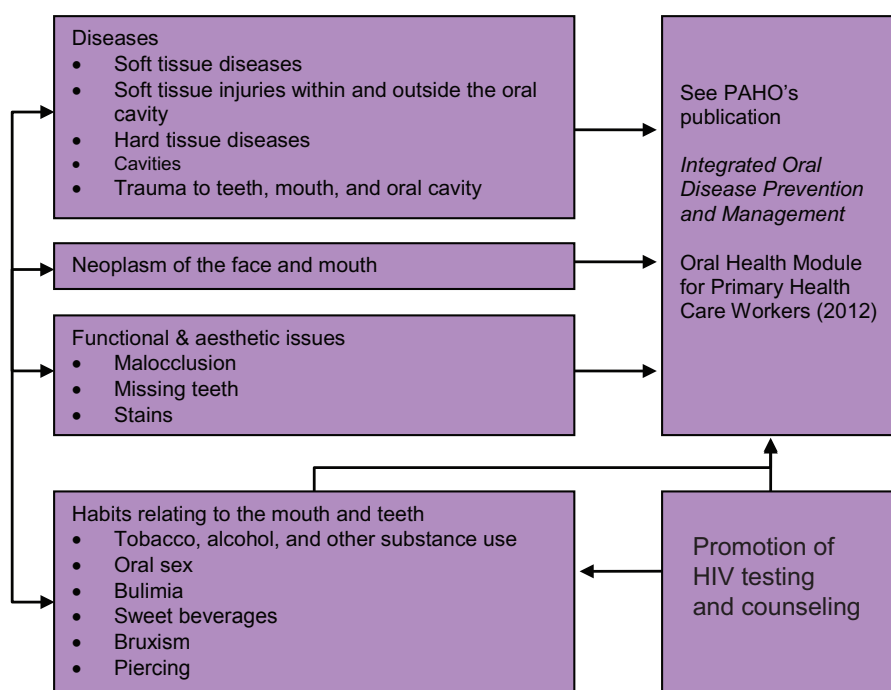
There is limited information about the oral health of trans persons. Nevertheless, it can be assumed that as with other marginalized groups, many trans persons are affected by multiple clinically significant oral health problems. Some are associated with behaviors, such as high consumption of sugar (candy, soda, energy drinks); unhealthy habits (smoking, bulimia); and practices (unsafe oral sex, oral piercing) (see Figure 2 below). Trans men may complain of gum tenderness, bleeding, irritation, swelling, and pain as a side effect of testosterone use. This complaint might be more frequent among persons who take testosterone in lozenges, which are known to cause mucosal irritation. Oral health care providers should be attentive to manifestations of periodontal problems and recommend that providers who administer hormones take oral health into account when choosing the route of androgen administration.

Because trans persons are often financially marginalized, they are affected by the high costs of restorative dentistry. Their limited means may offer them no option except extraction of damaged teeth, without subsequent oral rehabilitation treatments, such as crowns or bridges, let alone implants. The lack of appropriate treatment leaves persons with cause gaps, misalignment, chewing difficulties and occlusion problems, which also affect self-image and self-esteem.

Properly trained oral health practitioners can provide comprehensive oral health care to trans persons and link them to general comprehensive care services. These providers may identify systemic problems that have oral manifestations and can refer the client to general practitioners and specialists. Furthermore, they can offer trans clients information (e.g., health risks such as HIV, hepatitis B, violence, smoking, use of alcohol and other substances) and make referrals as appropriate.

A dentist, dental hygienist, and any other member of the oral health care team can also enhance—or decrease—the trans client's confidence in the health system. Thus, it is important to ensure that those who provide oral health care are properly trained in gender and cultural competency. As with other health care providers, the oral health care team should be trained in the basic elements of sexual health and sexual and gender diversity. Once again, empathy, respect, and sensitivity are crucial for the success of services. Figure 2 shows a flow chart for dental care for trans clients.

**Figure 2. Oral Health Problems among Trans Persons**



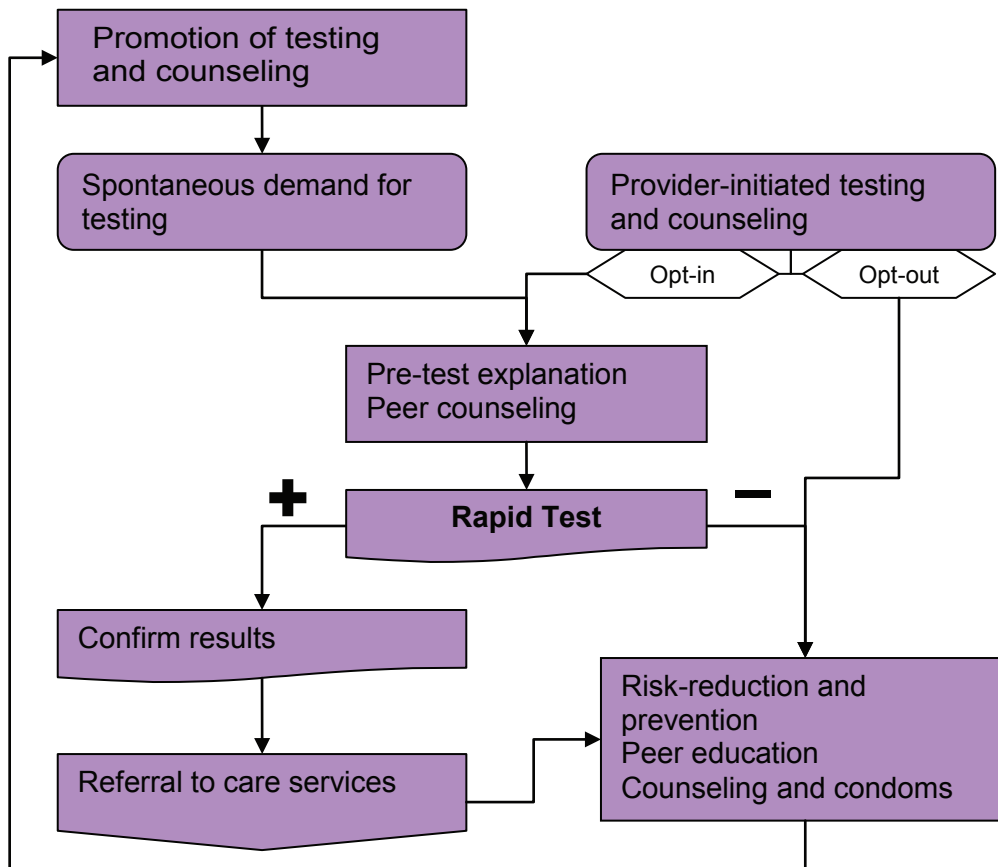


## 7.4. HIV and STI testing, counseling, and treatment

Research has shown that trans persons are less likely to have been tested for HIV and other STIs than people in other risk groups, such as MSM, despite the disproportionately high prevalence of HIV and STIs among subgroups of the trans population (*Herbst et al., 2008*). In addition to fears and concerns common among other MARPs, trans persons may fear that an HIV-positive diagnosis will reduce their access to hormone therapy and surgery, or their ability to attract commercial or non-commercial sexual partners. However, it is possible to provide reassurance. The WPATH Standards of Care specifically state that, “It is unethical to deny availability or eligibility for sex reassignment surgeries or hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV, or hepatitis B or C, etc.” (*Coleman et al., 2011*). Guidelines have been established for surgery for HIV-positive trans individuals (*Kirk, 1999*) and outcomes have been positive (*Wilson, 1999*).

HIV counseling should take into account trans-specific risk factors and co-factors. In addition to the risks of unprotected anal/vaginal intercourse (including receptive vaginal intercourse for trans men and insertive anal intercourse for trans women), trans individuals may be at risk from sharing injection paraphernalia during drug, hormone, and soft tissue filler injections. Furthermore, erratic hormone use can result in mood swings; masculinizing hormones increase libido and decrease control over sex, while feminizing hormones may impair erections, making condom use more difficult (*Bockting, Robinson, & Rosser, 1998*). Sex work, particularly when clients offer more money for unprotected sex, may contribute to risks. Trans women and men may face risks stemming from difficulties in negotiating condom use and other sexual behaviors (*Nemoto et al., 2004*).

**Figure 3. HIV Testing and Counseling for Trans Persons**

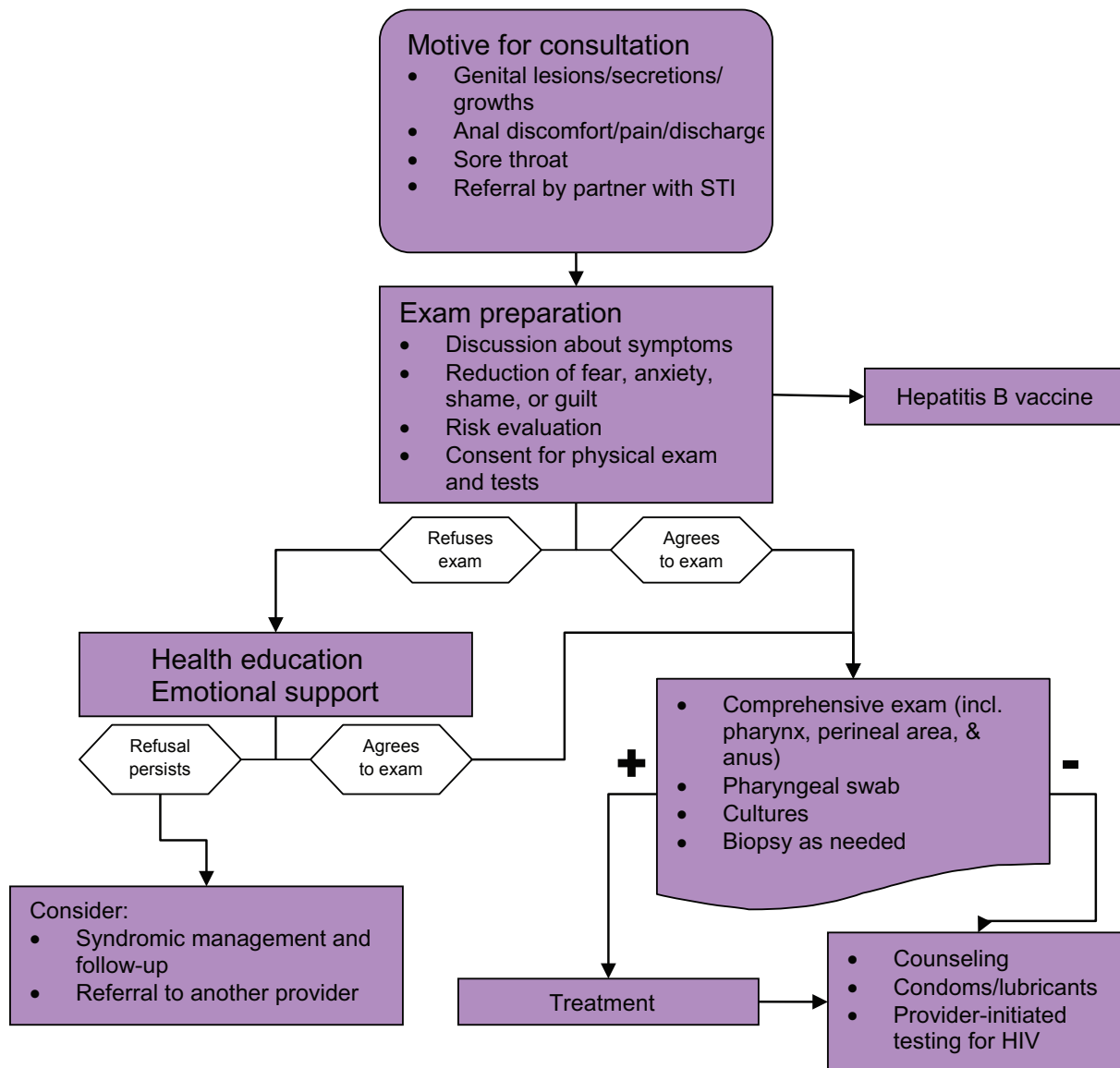


Trans populations have historically had limited access and adherence to HIV and STI treatment. Providers should encourage HIV-positive trans persons to access and adhere to HIV and STI treatment; one way to facilitate this might be to combine HIV treatment with hormone therapy, which is a priority for many trans persons. HIV-negative trans persons should be strongly encouraged to be tested for HIV and to develop a plan for regular (i.e., twice-yearly) HIV tests. Finally, social support is essential, but trans women in particular might not feel comfortable or accepted in existing support groups, which are often segregated by gender.

HIV-positive trans clients may have specific needs for support that might not be adequately addressed by support groups for MSM or for women. Trans peers should provide support, including online support, whenever possible (Bockting, Robinson, & Rosser, 1998).

HIV-positive trans people may follow the approved antiretroviral therapy (ART) national guidelines. Figure 3 shows the flow of HIV testing and related care for trans persons; Figure 4 displays an algorithm for STI management.

**Figure 4. Diagnosis and Management of STIs**



## 7.5. Addressing mental health concerns

Mental health is one of the main health concerns among the trans population (*IOM, 2011*). Anxiety and depression, including suicidal ideation and attempts and post-traumatic stress disorder are prevalent and associated with stigma and discrimination. Although family and peer support, along with identity pride, have been shown to mediate the negative impact of stigma and discrimination on trans people's mental health, this group tends to have much lower levels of such support relative to other segments of the LGBT population (*Bockting et al., 2005*). A mental health assessment is therefore a critical element of any medical assessment, with particular emphasis on how the trans client has coped with the social stigma attached to gender variance. Anxiety and depression should be distinguished from gender dysphoria (i.e., distress associated with a conflict between natal sex and gender identity, which can include both physical and role conflicts).

When treating trans clients, health care providers must be alert to manifestations of suicidal ideation. The American Association of Suicidology provides a list of signs the provider should pay attention to assess risk for suicide.<sup>35</sup> Those signs can be remembered with the mnemonic: "IS PATH WARM?"

- Ideation
- Substance use
- Purposelessness
- Anxiety
- Trapped feeling
- Hopelessness
- Withdrawal
- Anger
- Recklessness
- Mood changes

Signs of acute suicide risk include: talk about or threats of killing oneself; looking for ways to commit the deed (e.g., purchasing pills, a firearm, poison); and talking or writing about dying or killing oneself. In the presence of such signs, clients should be referred to a mental health service immediately and support from a suicide prevention task force or service sought.

As with all clients, the primary care medical provider should screen for psychiatric illness. Depression is common among trans persons, and providers should ask about persistent depressed mood, anhedonia, and suicidal ideation, and treat or refer those with clinical depression. Trans people may have suffered harassment or physical trauma. Clients who have experienced trauma should be asked about symptoms of post-traumatic stress disorder, as well as other anxiety disorders. Substance use may occur as avoidance coping in clients with gender dysphoria and/or stressful environments. Referrals for psychiatric management should be made to mental health care providers who have an understanding of trans issues.

## 7.6. Alcohol and other substance use and addiction

Quantitative assessments documenting the extent and intensity of alcohol and other substance use among trans persons are scarce. Studies based on convenience samples (e.g., bar patrons or attendees of social events) suggest levels of substance use significantly above that of the general population. These results, however, may reflect sampling biases and lead to a misrepresentation of trans persons

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35. <http://www.suicidology.org/web/guest/stats-and-tools/suicide-warning-signs>

as “partiers,” while losing sight of the hardships that may contribute to substance use. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) of the National Institutes of Health in the United States has published a set of modules on *Social Work Education for the Prevention and Treatment of Alcohol Use Disorder*. Module 10G includes information relevant to trans populations.<sup>36</sup>

The module analyzes protective and risk factors for alcohol consumption, suggesting that stress related to gender dysphoria and transphobia, depression, violence, and limited socialization may be strongly associated with increased alcohol consumption.

Smoking and chewing tobacco are strongly associated with aesthetic and health problems. Staining of teeth and fingertips, bad breath, and wrinkles around the lips are common among heavy smokers. In addition to these effects, tobacco use is associated with cancer of the mouth, larynx, bronchia, and lungs, and also with emphysema and other respiratory ailments. Potential problems associated with the use of other substances, including cocaine, crack, marijuana, amphetamines, and recreational drugs (ecstasy, poppers), are manifold, depending on the frequency of use (e.g., repeated use of inhaled cocaine causes damage to nasal tissues, and smoking crack causes damage to gums and teeth); route of administration (drug injection is linked to transmission of blood-borne infections such as HIV and hepatitis B or C); amount or dose used (excessive doses may lead to acute intoxication or overdose); quality of the drug used (impurities may cause toxic effects); and pharmacological interactions (the use of “poppers” in conjunction with the erection enhancer sildenafil, for example, may cause severe vasodilation and cardiovascular problems).

Every person attending a health care service should be asked about use of alcohol, tobacco, and other substances via a standardized questionnaire. Questions should address frequency of use, types of substances, doses, route of administration, conditions in which the use is more likely (e.g., smoking when nervous), and related mental or behavioral experiences (for example, acting out, brawling, fighting or having “black-outs”). Questions should be asked in a tactful and non-judgmental manner.

If responses suggest zero-to low-risk of substance use, service providers should follow up by inquiring about intentions of future use and strategies to deal with peer pressure or external stressors. For persons with moderate-to high-risk, educational and biomedical interventions are recommended. The length of treatment should depend on the level of risk, duration of substance use, and level of dependency. Motivational counseling should be provided, preferably by peers. The availability of safe spaces for socializing with peers independent of alcohol consumption can play an important role in substance use prevention and rehabilitation, especially for young trans persons.

### **7.7. Addressing stigma, discrimination, and violence, and promoting resilience**

Providers should assess how the client has coped with stigma and discrimination encountered during his/her coming-out process. This includes an assessment of both perceived and experienced stigma (*Bockting et al., 2011*). The clinician should pay particular attention to whether or not the client was gender-role nonconforming in childhood, and what stigma management strategies were employed. If indicated, the provider can help the client to identify or adopt effective stigma management strategies. The negative effects of abuse and violence should be assessed, and referrals to counseling provided as needed.

The minority stress model mentioned earlier in this document posits that certain minority coping processes, such as social support, can mediate or moderate the impact of this added stress on health. This model has been tested primarily with gay, lesbian, and bisexual populations to date, with a report on stigma, mental health, and resilience among the U.S. trans population (*Bockting et al., 2011*). As far as we know, this model has not been specifically tested with trans populations in Latin America or the

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36. <http://pubs.niaaa.nih.gov/publications/social/Module10GSexualOrientation/Module10G.html>



Caribbean, yet research has identified a number of factors that may be predictive of resilience. These factors include family support, peer support, and pride in trans identity (e.g., *Loehr, 2007*, for examples of exceptions among travestis who do have family support). This is particularly salient in Costa Rica and consistent with what was found in North America (*Bockting, Huang, Ding, Robinson, Rosser, 2005*), where trans individuals reported lower levels of social support than MSM (*Schifter, 1999*). Figure 5 describes the care flow in this model.

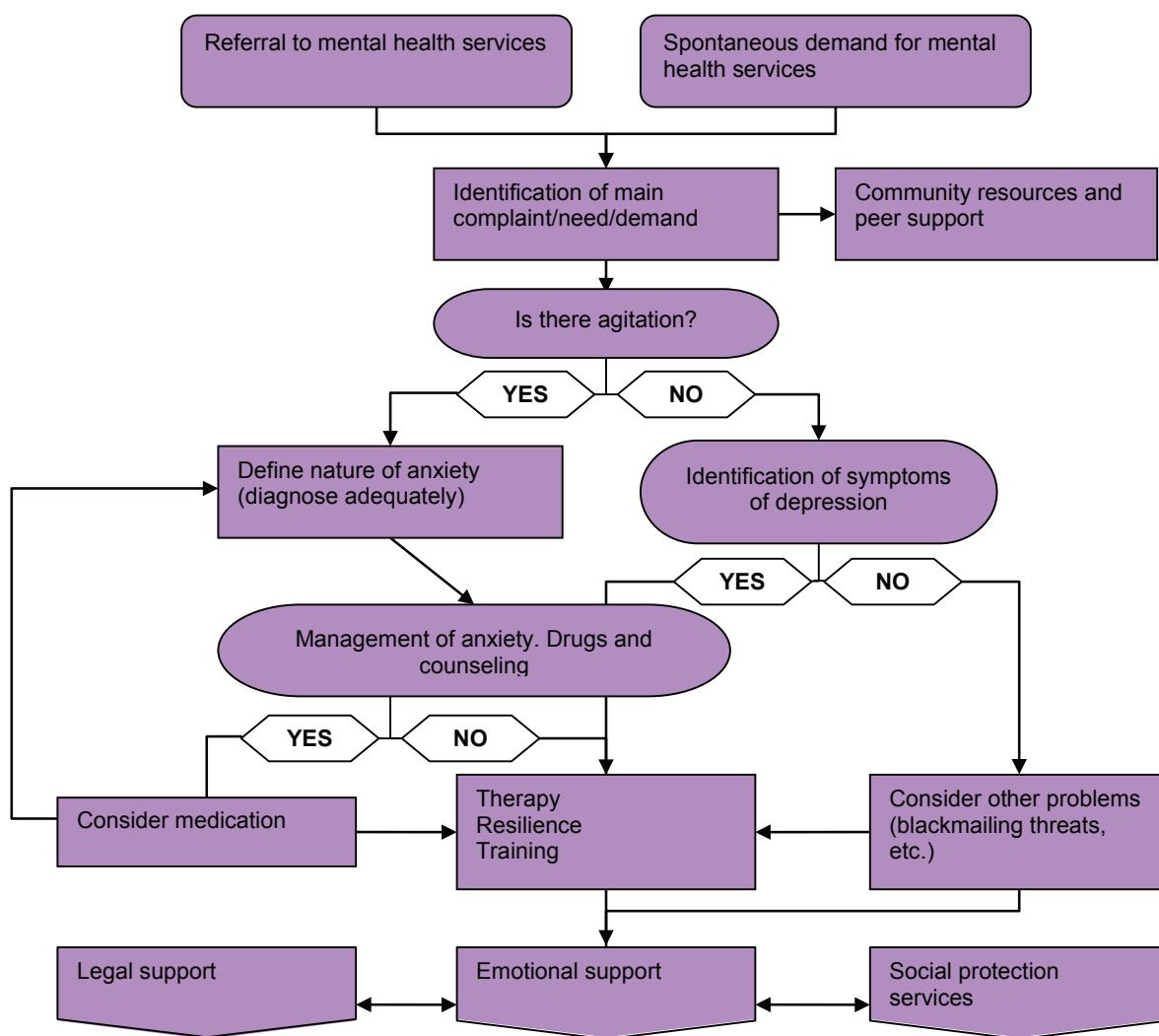
**Interviewer:** And you told me that in the report that the community had 35% HIV prevalence...

**Interviewee from Peru:** Yes. We found, of course, a lack of education, low access to education, low access to housing, state violence toward our sisters. We're talking about the state; that's the police, health care services. And, of course, not seeking out health care as a result of the violence.

If a police officer harasses her, if a police officer chases her or kills her, at that time, she's not thinking about prevention but rather about immediate survival.

-Interview conducted by JoAnne Keatley

**Figure 5. Management of Minority Stress**



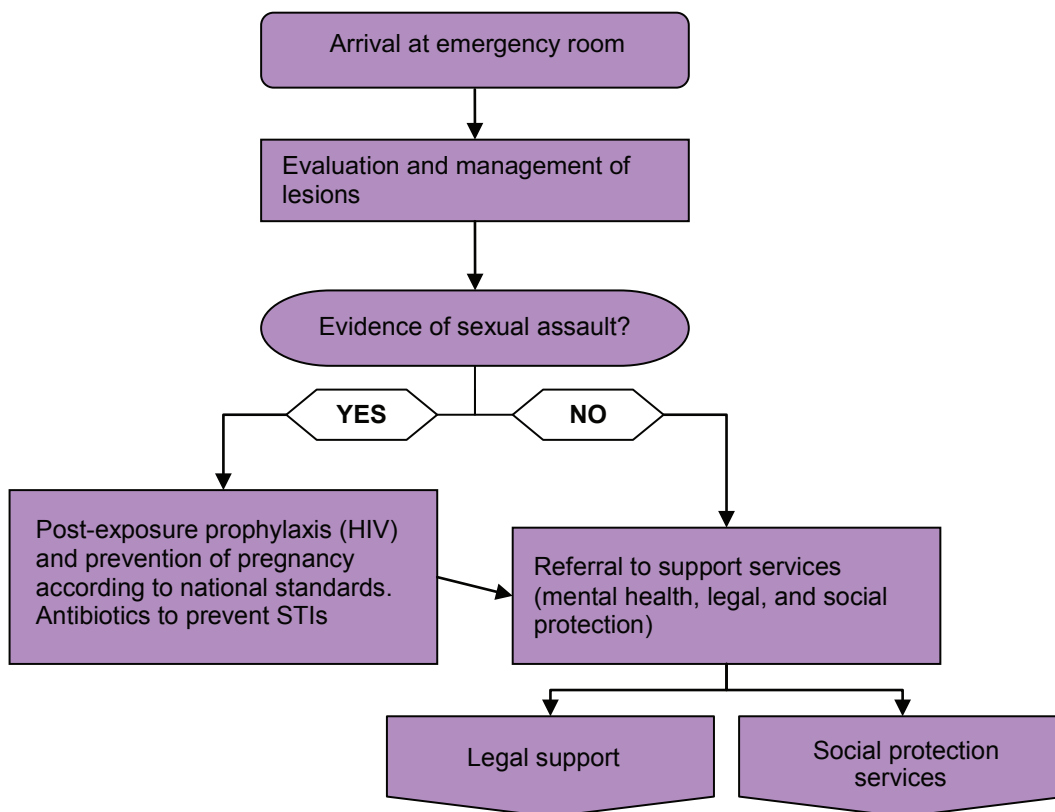
## 7.8. Addressing the consequences of physical violence

Care providers need to be aware that trans persons experience a disproportionately high level of violence in comparison to many other groups and populations. This violence stems from transphobia—individual and group attitudes of rejection, disdain, and violent behaviors toward trans persons and takes many forms. Violence against trans persons is so pervasive in Latin American and Caribbean cultures that they live constantly in a state of defensive stress. As a result of attacks, many of a very serious nature, the point of entry for many trans persons to the health system are the emergency rooms of clinics and hospitals.

Given that trans persons are often also victimized, poor, and homeless, a violent attack has a serious effect on health and quality of life. Providers need to be aware of the numerous stresses that affect trans people, and must avoid adding to the already difficult situation. Providers must be open, respectful, and non-judgmental.

Sexual assault may occur during or after physical attacks. Trans persons who have been victim of physical and sexual violence are likely in a deep emotional shock that must be treated along with physical injuries. If appropriate, treatment should include post-exposure prophylaxis for HIV and other STIs, as well as prevention of pregnancy according to national standards. Health care providers in emergency rooms constitute a first line of health care teams and must be cultural competent and have skills to deal with trans persons. Figure 6 describes the flow of care for trans persons who present following violent incidents. These procedures, along with appropriate sensitivity training, should be taught to both medical practitioners and police personnel.

**Figure 6. Management of Trans Clients Following Physical Violence**



## 7.9. Specific health care related to body modifications (including hormone therapy and surgery)

Trans persons have severely limited access to specific health care such as specialized counseling, hormone therapy, and/or surgery. Yet these services are crucial to their survival and well-being. The WPATH maintains an international directory of specialized providers ([www.wpath.org](http://www.wpath.org)), although specific aspects of care, such as hormone therapy, can also be provided in the primary care setting (Dahl *et al.*, 2006). When necessary, physicians should offer (or refer for) specific body care in accordance with the WPATH's Standards of Care (Coleman *et al.*, 2011).

### 7.9.1. Facial and body hair

Body hair grows during and after puberty. Its distribution is strongly affected by androgens, which are more abundant in natal males and lead to a more extensive distribution of hair. For trans men, administration of androgens usually stimulates growth of body hair, including facial, if the person has inherited a predisposition for hirsutism (i.e., hairiness). For trans women, in contrast, the administration of female hormones does not eliminate body or facial hair that has developed during puberty. For this reason, many trans women have to deal with the discomfort of a male-type hair distribution, including moustache and beard, that need to be shaved or depilated and covered with make up on a daily basis. For many trans women, a more permanent solution is highly desirable.

Laser hair removal may be a solution if provided by qualified professionals, but it carries risks that increase in darker skin. Different laser techniques have different levels of risk with darker skin. Clients with dark skin, and even those with olive or light brown skin, should carefully research their laser providers to be sure they have the skills and equipment to work on their skin type.

Electrolysis is another option for eliminating body and facial hair, but it is expensive, lengthy, and uncomfortable. Electrolysis should be performed by a qualified professional who is knowledgeable about the procedure and the necessary post-procedure care (e.g., avoid exposure to sunlight, no use of makeup). Alternatives should be openly discussed with the primary health care provider to ensure that the procedures chosen are safe and give satisfactory results. Figure 7 describes the care flow for hair removal procedures.

**Figure 7. Hair Removal Procedures for Trans Persons**

Prevention measures	Potential complications	Clinical management
<ul style="list-style-type: none"><li>• Medical supervision is advised for hair removal in immunosuppressed individuals.</li><li>• Laser removal in “aesthetic clinics” without no medical supervision is not advised.</li><li>• Peer education on safety of hair removal procedures is strongly advised. A manual can be developed for that purpose.</li><li>• Special care should be taken with persons with existing skin conditions or predisposition to form keloid scars.</li></ul>	<p>Shaving</p> <ul style="list-style-type: none"><li>• Razor bumps (pseudo-folliculitis)</li><li>• Razor burns</li><li>• Folliculitis</li></ul> <p>Waxing</p> <ul style="list-style-type: none"><li>• Burning</li><li>• Infectious folliculitis, including boils</li></ul> <p>Chemical depilation</p> <ul style="list-style-type: none"><li>• Burning</li><li>• Infectious folliculitis</li></ul> <p>Electrolysis</p> <ul style="list-style-type: none"><li>• Burning</li><li>• Folliculitis and cellulites</li></ul> <p>Laser hair removal</p> <ul style="list-style-type: none"><li>• Burning</li></ul>	<ul style="list-style-type: none"><li>• Assess extent, severity and causes of the problem.</li><li>• Provide clear and respectful information and guidance.</li><li>• Develop treatment plan.</li><li>• Evaluate use of medication (antibiotics, corticosteroids, antifungals).</li><li>• Support use of alternative procedures.</li><li>• Follow up.</li></ul>

## 7.9.2. Skin care

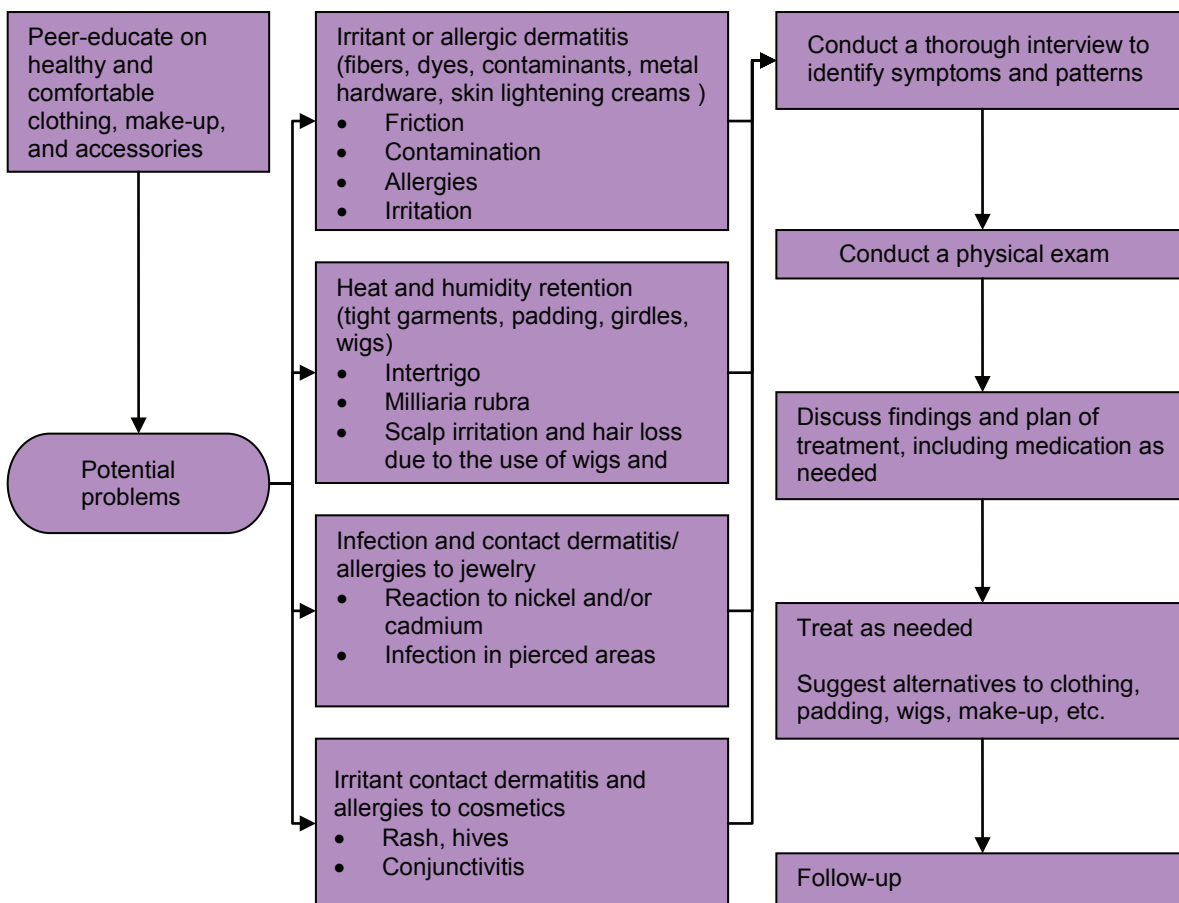
It is not expensive cosmetics, but overall health and well-being that contribute to healthy skin. Dermatologists and other providers attending to trans clients should be aware of several risks in this population.

Deep tans are attractive in many cultures. However, excessive exposure to sunlight damages skin, causing wrinkles and spotting; thus, all persons (including trans persons) need to be aware that deep tanning involves risks to the health and appearance of the skin. Skin lightening procedures also involve risks and potential complications. Smoking also causes damage to skin, especially facial skin.

The skin of natal males generally has bigger pores and more sebaceous glands. The administration of female hormones helps to modify these features and gives the skin a smoother texture. However, applying too much makeup, especially if it is oily, can clog pores and cause inflammation of sebaceous glands.

A general recommendation for trans women is to avoid sharing cosmetics, especially those applied on the eyelids and lips, since sharing can transmit certain infections. Equally important is to avoid sharing cosmetic contact lenses, which may cause infections or severe damage to the cornea. Also, trans women should wear clothing that is comfortable and healthy for their climatic conditions. Some fabrics and materials cause skin problems. Also worth mentioning is the problem of breast swaddling in trans men, and male genitalia concealment methods in trans women. Peer education or peer-produced manuals may help trans people protect their skin by providing ideas and hints on the use of make-up, clothing articles (including prosthetics and padding), and ornaments. Figure 8 describes considerations for healthy skin among trans persons.

**Figure 8. Care of Skin and Use of Clothing and Accessories**





### 7.9.3. Hormone administration

The use of cross-sex hormones to balance gender (induce or maintain the physical and psychological characteristics of the sex that matches the client's gender identity) is increasing around the world. Cross-sex hormone administration has not been studied in prospective, randomized controlled trials; however, over 50 years of clinical experience have shown that this practice is effective in treating gender dysphoria (*Hembree, et al., 2009* and *Gooren, et al., 2008*). It is important that the ability to understand and monitor this treatment become a part of primary care practice. This protocol is intended to aid in that process.

Not all trans clients want to take cross-sex hormones, but if a trans client consistently wishes to express a gender different from their natal sex, cross-sex hormones are the most common and accessible means of self-actualization, because they bring the endocrine and psychological systems into balance, for female-expressing trans persons, allow feminization without requiring clients to turn to unsupervised soft tissue filler injections.

The client presenting for initiation of cross-sex hormonal therapy may require particular attention. While the transition itself often provides great relief from gender dysphoria, it may be a time of heightened environmental stress that challenges the client's family, partner, school, and/or place of employment. Referral to a psychotherapist experienced in working with trans people is helpful for many. The WPATH publishes and periodically updates standards of care (*Coleman et al., 2011*). These protocols may be reviewed at [www.wpath.org](http://www.wpath.org). The text that follows reflects these standards.

The primary care provider should assess every client initiating cross-sex hormonal therapy for ability to clarify individual risks and benefits and should discuss these with the client and consider obtaining a signed consent of understanding (see Appendix C for sample consent forms). Some clients may already have been using cross-sex hormones, either prescribed by another physician or obtained over the counter, through acquaintances, or other means without prior evaluation by a physician. If hormone therapy was initiated without medical evaluation, the WPATH Standards of Care include provisions for physicians to continue the medical treatment, regardless of the client's ability or desire to receive gender-related psychiatric/psychological evaluation. Physicians may provide treatment based upon the principle of harm reduction. In this instance, when clients are determined to continue using medication with or without medical oversight, it is usually advisable to assume a client's medical care and prescribe appropriate hormones. Denying care will likely result in continued independent treatment, possibly to the client's detriment.

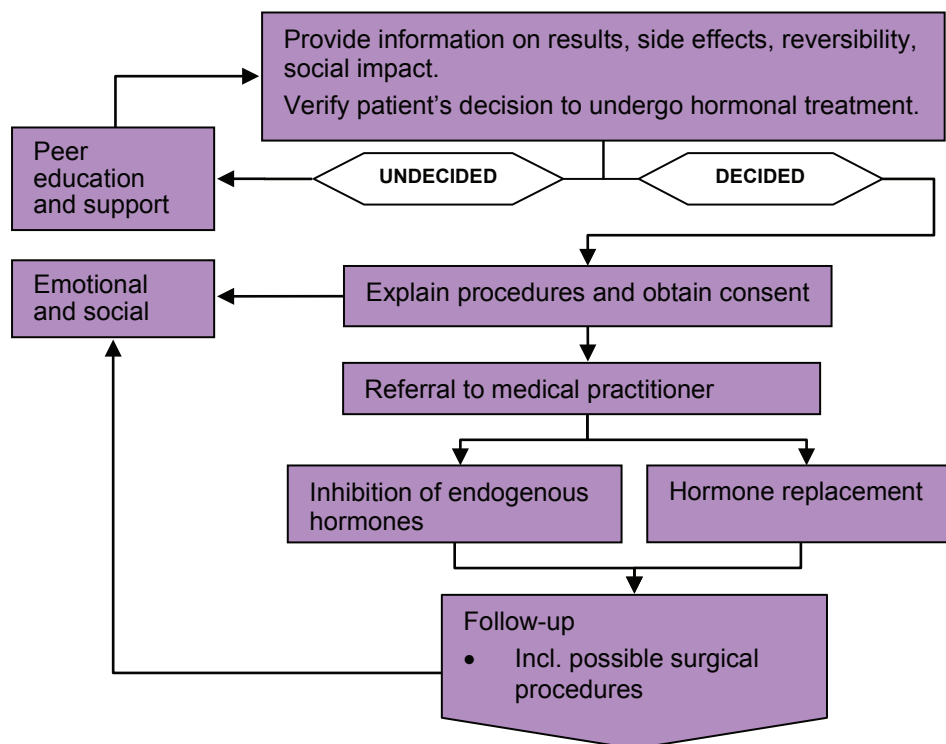
An individual may already be receiving cross-sex hormones when s/he becomes the physician's client. Review the current regimen in combination with a thorough assessment of the client's general health to determine whether to recommend changes in dosage or preparation.

Most medical problems that arise in the trans client are not secondary to cross-sex hormone use.

Discuss fertility issues with all clients considering hormone therapy (see Section 7.9.3.3). Trans clients taking testosterone should clearly understand that testosterone is not a contraceptive substance; trans men having unprotected sex with fertile non-trans males are at risk for pregnancy if they have not had a hysterectomy.

If prescribing cross-sex hormones for a client who has not used them before, assess for pre-existing conditions to determine which preparation and dosage to prescribe (see Figure 9). It is the clinician's responsibility to monitor the effects of hormones.

**Figure 9. Hormone Administration for Trans Clients**



### 7.9.3.1 Readiness for hormones

The WPATH *Standards of Care* includes a list of recommended general criteria for the assessments of a client's individual preparedness for hormone treatment (Coleman *et al.*, 2011, also available in Appendix C). Informed consent requires a detailed discussion with the client covering the risks and benefits of treatment. All treatment for minors requires consent from parent (usually both parents) or guardian.

The only absolute medical contra-indication to initiating or maintaining estrogen or testosterone therapy is an estrogen- or testosterone-sensitive cancer. Other conditions such as obesity, cardiovascular disease, and dyslipidemia should not preclude treatment in the setting of informed consent. While in the past, history of venous thromboembolism was a contraindication to estrogen hormone replacement, recent data show that safer estrogen preparations, such as transdermal, do not preclude this.

### 7.9.3.2. Baseline laboratory tests

- *Essentials for trans women:* Fasting lipid panel (if on oral estrogen). If taking spironolactone, include potassium and creatinine. Use female reference values for trans women taking estrogens. Creatinine clearance should be a clinical judgment based on muscle mass and body fat distribution.

The standard for testing liver function in trans women is based on older studies with methodological flaws that used formulations no longer prescribed (ethinyl estradiol), and did not control for conditions that cause elevated liver function, including alcohol and hepatitis B. Transient elevations with no clinical significance were included in the evidence that estrogen causes liver abnormalities. There is no current clinical evidence for checking liver function in trans women using estrogen. Current publications make no mention of liver function abnormalities in relation to estrogen use. However, it may be useful to check transaminases if the client is taking oral estrogen.

- *Essentials for trans men:* Hemoglobin, LDL/HDL. Use M reference values for trans men taking testosterone.
- *Considerations with respect to laboratory tests:* Family history, age, concomitant illnesses, sexual activity, and other relevant risk factors.

### 7.9.3.3. Fertility issues

Providers should discuss fertility with clients who are considering hormone therapy. Cross-sex hormone use may reduce fertility, and this may be permanent even if hormones are discontinued. Estrogen may have the effect of reducing libido, erectile function, and ejaculation. Testosterone generally increases libido; as mentioned earlier, providers should be sure clients understand that testosterone is not a contraceptive substance.

### 7.9.3.4. Hormone administration for feminization

Hormonal therapy for trans women may include anti-androgen therapy as well as estrogen therapy.

Estrogens:

- Non-oral estrogens, including sublingual, transdermal, and injectable hormones are preferable. These have the advantage of bypassing the liver. Side effects associated with estrogens are mentioned in section 4.1.4
- Route of administration: Sublingual (dissolve oral formulation under the tongue); transdermal; intramuscular (IM).
- Oral estrogens confer an increased risk of thromboembolic disease for over 35/smokers.
- After gonadectomy lower doses are recommended. Titrate to effect, considering client tolerance.

Progesterone:

- The risks and benefits of progesterone are not well-characterized. Some providers have found it to have positive effects on the nipple areola and libido. Mood effects may be positive or negative. There is a risk of significant weight gain and depression in some individuals.
- As per other studies using oral progesterone in post-menopausal women (e.g., the Women's Health Initiative study<sup>37</sup>), the use of medroxyprogesterone orally may increase the risk of coronary vascular disease, whereas IM injections (e.g., Depo-Provera) may minimize this risk.

Anti-androgens:

- Initial administration of spironolactone in a single or divided dose, with weekly titration. Occasional clients—especially larger or younger—require higher doses. Progesterone may have some anti-androgenic activity, and may be an alternative if spironolactone is contraindicated.
- If clients have significant hair loss issues, finasteride may be added as an adjunct (even initially). Hair implants may also be considered.

### 7.9.3.5. Hormone administration for masculinization

Hormone therapy for trans men consists of the androgen testosterone, which is available in several forms: intramuscular, transdermal patch or gel, or subcutaneous implant.

Adult trans men are initiated on IM depo-testosterone IM every two weeks. Doses are titrated to effect. If clients have side effects attributable to peak or trough levels, doses are changed to q 7–10 days depending on client's preference (weighing the adverse effects against the increased frequency of injections). Some clients do well on lower doses and weekly injections, especially those with history of

37. <http://www.nhlbi.nih.gov/whi/>

trauma (avoiding excessive peaks and troughs, which may set off emotional reactions). Excessive testosterone can convert to estrogen and impede the desired effects. Testosterone therapy is not withheld for hyperlipidemia.

Clients should be taught to self-inject, including how to keep equipment sterile. A family member or friend may also be taught to apply the injection. Clients who develop polycythemia may respond well to transdermal gel preparations.

*Allergy alert:* Testosterone cypionate is suspended in cottonseed oil. Testosterone enanthate is suspended in sesame oil. Some clients experience skin reactions to the adhesive in transdermal patch. Compounding pharmacies may be able to provide testosterone cypionate in sesame oil.

Use of transdermal preparations may be recommended if slower progress is desired, or for ongoing maintenance after the desired virilization with intramuscular injection has been accomplished.

Rarely, use a progestin to stop periods if client only wants a low dose of testosterone, or is having difficulty stopping menses.

Each country should develop protocols based on the medications and formulations available.

Other medications sometimes prescribed for trans men:

- For male-pattern baldness (MPB): finasteride or minoxidil. Caution clients that finasteride will likely slow or decrease secondary hair growth, and may slow or decrease clitoromegaly.
- For clients with concerns about excessive secondary hair growth (e.g., male relatives are excessively hirsute): finasteride, dutasteride.
- For clients with too-significantly increased sexual interest: low dose selective serotonin reuptake inhibitors (SSRIs).
- For clients who desire greater clitoromegaly: topical testosterone on clitoris (must be subtracted from total dose and clients must be warned that this may hasten MPB).

Clients undergoing hormonal therapy may also desire therapy to align their voice with their gender identity (see Sidebar 4).

#### **Sidebar 4. Phoniatic Considerations in Relation to the Development of a Gender-congruent Speaking Voice**

After puberty, a person's speaking voice pitch adopts a permanent pattern, depending on biological sex characteristics. Lower pitches are usually associated to larger larynxes that result from androgenic stimulation as well as from the development of resonating cavities and vibrating structures that endow most male voices and the female contralto voices with a peculiar quality known as "chest voice." Higher pitches are more distinctive of female phonation. Most female speaking voices have higher formants and tend to have higher overtones that are referred to as "head voice." For a trans person, attaining a voice with higher formants (i.e., "more head resonance") can be a crucial step in the process of transitioning and a source of self-affirmation and well-being. Among trans men, the use of androgenic hormones can help lower the pitch of the voice and increase chest resonance and volume. In the case of trans women, however, anti-androgens and estrogens have no effect on voice properties.

Speech therapy may be of great value in helping trans persons to re-educate the voice to sit at a lower or higher pitch without strain, or to use different resonators, more or less volume, and adopt different intonation patterns while speaking. Maximum vocal efficiency without tension may be obtained by adopting an adequate (i.e., costoabdominal) breathing technique, which also helps to keep attention focused on the desired goal (Mészáros et al, 2005). Speech therapy may be combined with singing lessons in higher or lower ranges to make the voice more flexible at different pitches. However, the success of these approaches will depend on an accepting, respectful, and open attitude by therapists and instructors.



## Follow-up care

Clients using hormones may have ongoing psychosocial and primary care needs. Clients initiating hormones should be followed up medically at four weeks, three months, six months, and every 6–12 months thereafter (more frequently if other problems arise). Attention is usually focused on blood pressure, side effects, emotional changes, sexuality, weight, and quality of life (including risk behaviors if indicated). Clinical progress should be monitored through assessment of subjective and objective physical and emotional changes.

Consider supplemental calcium and vitamin D in accordance with current osteoporosis prevention guidelines to help maintain bone density. Note that this may be applied to trans men at ages younger than typical starting age for osteoporosis prevention treatment due to the unknown effect of testosterone on bone density.

### First few follow-up visits—4 weeks to 6 months

Assess for desired and adverse effects of medication. Check weight, blood pressure. Review health maintenance. Provide directed physical exam as needed. Discuss social adjustment, libido and sexual behavior, and quality of life (risk behaviors if indicated).

- *Trans women:* If on spironolactone (an anti-androgen medication), check potassium.
- *Trans men:* Assess menses; anticipate amenorrhea within 2–3 months. If menses persist, consider increased dosage or use of a progestagen.

### Six-month visit

Assess for desired and adverse effects of medication. Check weight, blood pressure. Review health maintenance. Provide directed physical exam as needed. Discuss social adjustment, libido and sexual behavior, and quality of life (risk behaviors if indicated).

- *Trans women:* If spironolactone dose increased, consider potassium recheck. Testosterone is generally not checked unless clients have little evidence of feminization.
- *Trans men:* Check testosterone level if after 6 months on stable regimen client is having a difficult time virilizing or stopping menses, or experiencing anxiety or other mood symptoms. Check testosterone levels mid-cycle between injections, at times in trough (especially if mood or energy symptoms). Be sure to compare hemoglobin levels to age-appropriate male levels. Follow-up labs are done generally every 6–12 months (6 for older clients, clients with other serious illnesses, and 12 for young, healthy clients).

### Annual visit

Assess for desired and adverse effects of medication. Check blood pressure and weight. Review health maintenance. Provide directed physical exam as needed. Discuss social adjustment, libido and sexual behavior, and quality of life (also risk behaviors if indicated).

- *Trans women:* Prolactin screening once at 1–2 years after beginning HRT.
  - Mammogram according to national standards, assessing risk factors on a case-to-case basis and according to current-evidence-based algorithms. Annual rectal exam +/- PSA according to national standards, taking into consideration family and personal history and risk factors.
- *Trans men:* Check testosterone level at 6 months or when on stable regimen, when having a difficult time virilizing or stopping menstruation, or experiencing anxiety. Check testosterone levels mid-cycle between injections, at times in trough (especially if mood or energy symptoms are present). Be sure to compare hemoglobin levels to age-appropriate male levels.
  - Annual lipids only for clients over 30 or who have hyperlipidemia before or after starting testosterone.

- Annual mammogram beginning at age 40–50 depending on risk factors, family history, and presence of breast tissue. Did client have mastectomy or simple liposuction/reduction? Some mammary tissue may remain with liposuction/reduction. Palpate chest for trans men who have undergone mastectomy.
- Bimanual pelvic exam every 1–2 years screening for masses. Pap screening every 2–3 years based on current recommendations (strongly recommended, but not required).
- Pelvic ultrasound as needed for new bleeding, and perhaps every few years until hysterectomy/oophorectomy.
- Thyroid stimulating hormone TSH every year or two or as needed.
- Bone density at 5–10 yrs after beginning testosterone, and periodically thereafter.

### **Aging issues: Special considerations**

#### **Considerations for beginning or continuing hormone treatment in older clients**

There is no set upper age limit for hormonal therapy. Trans male clients beginning hormones after age 40 generally will progress more slowly in exhibiting desired results.

Osteoporosis has been reported in both older trans men and trans women, and is frequently associated with poor compliance with the hormone regimen.

Some clients prefer to stop hormonal therapy; for post-gonadectomy clients under age 50, this is not recommended due to bone loss and potential symptoms similar to menopause in both trans women and trans men.

Upper age limits that might preclude surgical interventions should be considered. There is currently no information about outcomes for older clients, and some surgeons impose upper age limits for specific procedures. Older trans people considering surgery should consult with surgeons to determine what physical readiness requirements might be advisable to be medically eligible for surgery. Anticipated recovery times may be longer.

#### **Additional screenings to consider in older clients**

- *Trans women clients on feminizing hormone therapy:* Mammograms are recommended for trans women when clients have been using estrogen for at least 30 years **and** are at least 50 years of age, unless there is a strong family history of early breast or ovarian cancer.
- Follow national guidelines for prostate screening. PSA is not useful if client is on estrogen.
- *Trans men without hysterectomy:* Pelvic exams every 1–3 years for clients over age 40 or with a family history of uterine or ovarian cancer; increase to every year if polycystic ovarian syndrome (PCOS) is present. Consider hysterectomy and oophorectomy if the client's health will not be adversely affected by surgery, or if the client is unable to tolerate pelvic exams.
- *Trans men:* Consider bone density screening if age > 60 and taking testosterone for < 5–10 years; if taking testosterone for > 5–10 years, consider at age 50+, earlier if additional risk factors for osteoporosis are present; recommend supplemental calcium and vitamin D in accordance with current osteoporosis prevention guidelines to help maintain bone density. Note that this may be applied to trans men at ages younger than typical starting age for osteoporosis prevention treatment due to the unknown effect of testosterone on bone density. Trans men stopping testosterone will experience loss of libido, hot flashes, loss of body hair and muscle tone, and weight redistribution in a female pattern.

#### 7.9.4. Surgical and other medical procedures

This section provides background information on the surgical procedures clients may be considering or may have already undergone. Procedures should generally be conducted subsequent to an assessment of a client's individual preparedness for the intervention in question. The WPATH *Standards of Care* include a list of recommended criteria for such assessments (Coleman *et al.*, 2011; also see Appendix C). Primary care physicians may need to play a number of roles relative to the surgery:

- Recommending procedures necessary for a client's overall health and well-being, such as a hysterectomy/oophorectomy for a female-to-male client or urological consults for a male-to-female client; and to assist clients in understanding surgical options.
- Understanding the effects of body modifications.
- Providing post-operative care for clients who have had surgery in another state or country.
- Advocating with insurance carriers or other specialists for a client's medical needs.

##### 7.9.4.1. Male-to-female surgeries

###### Orchidectomy

This is the removal of the testes. Some trans women will have this procedure without a vaginoplasty or penectomy. Estrogen therapy in progress may need to be adjusted post-orchidectomy; orchidectomy may permit lower doses of estrogen therapy and eliminates the need for testosterone blockers.

###### Vaginoplasty

Vaginoplasty is the construction of a vagina to enable female sexual function using penile tissue or a colon graft. The use of penile tissue is a complex procedure intended to utilize analogous tissue and maintain nerve function to preserve sexual responsiveness. The procedure usually involves clitoro-labioplasty to create an erogenous sensitive clitoris and labia minora and majora from surrounding tissues and/or skin grafts, as well as a clitoral hood. Colon grafts do not require dilation and are self-lubricating; however, the lubrication is present at all times and may become bothersome to some persons. Additionally, colon grafts must be screened and monitored for any macro- or microscopic abnormalities. In cases where the person has developed inflammatory bowel disease, close monitoring of the colon graft is strongly recommended.

###### Penectomy

Penectomy is the removal of the penis. This procedure is not commonly done. Generally, penis removal is done in concert with vaginoplasty. In some surgical techniques, the penile skin is used to form the vagina, so it is not a straightforward amputation, but a potentially complex procedure intended to utilize analogous tissue as well as maintain nerve function to preserve sexual responsiveness.

###### Breast augmentation

If breast growth stimulated by estrogen is insufficient (only progressing to the "young adolescent" stage of breast development), augmentation mammoplasty may be medically necessary to ensure that the client is able to function socially as a woman.

###### Reduction thyroidchondroplasty

This procedure reduces prominent thyroid cartilage.

###### Voice surgery

This still-evolving procedure is intended to raise the pitch of the speaking voice. Speech therapy is recommended prior to seeking a surgical solution.

## Facial feminization

Facial feminization includes a variety of aesthetic plastic surgery procedures that modify the proportions of the face to facilitate social functioning. These procedures are not necessarily simply cosmetic interventions; for many persons they are medically necessary to be able to transition and fully assume their gender identity.

### 7.9.4.2. Female-to-male surgeries

#### Chest reconstruction/bilateral mastectomy

Chest reconstruction/bilateral mastectomy is the procedure most frequently required by trans men. A variety of techniques may be used, depending on the amount of the client's breast tissue. Scarring may result, and nipples may be large or small and grafted, depending on the surgeon's technique.

#### Hysterectomy/oophorectomy

This procedure may be necessary in the event of fibroid growth or endometrial conditions, or as a prophylactic procedure in clients with a family history of cancer. Hysterectomy may be a part of a phalloplasty/vaginectomy procedure when the vaginal tissue is used to construct the urethral canal.

#### Metoidioplasty

Metoidioplasty is the construction of male-appearing genitalia employing the testosterone-enlarged clitoris as the erectile phallus. The phallus generally will be small and has the appearance of an adolescent penis, but erectile tissue and sensation are preserved. This procedure releases the clitoral hood, sometimes releasing the suspension ligaments to increase organ length. It may involve raising the position of the organ a centimeter or so toward the anterior, and may include scrotoplasty and (less frequently) urethroplasty. Closure of the vaginal opening may be full or partial, or the vaginal opening may not be impacted at all, depending on the surgeon's technique. This procedure is much less invasive than a phalloplasty procedure (see below), and emphasizes preservation of erotic sensation.

#### Phalloplasty

Phalloplasty is the construction of a phallus that more closely approximates the size of an erect male organ, using tissue from another part of the client's body. Size and appearance are prioritized over erectile capacity and in some cases over erotic sensation. Skin flaps used in this procedure include abdominal flap (no erotic sensation), radial forearm flap, deltoid flap, and calf flap (all of which contain nerves that may be grafted to the pudendal nerve to provide erotic sensation). Erectile capacity is provided via implanted semi-rigid or inflatable penile prostheses.

#### Scrotoplasty

Scrotoplasty is the construction of a scrotum, usually using labia majora tissue and saline or silicone testicular implants. Some surgeons will use tissue expanders and place the implants after the tissue has been stretched sufficiently to accommodate the implants. This procedure is rarely done separately and is usually performed in conjunction with either a metoidioplasty or a phalloplasty procedure. With some phalloplasty/urethral extension techniques, it may be necessary to perform the scrotoplasty as a later stage, after urethral healing.

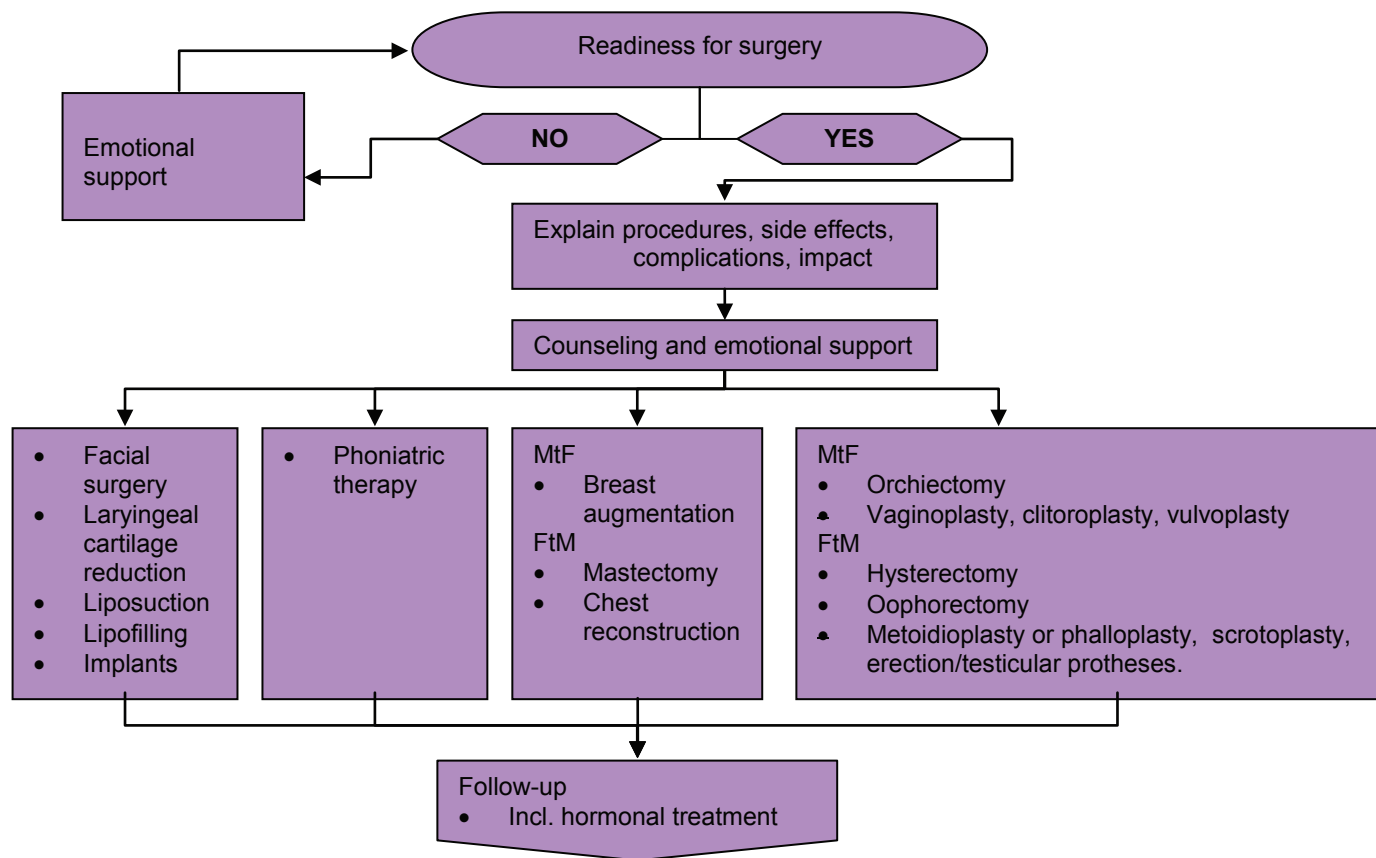
#### Urethroplasty

Urethroplasty is the creation of the urethral canal through the neophallus to facilitate standing micturition. This is usually, but not always, done in conjunction with genital reconstruction.

#### Vaginectomy

The removal of the vagina may be done with ablative technique or surgical techniques. This is required if the vaginal opening is going to be closed. Figure 10 gives an outline of surgical procedures for trans persons.

**Figure 10. Surgery and Other Medical Procedures for Trans Persons**



### 7.9.4.3. Post-surgical follow-up

- *Trans women:* Examine for difficulties in healing. After pedicled penile flap technique vaginoplasty, the client must dilate 3–4 times daily, per the surgeon’s recommendations, using progressively larger dilators. After the initial 6–12 month period, if the client is having regular sexual intercourse, no further dilation is required. Otherwise, continue routine dilation once or twice per week. Lubrication will be necessary for intercourse. Post-operative complications may include bleeding, infection, or impaired wound healing. Possible late complications include stenosis of the new urethral meatus. Refer to a surgeon with expertise.
- Pap smears in neovaginas are not indicated; the neovagina is lined with keratinized epithelium and cannot be evaluated with a Pap smear. Perform periodic visual inspection with a speculum, looking for genital warts, erosions, and other lesions. If STI is suspected, do a culture swab, not PCR. Neovaginal walls are usually skin, not mucosa; when it is mucosa, it is urethral or colon mucosa.
- *Trans men:* Examine for difficulties in healing. Complications in chest reconstruction may include hematoma, partial or total nipple necrosis, and abscess formation. Drains and compression bandages do not always prevent these complications. Keloid scarring may occur, particularly in people of color. In some instances, scarring may be lessened by ensuring that incisions are not stretched prematurely during healing. Complications of genital reconstruction include implant extrusion; urethral fistulas and strictures; loss of sensation; and tissue necrosis in the neophallus created by phalloplasty (not generally a problem with metoidioplasty).



## 8. Working with Gender Variant Children and Adolescents

The recommendations in this section are based on the care protocols developed by the UCSF Center of Excellence for Transgender Health, available at [www.transhealth.ucsf.edu/protocols](http://www.transhealth.ucsf.edu/protocols) (accessed July 2, 2014).

### 8.1. Gender variant behavior versus gender variant identity

Gender-variant behavior may not be reflective of a gender-variant identity. For example, most children with gender variant behavior (or childhood gender role nonconformity) grow up to be gay or lesbian, not trans.

However, the degree of childhood gender variant expression can have a profound impact on how a child with a gender variant identity might cope with the attached social stigma (Bockting & Coleman, 2007). On one hand, those who are more outwardly gender role nonconforming tend to come out early in life and face enacted stigma. On the other hand, those who are outwardly conforming are more likely to isolate and keep their gender variant identity hidden, contributing to felt stigma. Both types of stigma have shown to be negatively associated with mental health (Bockting et al., 2011).

The clinician should assess a child on both dimensions. If the child is gender variant in behavior but not in identity, family education and anti-bullying interventions in school might be needed. If the child may have a gender variant identity, additionally, the option of early medical intervention should be discussed.

### 8.2. Special considerations

Children under age 18 should be seen with their parents or guardians for treatment, not for assessment. With pre-pubertal children, the primary focus is on providing parental support and education so that a safe environment is developed for the child, and the parents and child know what the treatment options are once puberty begins. It is important to recognize the context of Latin America and the Caribbean and to design interventions that prepare the child, family, school, and community for a transition to the desired gender.

The first visit usually entails getting a complete medical history, reviewing treatment options with the client or the family, answering all questions and conducting baseline laboratory work. Physical exam is deferred to a second or later visit as per the client's wishes, but is required before prescribing any medication. Social transition, in and of itself (without physical intervention), is possible and may alleviate dysphoria, at least until puberty.

Youth under the age of 18 are strongly advised to see a mental health professional experienced in trans issues prior to cross-sex hormone treatment to ensure their readiness for transition and to help them explore the ramifications of gender transition, potential complications, and other issues. Notwithstanding any favorable indications that the transition will be well accepted and supported socially, it is always desirable to have the support of mental health professionals, provided this does not become a barrier to ensure access to hormone treatment.

If a young client has not completed development (i.e., stage V in the Tanner scale), strong consideration should be given to consulting (provider-to-provider) with an expert in trans medicine.

### 8.3. First clinical evaluation of family with a gender variant youth

Generally, it is best for the provider to meet first with the youth and his or her family and solicit concerns the family and child might have. After that, time can be spent individually with the youth and with the parents as appropriate. A nonjudgmental stance is critical. The youth's gender identity and gender expression should be assessed separately.

#### 8.4. Trans-positive interventions (child, family, school, early medical intervention)

Interventions for children should focus on facilitating gender identity development (irrespective of the nature of gender identity) and preventing problems in psychosocial adjustment occurring either with the child specifically or with his or her environment (family and friends, school). Since the child's distress is often due to a negative reaction within the social environment to gender variance, it may be appropriate to take other approaches that focus on the environment (family and friends, school, and also community and society) and on fostering acceptance of the child's gender variant identity. Providers should help the child and family to balance a nonjudgmental attitude toward the exploration of gender identity and expression with prevention of negative reactions from the child's environment. Rather than initiating a gender role transition that may be premature, parents need support to cope with uncertainty surrounding the child's evolving gender identity and expression. Opportunities for support from other families with a trans child are often available either online or in person through support or peer groups.

In the United States and Canada, there are schools and communities that may provide much-needed opportunities to socialize with peers, including GLBT support and advocacy groups. Although there are similar initiatives in Latin America, no information about their results is available.

As early as Tanner Stage II of pubertal development (when pubic hair begins emerging and changes in the genitalia commence), medical interventions that can be divided into fully reversible, partially reversible, and irreversible interventions are available (*Hembree et al., 2009; Coleman et al., 2011*).

Fully reversible treatment consists of puberty-delaying hormones. The advantage of this intervention is that it alleviates the distress associated with the development of secondary sex characteristics and prevents undesired, permanent changes to the body (e.g., breast development, beard growth, changes in the pitch of the voice). This treatment gives the adolescent and family more time to evaluate the option of developing cross-sex characteristics. To be eligible for puberty-delaying hormones, the adolescent must have demonstrated a history of persistent and intense gender dysphoria that increases with the onset of puberty, and the family must consent and participate in therapy.

Partially reversible treatment consists of feminizing or masculinizing hormone therapy that is available as early as age 16 and after a reasonable period of psychotherapy with a specialized mental health professional.

Irreversible treatment consists of surgery. Genital reconstructive surgery is available as early as age 18 after living 1–2 years full time in the desired gender role; female-to-male chest surgery may be available before that. Surgery must be recommended by specialized mental health professionals.

Balteiri and colleagues (2009) reported on two transsexual adolescents in São Paulo, Brazil, who were denied hormone therapy because of their age, since a policy for access to such treatment for minors was lacking in the country. The authors made the case that the lack of access led the adolescents to engage in sex work so that they could afford and self-administer hormones, and recommended better access as a form of harm reduction. Furthermore, participants in a small exploratory study in Puerto Rico emphasized the potential role of elementary and middle school teachers in promoting greater understanding of gender variance and sexual diversity. (*Finlinson et al., 2008*). School-based anti-bullying initiatives, involvement of family members, and age-appropriate, peer-based social activities were recommended to prevent harmful behaviors and to support gender diversity among youth.

## 9. Recommendations

As mentioned in Section 1, this document was developed by representatives from multiple sectors including academia, the health sector, multilateral and bilateral agencies, governmental and nongovernmental organizations, trans communities, and other stakeholders. The authors' multidisciplinary and intersectoral perspectives allowed a comprehensive view of the health needs of trans people.

We have made a special effort to ensure that this document is relevant to different audiences and can inform plans and actions in multiple settings. While topics relevant to health professionals received particular emphasis, the recommendations below are also directed to other public sectors, academic communities, community leaders, transgender persons and their families and friends, and other stakeholders who can contribute to improving the quality of life of trans persons. These recommendations were organized according to their intended audiences. It is important to point out that initiatives to ensure broad community participation in providing health services and promoting the health and well-being of trans persons may overlap across sectors and actors. These possible overlaps should serve to create synergy rather than duplications or redundancies.

### **Recommendations to governments**

- Undertake reviews and legal reforms to ensure that trans persons have access to health, protection, and full enjoyment of citizenship rights in all public and private spheres.
- Review or repeal laws that discriminate based on gender expression and consensual sexual acts.
- Ensure the existence and enforcement of laws and regulations that penalize people who discriminate against and assault trans people.
- Establish measures and strategies, (including campaigns, training, and other approaches) to prevent and reduce stigma, discrimination, and violence (verbal, emotional, sexual, and physical) against trans people.
- Ensure that trans people have equal rights for employment opportunities in public and private sectors.
- Ensure equal access to health care for trans persons and their communities.
- Train staff in all relevant public sectors/services, including legal system staff (such as judges, prosecutors, and defenders) and law enforcement officials (e.g., police) on human rights principles that are applicable to trans gender issues.
- Create mechanisms to ensure that transgender people have access to identity documents that adequately reflect their gender identity.
- Guarantee that public health systems provide comprehensive quality services that are acceptable and accessible to trans people and that appropriate training is provided to health care workers.
- Ensure the safety of, access to, and quality of comprehensive health care for trans people in detention, and that they are kept in a facility according to their expressed gender identity.
- Collect, analyze, and disseminate relevant data and strategic information for a basis and reference for improving programs and services for trans people.
- Establish monitoring and evaluation mechanisms based on standardized indicators for social determinants of health in trans populations.
- Support and endorse global, regional, national, and local efforts targeting transphobia and all forms of hatred, exclusion, and intolerance.

- Ensure that measures are taken to guarantee respect for gender identity and integrity of trans minors, especially in education in order to prevent dropouts resulting from transphobia.
- Support the inclusion of gender identity topics in school curricula.
- Include trans women in all programs against gender-based violence.
- Amend existing anti-bullying campaigns to include messages about transphobia.

### ***Recommendations to policy- and decision-makers within the health sector***

- Formulate public policies that ensure comprehensive and equal care for trans people including explicit rules and procedures to implement them.
- Recognize the negative impact of transphobia in the provision of health services and define regulations aimed at preventing and addressing transphobia.
- Ensure that the provision of care for trans people is comprehensive, taking into account all areas related to individual and community well-being, rather than only addressing HIV and other STIs. This can be accomplished through health personnel training and wide dissemination of services.
- Recognize that biomedical interventions for body modification are not merely cosmetic, but are medically indicated and necessary for individual well-being.
- Denounce the practice of so-called “conversion and reparative therapies” (approaches that seek to change gender nonconformity or non-heterosexual orientation) in view of the questionable usefulness and negative effects of these programs.
- Adapt trans-affirming algorithms for the provision of care to trans persons to reflect universal human rights norms and to conform to the specific realities of relevant populations.
- Ensure that comprehensive health care recommendations for transgender people are based on both scientific evidence and the expressed needs of trans people. Promote collaborations to facilitate research on transgender health, including epidemiological, sociobehavioral, and health services research.

### ***Recommendations for public agencies and private businesses and companies.***

- Implement and enforce policies against gender-based stigma and discrimination.
- Establish and enforce zero-tolerance policies against transphobia in public services.
- Implement measures to ensure respect for the use of a social or preferred name, which may be different from that used in a person’s civil or legal documentation.
- Establish referral networks that respect privacy and confidentiality. Ensure that compensation policies do not discriminate based on gender identity or expression. Ensure protection of personal information (health records, name in official documents, and other confidential information) that may violate privacy and lead to stigma and discrimination within the service.

### ***Recommendations to health personnel***

- Develop the technical skills and cultural competence necessary to provide adequate health promotion, prevention, treatment, monitoring, and support for trans people.
- Respond to the health care demands of trans people, providing the highest possible standards of equitable care.
- Ensure that trans people are treated with respect, using the name and pronouns of their choice.

- Design and organize health services and other spaces (dressing rooms, client wards) and support client's hospitalization according to their gender identity.
- Certify that biomedical interventions for body modifications (e.g., hormone therapy) are managed and performed by properly trained and qualified professionals.
- Ensure appropriate health conditions for trans people in detention.

### ***Recommendations for academia and biomedical and public health professional associations***

- Require the participation of trans persons in research design, implementation, and dissemination of findings.
- Foster research on needs, common problems, and social determinants of health of trans people. Avoid conflation of research data and results relevant to trans people and avoid mixing data referring to gay, lesbian, bisexual, and other populations.
- Close gaps in biomedical research, such as on the use of hormones concurrently with ART, and side effects associated with hormonal administration and soft tissue fillers.
- Favor research on effective approaches for treating side effects and complications related to or resulting from hormonal treatments and associated with the process of gender reassignment.
- Create networks for research and analysis of issues relevant to trans populations. These networks should include trans persons.
- Use existing academic associations (at the national and regional level) to mainstream the dissemination of data.
- Formulate policies to ensure that academic settings provide a safe environment for the overall development and welfare of trans persons.
- Develop evidence-based academic curricula for education on sexual and gender diversity.
- Create scholarships and foster institutional policies that enable trans persons to obtain an education and become empowered citizens. Publicly and openly proclaim that gender nonconformity is not a disease, and promote greater public awareness of this issue.

### ***Recommendations to bilateral and multilateral organizations***

- Promote and support national dialogue on trans persons.
- Promote and increase access to education and training of trans people, including support for initiatives by organizations working with this population.
- Develop partnerships to synergize efforts and actions to benefit trans people.
- Promote and support global, regional, national, and local efforts aimed at educating the public on sexual and gender diversity so as to eradicate all forms of transphobia and hatred, exclusion, and intolerance.
- Allocate resources to the health sector and other areas of public administration, including legislation and law enforcement to develop skills to address the needs of trans people.
- Publicly and openly proclaim that gender nonconformity is not a disease and promote greater public awareness of this issue.



### **Recommendations for leaders and members of community-based organizations**

- Identify local organizations to partner and build capacities with regard to trans-specific issues.
- Promote the development of community organizations and networks at all levels; worldwide, regional, national, and local.
- Establish partnerships to maximize efforts and optimize resources for activities directed to improve the overall health and quality of life of trans people.
- Proclaim and advocate for respect for human dignity of trans people.
- Create mechanisms for monitoring and following-up official commitments regarding the protection of human rights of all citizens, including trans persons.
- Participate in legislative committees at state, provincial, and national levels to ensure equitable, appropriate, and accessible health care, education, and justice for trans people.
- Provide peer support and assistance to trans people (including their communities, families, relatives, and allies) facing stigma and discrimination, family rejection, violence, harassment, anxiety, depression, or any other adversities that may be addressed through solidarity and support.
- Develop processes and materials for peer education on issues that are relevant to the welfare of transgender people, such as soft tissue fillers, self-prescription of hormones, nutrition, use of cosmetics, apparel, post-surgery recommendations, and safer sex activities.
- Promote the development of leadership and other skills that contribute to the improvement of personal life skills.
- Create mechanisms to develop the skills of trans community representatives to enhance their participation in public discussions, conferences, and social gatherings.
- Develop skills and promote vocational training to improve access to stable and dignified financial resources.
- Strengthen training in administration and management for trans organizations.
- Encourage reporting of rights violations and abuse at all levels, including those perpetrated by family members and partners of trans people.

### **Recommendations for partners, families, and friends of trans people**

- Recognize and report to the appropriate authorities any form of harassment, violence, sexual exploitation, and discrimination in homes and schools, health care facilities, workplaces, and other public places.
- Seek professional advice or support from peer community groups to help trans people who are experiencing personal problems or concerns.
- Show affection and respect for the trans person who is part of the family or group of friends and significant others.
- Offer greater support to family members who are involved in a person's transition process.
- Seek guidance from qualified clinics and health centers for the appropriate care of children who express a gender identity different from their natal sex.
- Protect trans persons and family from all forms of abuse, as well as from so-called "reparative therapies" and other potentially harmful approaches to their health, welfare, and human dignity.
- Encourage support for all family members who offer solidarity with trans persons. Involve faith-based organizations in discussions of trans issues, and promote awareness and education of these communities. Educate faith-based organizations on the human rights of trans people and the relevance of religious regulations to the full enjoyment of civil rights.

## 10. Trans Resources

- Center of Excellence for Transgender Care (University of California, San Francisco): [transhealth.ucsf.edu](http://transhealth.ucsf.edu) (accessed June 2, 2014).
- The Western Hemisphere Region Office of the International Planned Parenthood Federation (IPPF) has developed a tool kit for assessing agency readiness (i.e., health care systems and services) for working with sexually diverse populations, including trans persons. The tool kit can be downloaded at [www.ippfwhr.org](http://www.ippfwhr.org).
- National Academy of Sciences, Institute of Medicine. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011). Online at <http://www.ncbi.nlm.nih.gov/books/NBK64806/> (accessed July 2, 2014).
- Transgender Europe (European advocacy organization): <http://www.tgeu.org/missionstatement>.
- Trans Murder Project statistics: [http://www.transrespect-transphobia.org/uploads/images/maps/TvT-TMM-Map-2008-12\\_EN.png](http://www.transrespect-transphobia.org/uploads/images/maps/TvT-TMM-Map-2008-12_EN.png) (accessed June 1, 2014).
- University of California (USCF): Recommendations for collection of data on trans persons, developed by UCSF, available at <http://transhealth.ucsf.edu/pdf/data-recommendation-2page.pdf> (accessed July 2, 2014) World Professional Association for Transgender Health (WPATH): [www.wpath.org](http://www.wpath.org) (accessed June 1, 2014).
- Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (Coleman et al., 2010) describing comprehensive care for trans persons, online at [http://www.wpath.org/site\\_page.cfm?pk\\_association\\_webpage\\_menu=1351&pk\\_association\\_webpage=4655](http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=4655) (accessed July 7, 2014).

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## Appendix A

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Technical Meeting: Provision of Comprehensive Care to Transgender Persons in Latin America and the Caribbean – Washington DC 19–21 December 2011

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## Appendix B

### List of participants

#### Consultative working group meeting

#### Blueprint for Comprehensive Services for Trans Persons and Their Communities in Latin America and the Caribbean

#### Hilton Hotel, Port of Spain

16-20 April 2013

#	Proposed Participants	Organization/Profession	Email
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## Appendix C

### Sample consent forms

Initiation and continuation of medical interventions and procedures intended to balance the gender identity of a trans person with her or his physical and psychological are not cosmetic or trifling medical acts, but are essential for the health and overall well-being of the trans persons who require them.

Trans persons have the right to know what the interventions mean, what benefits, risks, gains, and side effects they may entail, and the impact they may have in their daily life, in addition to degree of permanence. Once they are properly informed, they must express full consent for undergoing the required or suggested treatment.

The Center of Excellence for Transgender Health of the University of California, San Francisco provides examples of consent forms for some interventions including the hormone treatments for which the algorithms suggested in this Blueprint have been adapted.

Sample consent forms can be retrieved at the following links:

For use of feminizing hormones:

[http://transhealth.ucsf.edu/pdf/protocols/Sample\\_1\\_MTF.pdf](http://transhealth.ucsf.edu/pdf/protocols/Sample_1_MTF.pdf)

For use of other feminizing treatments:

[http://transhealth.ucsf.edu/pdf/protocols/Sample\\_3\\_Feminizing%20Medications.pdf](http://transhealth.ucsf.edu/pdf/protocols/Sample_3_Feminizing%20Medications.pdf)

For use of testosterone and the female-to-male transition:

[http://transhealth.ucsf.edu/pdf/protocols/Sample\\_2\\_FTM.pdf](http://transhealth.ucsf.edu/pdf/protocols/Sample_2_FTM.pdf)

For the use of testosterone:

[http://transhealth.ucsf.edu/pdf/protocols/Sample\\_4\\_Testosterone.pdf](http://transhealth.ucsf.edu/pdf/protocols/Sample_4_Testosterone.pdf)

For parents/guardians approving procedures among underage persons:

[http://transhealth.ucsf.edu/pdf/protocols/Sample\\_5\\_FemMinorparent.pdf](http://transhealth.ucsf.edu/pdf/protocols/Sample_5_FemMinorparent.pdf)



