

THEMATIC SEGMENT

Priority and key populations especially transgender people, and the path to 2025 targets: Reducing health inequities through tailored and systemic responses

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All case studies have been compiled as a Conference Room Paper (UNAIDS/PCB (52)/CRP7), which is available on the PCB website.

I. Executive Summary

Key populations are disproportionately affected by HIV in all regions

1. Key populations - sex workers and their clients, gay men and other men who have sex with men, people who inject drugs, transgender people - account for less than 5% of the global population, but in 2021, key populations and their sexual partners accounted for the majority of new HIV infections in most regions, and over 90% of new HIV infections outside of sub-Saharan Africa.ⁱ Intersecting inequalities exacerbate risks. People in prison are over 6 times more likely to be living with HIV than adults in the general population.ⁱⁱ Transgender people in prison have a higher prevalence of HIV and other STIs and are estimated to be up to 13 times more likely to be sexually assaulted than cisgender¹ people in prison.ⁱⁱⁱ
2. Priority populations, on the other hand, are vulnerable to HIV in particular countries and regions. This may include, depending on region, children, adolescent girls and young women, indigenous people and other populations. This background note focusses on key populations who are disproportionately affected by HIV in all epidemic settings, and face high levels of stigma, discrimination and violence, especially transgender people who, in many settings, face highest levels of stigma, discrimination and violence among key populations.

Specific focus on transgender people in the HIV response: Needs, gaps and challenges

3. Transgender people are diverse. They may identify in many ways including as men, women, or non-binary, etc. In many pre-colonial societies, gender identities other than women and men existed, such as *muxe* in Mexico,^{iv} *hijra* in South Asia,^v 'male daughters' or 'female husbands' in Africa,^{vi} or 'twospirit' in North America.^{vii} Colonialism suppressed these identities, and imposed binary ideas of gender and sexuality,^{viii} however some of these identities continue or are being reclaimed today.^{ix} There are still huge gaps in data on transgender people, but in recent years countries increasingly report these data to UNAIDS. These include population size estimates from Armenia, of 1000 people, Mexico 123,000, Philippines 205,000, South Africa 179,000, and the USA 1 million.
4. The rights of transgender people are established in international human rights law. States have an obligation under international human rights law to provide for the legal recognition of a person's self-identified gender, including for non-binary persons, without additional requirements that may violate human rights, such as surgery.^{xi} In 2019, the World Health Assembly adopted the eleventh revision of the International Classification of Diseases (ICD-11), which depathologised transgender.^{xii}
5. Transgender people face high levels of gender-based and other violence, stigma and discrimination which intensifies the risks and impacts of HIV. A transgender man in

¹ A person whose sense of personal identity and gender corresponds with their birth sex. (From UNDP, 2020, Stories of Stigma: Exploring stigma and discrimination against Thai transgender people. Bangkok, UNDP. p.iv)

Uganda reported rapes by cisgender men “*who want to prove a point that you are not a man; you should be a woman.*”^{xiii} A transgender woman in rural South Africa was gang raped and beaten by five men because of her transgender identity. A friend helped her get to the hospital to receive treatment and preventative HIV care, but the nurse refused to help her after looking at her identity document and “*told me to go home and take off my dress.*”^{xiv}

6. Transgender people have specific needs and challenges in relation to HIV prevention, treatment, retention, and care.^{xv} They may be criminalized or invisibilized in national policies and programmes. They may face high levels of societal discrimination and violence, exclusion from employment and education, and significant barriers to accessing health information and services, increasing the risk of acquiring HIV and reducing access to testing and treatment. Confidentiality and non-discrimination by services are critical to enable access. They may have feelings of alienation from the sexed bodies they were born with, which means language to communicate about safer sex and prevention needs to be appropriate.^{xvi} They may undergo gender affirming care and need tailored advice on healthy sexualities and safer sex.^{xvii} If they are taking hormones, PrEP, PEP and ARVs given need to be compatible.^{xviii} Others may not want or need medical interventions but can face pressure to undertake these to get legal recognition or conform to stereotypes around the gender with which they identify.^{xix xx}

Ways forward and Recommendations

7. The world is not on track to achieve the 2025 goals. The Global AIDS Strategy 2021–2026 provides a clear, evidence-informed blueprint for getting the AIDS response back on track. There are many examples of strategies that can help us get there. In India, some HIV services are tailored to transgender and hijra people and men who have sex with men.^{xxi} In Zimbabwe, lesbian and bisexual women, trans men, and non-binary people work to make health services more accessible.^{xxii} In Kenya, measures are taken to include men who have sex with men and transgender people in universal health coverage.^{xxiii} In Indonesia initiatives support transgender people to access identification cards and citizenship rights.^{xxiv} In different regions, Global Action for Trans Equality (GATE) works to increase capacity of transgender communities to respond to anti-gender movements.^{xxv} In Luxembourg, holistic support for drug users stemmed from an HIV outbreak.^{xxvi} In Peru, an emergency response is helping sex workers to safety in the face of death threats.^{xxvii}
8. These are positive examples of programmes and policies that will need to be scaled up to reach the Global AIDS Targets. To end HIV among key populations we need to:
 - Address gaps in the data and use strategic data for an evidence-based response.
 - Optimally resource and scale-up tailored and effective HIV interventions to combat inequalities.
 - Ensure sufficient and sustainable financing for key populations, including supporting and effectively resourcing community-led responses.
 - Address gender inequality, stigma and discrimination, end violence in all its forms, realize human rights and decriminalise.

- Understand anti-gender movements and their impact on the HIV response and on key populations and support joined up strategies to counter these movements.
- Address inequalities in HIV prevention, testing and treatment access and outcomes, and close the gaps that exist in specific localities and for and within certain groups.
- Integrate HIV services with broader health services tailored to and inclusive of key populations. Integrate health and social protection and take whole person approaches which address economic factors and structural obstacles as well as health.

II. Introduction

9. This introduction will present definitions of key and priority populations, and give an overview of available current epidemiological data related to these groups. Some important targets for key populations will be outlined. In the following sections, the note will focus specifically on key populations. The background note will take this direction both because priority populations differ based on country and region, which creates a scope that is too broad for one background note or a one-day thematic segment, and because, in every setting, key populations have increased vulnerability to HIV.
10. The following Section III analyses the inequalities that are preventing progress in the HIV response for key populations. Section IV focusses on the needs, gaps and challenges for transgender people in the HIV response. To show how the HIV response can more effectively reduce the risk and impacts of HIV on key populations, examples of initiatives being implemented in all regions will be presented in section V, especially those tailored by and responding to the needs of transgender communities in all their diversity. Finally, in section VI recommendations are made for the improvement of the HIV response at national, regional and global levels.

Who are we talking about? Defining key and priority populations

11. In 2021, the UNAIDS Programme Coordinating Board adopted by consensus The Global AIDS Strategy 2021-2026, End Inequalities, End AIDS.^{xxviii} This background note uses the definition of key populations agreed in the Strategy,² focusing on men who have sex with men, transgender people, people who inject drugs and sex workers and their clients. The term “key populations” is also used by some agencies to refer to populations other than the four listed above. For example, people in prison and other closed settings also are particularly vulnerable to HIV; they frequently lack adequate access to services, and some agencies may refer to them as a key population.^{xxix}
12. UNAIDS also uses the term priority populations to describe groups of people who in a specific geographical context (country or location) are important for the HIV response because they are at increased risk of acquiring HIV or being disadvantaged when living with HIV, due to a range of societal, structural, or personal circumstances.^{xxx} In sub-Saharan Africa, children, adolescent girls and young women are priority populations. Depending on the country, priority populations can include indigenous peoples, racial and ethnic minorities, migrants, people with disabilities, and others.

² Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context. (Global AIDS Strategy 2021–2026, p8.)

Key populations are disproportionately affected by HIV in all regions

13. Priority populations are varied and country and region-specific, while key populations are disproportionately affected by HIV in all epidemic settings. Despite commitments and efforts by multiple stakeholders, progress against HIV remains fragile in many countries and acutely inadequate among key populations globally and among priority populations. Key populations³ account for less than 5% of the global population, but key populations and their sexual partners accounted for the majority of new HIV infections globally: and over 90% of new HIV infections outside of sub-Saharan Africa.^{xxxii}

14. The most recent UNAIDS data shows that the risk of acquiring HIV is: 35 times higher among people who inject drugs than adults (15-49) who do not inject drugs; 30 times higher for female sex workers than adult (15-49) women generally; 28 times higher among gay men and other men who have sex with men than adult (15-49) men generally; and 14 times higher for transgender women than adult (15-49) women.^{xxxii}



15. In the HIV response, people who inject drugs are among the most frequently omitted or poorly served populations. An estimated 11.2 million people worldwide injected drugs in 2020 and those numbers are increasing. It is estimated that one in every 8 people who inject drugs is living with HIV (approximately 1.4 million people).^{xxxiv} Yet, criminalization predominates over public health approaches for these populations. Among users of opioids, the most commonly injected drugs, 85% are men.^{xxxv} Fewer women inject drugs, but those who do are more likely than male peers to be living with HIV, face higher rates of conviction and incarceration, and may be marginalised by harm reduction programmes focussed on the needs of men.^{xxxvi} Since 2013, when transgender sex disaggregation was included in the UNAIDS Global AIDS Monitoring process, six countries have reported data on HIV prevalence among transgender people who inject drugs: Bangladesh, Canada, Germany, Iran, Mauritius and Nigeria.^{xxxvii}

16. Most countries lack research and data on key populations, especially on issues of intersectionality. Some countries continue to turn a blind eye to key populations, denying

³ sex workers and their clients, gay men and other men who have sex with men, people who inject drugs, transgender people

their very existence. Stigma and, in some cases, criminalization also hinder data collection on key populations. Not enough is known about the sizes of key populations and the challenges they face. The lack of available data undermines efforts for evidence-informed advocacy and programmatic action.^{xxxviii}

17. There are gaps in the data particularly on transgender men. A recent systematic review and meta-analysis analysed a larger pooled sample than ever before of studies of HIV prevalence among transgender people. Most data for transmasculine⁴ people came from high income contexts. In the 18 studies of transmasculine people, HIV prevalence ranged from 0% to 8.7%, with a mean of 0.4, showing that transmasculine people are more likely to be living with HIV than the general populations in their countries.^{xxxix}
18. In general, there is even less data available on sex workers who are men or transgender, compared with those who are cisgender⁵ women.^{xi} Most countries do not report data to UNAIDS for prevalence of HIV among transgender sex workers, but countries that do report this data – 25 countries since 2013, when transgender sex disaggregation was included - show higher levels of HIV among transgender sex workers than female sex workers.^{xii} 38 countries reported data on HIV prevalence among male sex workers since 2011 through the Global AIDS Monitoring, and 18 have reported these data in recent years (2017-2021), one third of which show HIV prevalence is higher among male sex workers than female sex workers and lower than that of transgender sex workers. As documented in the last PCB Background Note,^{xlii} men (both cisgender and transgender men) do sell sex to women and men, make up a significant proportion of the population offering transactional sex, are highly vulnerable to HIV, and can face intersecting stigmas and criminalization because they sell sex and have same-sex relations.^{xliii}
19. Intersecting inequalities exacerbate risks. People in prison are over 6 times more likely to be living with HIV than adults in the general population.^{xliv} Transgender people in prison have a higher prevalence of HIV and other STIs and are estimated to be up to 13 times more likely to be sexually assaulted than cisgender people in prison.^{xlv}
20. Structural barriers prevent progress. Stigma, discrimination, violence and criminalization against key populations exacerbate social and economic inequality, poverty and exclusion, all of which can lead to increased vulnerability to HIV and other communicable and noncommunicable diseases and act as barriers to access to and retention in health services.
21. Access to combination HIV prevention services among key populations remains limited across most of the world. In some settings, prevention services for certain key populations are wholly absent, even though they are at markedly greater risk of acquiring HIV than the population as a whole. The percentage of key populations who have been recently tested for HIV and made aware of their status is also still low. Recent reported data indicate that, in median, about three in four sex workers, gay men and other men who have sex with men and transgender people globally either had taken an HIV test

⁴ The term transmasculine refers to people assigned female at birth who identify on the masculine spectrum, binary or non-binary. (<https://gate.ngo/transmasculine-hiv-aids-2022-conference/>).

⁵ A person whose sense of personal identity and gender corresponds with their birth sex. (From UNDP, 2020, Stories of Stigma: Exploring stigma and discrimination against Thai transgender people while accessing health care and in other settings. Bangkok, UNDP. <https://www.undp.org/thailand/publications/stories-stigma>. p. iv)

and received the results in the past 12 months or had previously tested positive for HIV.^{xlvi}

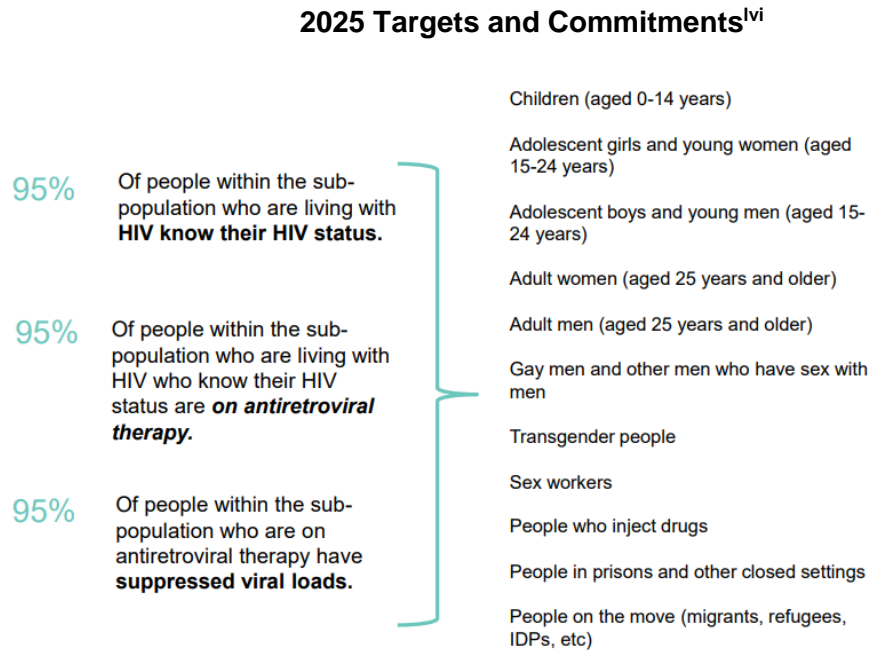
22. Much more extensive and equitable HIV prevention, testing and linkage to treatment programmes are needed for key populations and their sexual partners. In particular, community-led interventions are crucial for ensuring that key populations can access and fully benefit from HIV services.
23. For countries to meet the 95-95-95 targets by 2025 and to ensure no one is left behind in the HIV response, a differentiated approach must be used to tailor structural, systemic and multi-sectoral responses to address priority and key populations groups. As highlighted in the Global AIDS Strategy 2021-2026, “renewed political and financial commitments are needed to scale up interventions that will address the different structural, financial and economic inequalities and transform the harmful socio-cultural norms, gender-based inequalities and gender-based violence that continue to drive the AIDS epidemics”.^{xlvii}

Priority populations are left behind in different regions

24. New HIV infections among children declined by more than half (54%) from 2010 to 2020, due mainly to the increased provision of antiretroviral therapy to pregnant and breastfeeding women living with HIV. Last year Botswana was the first African country with high HIV prevalence to be validated as being on the path to eliminating vertical transmission of HIV.^{xlviii} However, that momentum has slowed considerably, leaving particularly large gaps in Western and Central Africa which is home to more than half of pregnant women living with HIV who are not on treatment.^{xlix}
25. In 2021, an estimated 800 000 children globally living with HIV were still not receiving HIV treatment. Children comprised 4% of people living with HIV in 2021 but 15% of AIDS related deaths. In recent years in Eastern and Southern Africa, Latin America, the Caribbean, and the Middle East and North Africa, the the gap in HIV treatment coverage between children and adults is increasing rather than narrowing.ⁱ
26. In sub-Saharan Africa, adolescent girls and young women (aged 15 to 24 years)—one of whom becomes infected with HIV every three minutes—are three times more likely to acquire HIV than adolescent boys and young men of the same age group. Global estimates based on data from 2000–2018 also indicate that more than one in 10 ever-married or partnered women aged 15 to 49 years have experienced intimate partner physical and/or sexual violence within the past 12 months.ⁱⁱ
27. Racial and ethnic minorities often experience substantial HIV-related inequalities, as shown in countries where data has been collected such as in Western Europe, where declines in new HIV diagnoses have been smaller among black than white populations.ⁱⁱⁱ
ⁱⁱⁱ In Australia, Canada and the United States, HIV acquisition rates are higher in indigenous communities than in non-indigenous communities.^{iv iv}

The 2025 targets for key populations – a snapshot

28. The 2025 HIV prevention targets emerged from the 2021 Political Declaration on HIV and AIDS, which the United Nations General Assembly adopted in June 2021, and they are underpinned by the Global AIDS Strategy (2021–2026) which sets out the principles, approaches, priority action areas and programmatic targets for the global HIV response. A snapshot of these targets – including for key populations – is given below.



2030 | Ending the AIDS epidemic



10% <

LESS THAN 10%
LESS THAN 10% OF PEOPLE LIVING WITH HIV AND KEY POPULATIONS EXPERIENCE STIGMA AND DISCRIMINATION

LESS THAN 10%
OF PEOPLE LIVING WITH HIV, WOMEN AND GIRLS AND KEY POPULATIONS EXPERIENCE GENDER BASED INEQUALITIES AND GENDER BASED VIOLENCE

LESS THAN 10%
OF COUNTRIES HAVE PUNITIVE LAWS AND POLICIES

(Global AIDS Strategy 2021-2026^{lvii} p20)

29. Community-led responses are vital to ensure inclusion of key populations in the HIV response. The community 30-80-60 targets were adopted by member states in the 2021 Political Declaration and in the Global AIDS Strategy– that by 2025, communities will deliver 30% of testing and treatment services, 80% of HIV prevention services and 60% of programmes support the achievement of societal enablers.

30. The world is not on track to reach the majority of the 2025 targets. Efforts to prevent HIV infections are particularly off track in the majority of countries outside of sub-Saharan Africa, with combination prevention interventions not reaching sufficient scale or intensity. The HIV response continues to fail key populations and the most vulnerable, and progress on societal enablers remains inadequate.^{lviii}

III. Inequalities preventing progress in the HIV response for key populations

Inequalities in HIV prevention, testing and treatment among key populations

HIV infections are increasing in some regions, including among key populations

31. Eastern Europe and central Asia, the Middle East and North Africa and Latin America have all seen increases in annual HIV infections over the past decade. In Asia and the Pacific—the world’s most populous region—UNAIDS data shows uncertain trends suggesting that new HIV infections may be rising where they had been previously falling. Malaysia and the Philippines are among the countries with rising epidemics among key populations. Increases in infections in these regions are alarming. Latin America, an early success story in the roll-out of treatment, has lost momentum, allowing epidemics among young gay men and other men who have sex with men and other key populations to rebound. Large portions of eastern Europe and central Asia do not have the harm reduction services needed to turn the tide of epidemics that are predominantly among people who inject drugs and their sexual partners.^{lix}

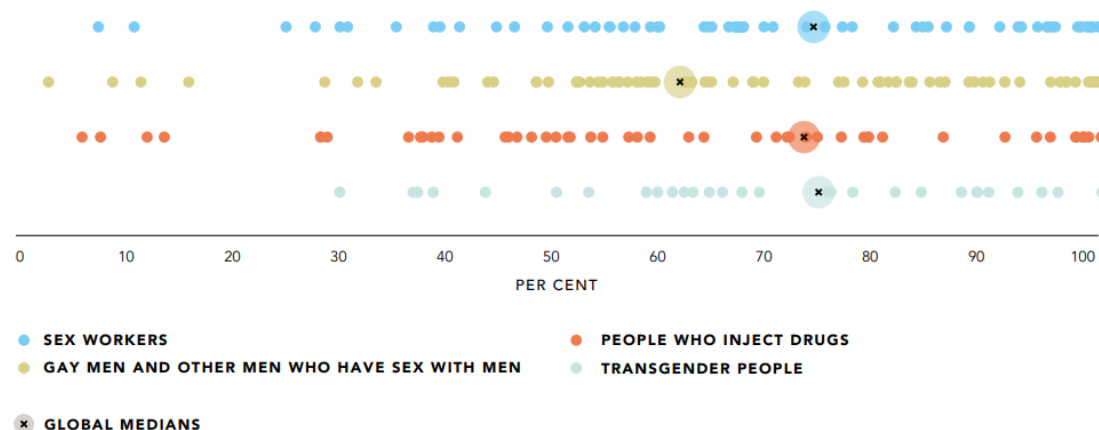
Prevention coverage

32. Less than half of gay men and other men who have sex with men were able to access at least two HIV prevention services in the past three months in 23 of 37 countries reporting data to UNAIDS in recent years.^{lx} Less than half of people who inject drugs were able to access at least two HIV prevention services in the past three months in 13 of 24 reporting countries.^{lxi} Less than half of sex workers stated that they were able to access at least two HIV prevention services in the past three months in 19 of the 39 reporting countries.^{lxii} Less than half of transgender people stated that they were able to access multiple HIV prevention services in nine of the 20 reporting countries.^{lxiii}
33. The coverage of HIV-specific prevention services does offer some bright spots. In 2021, 24 out of 83 reporting countries reached the target of 90% coverage of condom use at last sex among sex workers. In eight countries, coverage was above 95%. Eighteen out of 36 countries reported reaching the 90% target for use of sterile needles and syringes at last injection, with seven surpassing 95% coverage. Nonetheless, major gaps persist, and achievement of the 2025 targets requires a full range of prevention choices.^{lxiv}

Testing and awareness of status

34. The percentage of key populations who have been tested for HIV in the past 12 months and know their results or are aware of their HIV positive status is lower than for other populations. Recent reported data indicate that, in median, about three in four sex workers, gay men and other men who have sex with men and transgender people globally either had taken an HIV test and received the results in the past 12 months or had previously tested positive for HIV.^{lxv}

HIV testing and status awareness among key populations, global, 2017-2021^{lxvi}



Source: UNAIDS Global AIDS Monitoring, 2022 (<https://aidsinfo.unaids.org/>).

Note: Data include members of key populations who have been tested in the past 12 months and know that their results are negative, and ever-tested members of key populations who know that they are living with HIV.

Treatment coverage

35. The testing gaps have a negative cascading effect, reducing the number of key population members who initiate HIV treatment and achieve viral suppression. The most recent data reported to UNAIDS, as outlined below, shows that generally treatment access by member of key populations fall well short of the 2025 targets.⁶

- Eighteen countries reported levels of antiretroviral therapy (ART) coverage of people who inject drugs living with HIV from surveys in recent years (2017-2021), ranging from 14.1% in Myanmar to 90.6% in Estonia, with a median of 56.3%.^{lxvii}
- Thirteen countries reported in recent years (2017-2021) ART coverage among men who have sex with men living with HIV from surveys, ranging from 21.6% in Vietnam to 90.9% in India, with a median of 44.1%.^{lxviii}
- Only three countries reported recent ART coverage of transgender people living with HIV from surveys, India, 97.9% Indonesia 34.4% and Nigeria, 19.5%. Only Nigeria disaggregates and reports both transgender women and transgender men, showing transgender women have slightly higher coverage than transgender men.^{lxix}
- Fourteen countries reported recent ART coverage among sex workers living with HIV from surveys, ranging from 21.3% in Vietnam to 99.1% in Cameroon, with a median of 75.5%.^{lxx}

36. With the right links to treatment and support to remain in care, key population members living with HIV can reach similar levels of viral suppression as people living with HIV generally, as shown by experiences of gay men and other men who have sex with men, transgender women and genderqueer⁷ individuals in Zimbabwe.^{lxxi}

⁶ Countries report data on these and other indicators on key populations as part of the Global AIDS Monitoring process, which took place most recently in 2022.

⁷ Genderqueer, identity adopted by individuals who characterize themselves as neither female nor male, as both, or as somewhere in between. (Encyclopedia Britannica <https://www.britannica.com/topic/genderqueer>).

Inequalities in access to broader health services, and health service integration

37. Legal and structural barriers such as stigma, discrimination, criminal and punitive laws, policies and practices, and intersecting inequalities impede the HIV response at every step, limiting access to prevention services, testing, treatment and adherence, broader sexual and reproductive health services and tuberculosis services, cancer screening and services, and health care generally.^{lxxii} HIV-related stigma and discrimination can lead to poorer mental health, lower levels of services usage, and less adherence to antiretroviral medications. Due to multiple stigmas and discrimination around their intersecting identities, members of key populations living with HIV are likely to face multiple barriers to testing, treatment and care and negative health outcomes.^{lxxiii}
38. A study of transgender women in Argentina showed that those who had experienced discrimination in health-care settings were three times more likely to avoid health-care settings than those who had not.^{lxxiv} Surveys in sub-Saharan Africa found that between 10% and 40% of gay men and other men who have sex with men delay or avoid health care due to fear of stigma.^{lxxv}
39. Key populations are also disproportionately affected by viral hepatitis and sexually transmitted infections (STIs). There is increasing realisation of the importance of addressing these and HIV in an integrated, community-led, and person-centred manner.^{lxxvi} Health services should not be siloed around specific diseases but managed and delivered in a person centered way to enable people to receive a continuum of HIV prevention, testing and treatment services, together with services addressing other health needs, over time and across different levels of the health system. Health systems organized around the needs of people and communities work better, can avoid unnecessary costs, better engage clients, and are more prepared to respond to health crises.^{lxxvii} Health service integration includes the development of referral systems and networks, and empowering patients and communities to participate in their own care, as well as the provision of multiple interventions at one site.^{lxxviii}
40. Due to stigma related to HIV or targeted against key populations, members of key populations face a high burden of mental health conditions, and need mental health services.^{lxxix} Integration of mental health and psychosocial support with HIV services and interventions, including those led by communities, is one of the key priority actions in the Global AIDS Strategy 2021–2026. This highlights the need for person-centred and context-specific integration of services for HIV, mental health, psychosocial support, and other services across the life course, with a focus on people living with HIV and key populations and with full application of human rights principles such as confidentiality, privacy and informed consent. This should be fully considered across governments' and partners' health, social and economic strategies, recovery plans and budgets, and community support activities.^{lxxx}
41. The evaluation of UNAIDS work with key populations 2018-2021 found that there is a need to integrate key population programmes and costs in universal health coverage, as well as sustaining donor support and advocating for an increased share of domestic funding.^{lxxxi} This is part of an effort to ensure sustainability to this programming, by ensuring it is integrated into national health systems.
42. At the same time, measures to ensure tailored and differentiated approaches, with safe, supportive and inclusive access to key populations, must not be compromised. Many countries increasingly provide HIV-related services including for key populations through non-specialist settings including through primary health care. Without careful planning, these evolutions can present significant challenges to access and adherence by key

populations and other inadequately served populations. Ensuring confidentiality and non-discrimination by services is critical to enable access, as can be seen from the quote below.

“How is the public going to look at me? Yeah, I have just entered public hospital; people are staring, people are looking. People want to ask questions so that uncomfortable [feeling] is what I don’t want. The trans community is still, there is still that reluctance of going there. I think most of them now prefer when a [transgender] organisation has a drop-in center (DIC). They feel a sense of belonging. I know I will be safe there. No one will ask these personal questions so I will gladly want a DIC not a health facility” –
Transgender man Uganda.^{lxxxii}

43. Tackling structural obstacles to create enabling environments are needed, as well as guidelines and capacity building of the health workforce on how to provide more gender responsive and inclusive care. One example of this is the *Towards Transformative Healthcare Module* launched by the Asia Pacific Transgender Network this year. This interactive online training is designed as an introductory resource on trans competent and gender-affirming healthcare for medical professionals and other health workers in Asia and the Pacific, including those working in primary care and community-based health services.^{lxxxiii}

Structural Inequalities preventing progress in the HIV response for key populations

Stigma and discrimination

44. HIV-related stigma and discrimination significantly impacts the health, lives and well-being of people living with or at risk of HIV, especially key populations. Stigma and discrimination increase the risk of HIV acquisition and progression to AIDS, violence, and marginalization while reducing access to education, employment, community support and justice. People may experience intersectional discrimination and stigma on several grounds, including by belonging to more than one key population, and on the grounds of gender, race, disability, migrant status and socioeconomic status to name a few. The People Living with HIV Stigma Index,^{lxxxiv} a community-led research and advocacy initiative, found that HIV-related discrimination caused or contributed to job loss in more than 50% of cases in 7 of 11 countries with data.^{lxxxv}
45. Key populations, face varying levels of stigma and discrimination, reflecting the range of societal and legal environments across regions and countries. While a median of 16% of gay men and other men who have sex with men (nine reporting countries) and 22% of sex workers (nine reporting countries) say that they have experienced stigma and discrimination in the past six months, 47% of people who inject drugs (four reporting countries) and 81% of transgender people (four reporting countries) report similar experiences.^{lxxxvi}
46. As discussed below, anti-gender movements are increasingly influential worldwide, encouraging stigma, discrimination and legal changes which restrict the rights of key populations.

Violence

47. Recent data show key populations face high levels of violence. In median, more than one in four transgender people experienced violence in the past 12 months (seven reporting countries). The same is true for one in five sex workers (15 reporting countries), one in six people who inject drugs (seven reporting countries) and one in 14 gay men and other men who have sex with men (13 reporting countries).^{lxxxvii} In addition, a high proportion of women who use drugs suffer psychological or physical violence by partners, denoting gender-based vulnerability and a need for gender-based approaches to harm reduction interventions.^{lxxxviii}
48. Deep rooted gender discrimination deny women and girls equality of opportunities and outcomes across their life course. They translate into the denial of voice, participation and agency in education, health, the economy, politics and business. They also result in the denial of sexual autonomy, increased risk and vulnerability to HIV. Gender discrimination intersects with other discriminations faced by key populations, including transgender and cisgender women.
49. The same patriarchal frame that results in unhealthy power and status also perpetuates socially assigned and accepted forms of behaviour that harm men across their life course. Masculine ideals, such as the restriction of emotional expression and the pressure to conform to expectations of dominance and aggression, may heighten the potential for boys to engage in general acts of violence including, but not limited to, bullying, assault, and physical and verbal aggression.
50. Almost one third (31%) of women globally have been submitted physical to and/or sexual violence from any current or former husband or male intimate partner^{lxxxix}. Studies show that transgender individuals experience unique vulnerabilities to intimate partner violence and higher prevalence of IPV victimization compared with cisgender individuals, regardless of sex assigned at birth^{xc}.
51. Hostility to divergence from gender conformity can drive violence against transgender and gender-nonconforming people.^{xcii} These beliefs, among policy makers, service providers as well as survivors, can make it even harder to access support for escaping violence, and deal with trauma and HIV.

“When that perpetrator is raping you...he will be busy telling you that I am teaching you what it is to be a woman. You said you wanted to be a woman, this is what it is, and a woman should get this.” – transgender woman in rural South Africa^{xcii}

A transgender man in Uganda reported rapes by cisgender men *“who want to prove a point that you are not a man; you should be a woman.”*^{xciii}

“I am fearing for my life because the community boys have said they will rape me because I still have a vagina...They said ‘if we rape you and you experience a penis you can be alright, and stop the things you are doing.’ – transgender man in rural South Africa^{xciv}

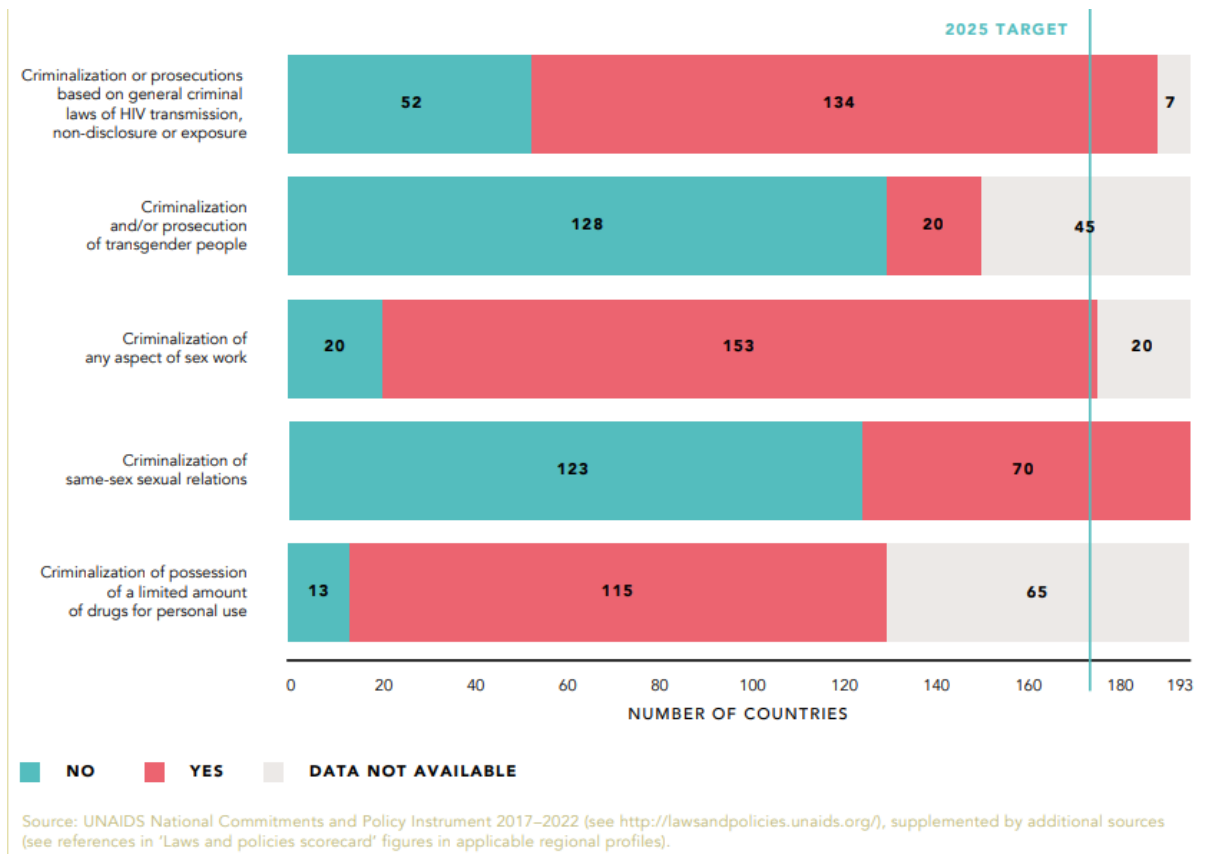
“Trans men [are] not going to tell you that [they] had a sexual encounter with this person but then it ended up as rape. They usually never want to open up and say those things to any health facilities or providers. So, there is going to be that barrier of he has raped me

and how do I go for screening? What has he given to me? Probably he had a few infections. I just come in secrecy; I confide in [someone] in the [trans] community that has access to these services. I will not tell them what is wrong, I will just tell them...help me get a [HIV] testing kit and some PEP [post-exposure prophylaxis]” - transgender man Uganda^{xcv}

Criminalisation

52. Punitive laws and the punitive use of law also block HIV service access and increase HIV risk. Harmful laws include the criminalization of same-sex sexual relations, transgender people, HIV exposure, nondisclosure and transmission of HIV, drug possession and use, and criminalisation of sex work.^{xcv} Law enforcement practices can also prevent people from utilising prevention tools. For example, in some cases, the possession of condoms and PrEP pills is used by police as grounds for harassment or “evidence” that a person is involved in sex work.^{xcvii xcviii}

Countries with discriminatory and punitive laws, global, 2022^{xcix}



53. Recent research in ten countries in sub-Saharan Africa shows that HIV prevalence among gay men and other MSM living in countries that criminalize same-sex relations is five times higher than in countries without such criminal penalties. In countries where there have been recent prosecutions, HIV prevalence is almost 12 times as high.^c A 2019 systematic review found that African countries with the most severe antigay legislation had substantially lower rates of HIV testing among gay men and other men who have sex with men, compared with countries with less severe legislation.^{ci}

54. Removing laws criminalising sex work has been estimated to avoid between 33% and 46% of new HIV infections among sex workers and clients over a ten-year period.^{cii} Clients of sex workers face criminalization in several developed countries where buying sex is illegal. Criminalizing clients increases risks for both clients and sex workers. A survey of 500 women and men who sell sex (including transgender women and transgender men) in France found that 98% of them opposed criminalizing clients, which they saw as increasing their vulnerability to violence and poverty by pushing the industry underground and discouraging safer clients.^{ciii} The criminalization of the clients of sex workers has been repeatedly shown to negatively affect sex workers' safety and health, including reducing condom access and use, and increasing the rates of violence. The criminalization of any aspect of sex work has similar negative public health, violence and well-being outcomes.^{civ cv cvi cvii}
55. Punitive drug control laws, policies and law enforcement practices have been shown to be among the largest obstacles to health care in many countries, along with financing and political will, being associated with higher rates of needle-sharing and reduced access to HIV services.^{cviii cix} Decriminalising drug use and possession for personal use are associated with significant decreases in HIV incidence among people who inject drugs.^{cx}
56. The criminalization of transgender and gender-diverse people is widespread, including through laws that criminalize "public nuisance" or "impersonating someone of the other sex" and other punitive laws, practices and policies. Such laws help perpetuate stigma, discrimination, hate crimes, police abuse, torture, ill-treatment and family and community violence.^{cxii cxiii cxiv} All of these reduce access to HIV services and increase risk of new infections and poor HIV treatment outcomes.

Decriminalisation: steps forwards and steps backwards

57. The world is not on track to ensure that less than 10% of countries have punitive legal and policy environments that create barriers to accessing HIV services. Most countries still criminalize at least one aspect of sex work, possession of a small amount of drugs for personal use and HIV transmission, exposure or non-disclosure.
58. Some progress, however, has been made in recent years. In some countries the evidence is being recognized. A number of countries have taken steps to repeal laws criminalizing HIV transmission, exposure or non-disclosure but this is not happening fast enough. For example, the Central African Republic, in 2022, restricted the scope of its laws criminalizing HIV transmission, as part of its work under the Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination (GP). In Argentina, the GP supported the National Bill on HIV, Hepatitis and TB, with a strong human rights perspective, establishing the rights of PLHIV, access to prevention and ART, and a broad social protection framework (i.e., access to decent work, basic social services and early retirement for PLHIV in social vulnerability). Also in Thailand, the country adopted a national Code of Conduct on HIV prevention and management in the workplace and the Ministry of Labor and private sector were mobilized to commit to ending stigma and discrimination and reviewing their HIV policies in line with the new Code of Conduct.
59. In 2022 Belgium completely decriminalized sex work, the only other country in the world to do so after New Zealand and two jurisdictions in Australia.^{cxv} A number of countries have also moved towards decriminalization of drug use and possession for personal

use, including, but not limited to Portugal, Switzerland, Ghana, Czechia, the Netherlands, Colombia, to name a few.

60. The percentage of the world's population living in a jurisdiction that criminalizes same-sex sexual relations has declined markedly. Several countries have decriminalized same sex sexualities in the last decade, repealing laws against homosexuality many of which were instated during the colonial era: Antigua, Barbuda, Trinidad and Tobago,^{cxvi} St. Kitts and Nevis, Barbados, in the Caribbean Belize in Central America, Botswana, Angola, Seychelles, Singapore, Bhutan, Cook Islands, Mozambique, Gabon, India, Nauru.^{cxvii}
61. Governments of Uganda, Kenya and Tanzania among others, are however making moves to further criminalise same-sex sexualities and transgender identities. Uganda already had laws criminalising homosexuality put in place prior to the country's independence. In May 2023, President Museveni signed into law the 2023 Anti-Homosexuality Bill, one of the harshest pieces of anti-LGBT legislation globally, entrenching the criminalisation, and instating the death penalty in certain circumstances including where someone is infected with HIV.^{cxviii} The bill endangers Uganda's significant progress on HIV. LGBT people in Uganda increasingly fear for their safety and security, and increasing numbers of people are being discouraged from seeking vital health services for fear of attack, punishment and further marginalization.^{cxix} Externally financed religious groups opposed to sexual and gender rights have had a formative influence on this debate in Uganda.^{cxx cxxi}
62. The law is also being used to restrict rights of transgender and gender diverse persons in other contexts. In April 2023 CNN reported that a record number of anti-LGBT bills had been introduced in the United States since the start of the year.^{cxixii} In Pakistan, the Federal Shariat Court of Islamabad recently struck down sections of The Transgender Persons (Protection of Rights) Act 2018 in Pakistan, using rhetoric which echoes narratives of anti-gender movements.

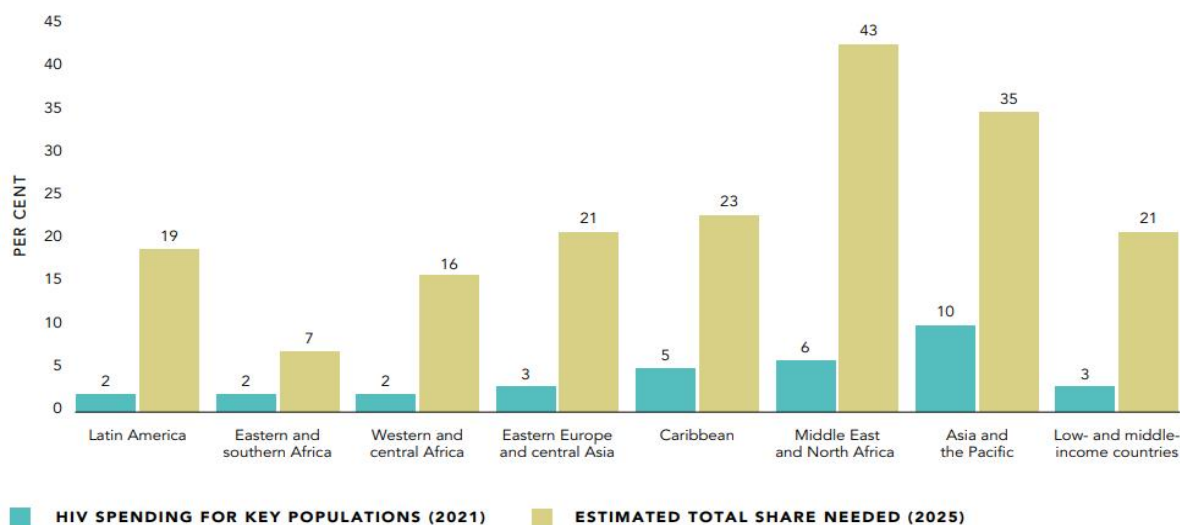
Trends and gaps in funding the HIV response for key populations

63. COVID-19, global economic downturns, financial crisis, extreme inequality, environmental crises and war pose challenges to the HIV response. Rising interest rates, a strong dollar and inflation are depleting budgets for education, health, including for HIV, and social services in highly indebted developing countries. Low-income countries are spending more on debt repayments than health, and cutting health and education spending. Donor funding for the AIDS response was 10% lower in 2020 than it was in 2010 and domestic financing fell 2% for a second year in a row in 2020.^{cxixiii} Key population programming is seriously under resourced.^{cxixiv} Community-led organizations face increased barriers to funding.

“Funding cuts have accelerated the repositioning of HIV and key population programming in agency strategies and work programmes, arguably with a lesser focus on key populations.”

- The Joint Evaluation of the UNAIDS's work with key populations, 2018-2021^{cxixv}

Percentage of total HIV spending for prevention and societal enabler programmes for key populations 2021, and estimated total share needed, 2025, in low- and middle-income countries and by region.



Source: UNAIDS financial estimates and projections, 2022; UNAIDS Global AIDS Monitoring, 2022; Stover J, Glaubius R, Teng Y, Kelly S, Brown T, Hallett TB et al. Modelling the epidemiological impact of the UNAIDS 2025 targets to end AIDS as a public health threat by 2030. *PLoS Med.* 2021;18(10):e1003831.

Note: Data are from 61 countries that reported their latest expenditures on prevention and societal enabler interventions. Testing and treatment services are not included.

64. More funding is needed, and at the same time, funding needs to be used more efficiently. For example, counselling that aims to change behaviours to reduce risks associated with these infections for key populations have not been shown to have an effect on HIV, viral hepatitis and STI incidence nor on risk behaviour such as condom use and needle sharing, and funds should be shifted away from these.^{cxxvi} Addressing structural and social obstacles, coupled with non-judgemental and supportive counselling can be more impactful.^{cxxvii}

Anti-gender movements

65. Anti-gender movements bring together individuals and organizations who incorrectly describe gender equality, LGBT rights, sexual and reproductive health rights and education as ‘gender ideology’ and oppose these. They believe that there are only two distinct and unchangeable categories of women and men, and that attempts to equalise the relationship between the two, or recognise that these categories are not totally fixed or all encompassing, will threaten the social order.^{cxxviii} They may promote ‘mandatory rehabilitation’ or ‘conversion therapy’, a harmful practice which falsely claims to make LGBT people straight and cisgender.^{cxxix}

66. Anti-gender movements use vigorous social media and communications strategies, which falsely claim that human rights approaches to gender and sexuality threaten family life and national security, to mobilise for broad political change.^{cxxx} The impact has been huge, promoting violence against LGBT, undermining sexuality education programs in Latin America, adoption of legislation undermining human rights in several countries.^{cxxxi} The Special Rapporteur on protection against violence and discrimination based on sexual orientation and gender identity reported to the General Assembly in 2021 on the “steep rise in ultraconservative political leaders and religious groups using

their platforms to promote bigotry, dehumanize persons on the basis of sexual orientation, gender identity, and gender expression, and foster stigma and intolerance among their constituencies.”

67. Many feminist organisations support transgender rights.^{cxxxii} However, some feminists view gender identity as being determined solely by biological sex, others fear that transgender women in some way undermine the identity of women, and that people who were assigned male at birth in general to pose a threat to cisgender women's spaces and rights, whether they are cisgender men or transgender women. Some of these feminists have allied with anti-gender movements with the goal of holding back transgender rights.^{cxxxiii}

IV. Specific focus on transgender people in the HIV response: Needs, gaps and challenges

Understanding who transgender people are

68. After community consultation, the World Health Organisation last year formulated the definition below, to be used in the *Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations*.

Trans and gender diverse people: an umbrella term for those whose gender identity, roles and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth; it includes people who are transsexual, transgender, or otherwise gender nonconforming or gender incongruent. Trans and gender diverse people may self-identify as transgender, female, male, transwoman or transman, transsexual or one of many other gender nonconforming identities. They may express their genders in a variety of masculine, feminine and/ or androgynous ways. The high vulnerability and specific health needs of trans and gender diverse people necessitate a distinct and independent status in the global HIV response.^{cxxxiv}

Colonial influences on gender identity and expression

The evidence suggests that, in many countries, the rigid understandings of the male/female binary as a main ordering social principle are the result of colonialism - Report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity Victor Madrigal-Borloz, presented by the Secretary General to the General Assembly, 15 July 2021^{cxxxv}

69. During the colonial period, a binary understanding of gender, that everyone should fit into the categories of either ‘woman’ or ‘man’, was promoted and introduced into legislation.^{cxxxvi cxxxvii} Precolonial gender identities and their contemporary iterations do not match these ideas, for example *muxe* in Mexico,^{cxxxviii} *hijra* in South Asia,^{cxxxix} and ‘male daughters’ and ‘female husbands’ in Africa.^{cxli} Today, across cultures, many terms are used to describe gender identities and expressions that differ from the sex assigned at birth.^{cxli}

Strategic information – what we know and gaps in the data

70. Transgender people are disproportionately impacted by HIV, and data are needed to better understand the transgender population and their relationship to HIV. Estimates for transgender people used to be extrapolated from data on gay men and men who have

sex with men. However, transgender people's lives differ from men who have sex with men in many ways which impact on their relation to HIV.

71. Since 2015 UNAIDS requests data on transgender people, and at a national level, data is increasingly being collected. Vietnam recently successfully piloted sentinel surveillance among transgender women in Hanoi to determine if and how to include that community in their annual sentinel surveys. In Latin America, programme and special surveys data are available and have been well-used in the HIV response. In 2020, the USA CDC released national HIV surveillance system data for transgender people for the first time.^{cxlii}
72. National censuses increasingly collect data on transgender people, but do not necessarily gather HIV related data. India's country wide census in 2011 offered three options for people to declare their sex – male, female or 'other'.^{cxliii} In Pakistan, transgender people were counted in the national census in 2017, although the implementation may have meant they were undercounted.^{cxliv} The UK and Canada in their 2021 census asked if people identified with a gender different from their sex registered at birth. In Bangladesh, a third gender option was included in the national census in 2022, developed in discussion with a Bangladeshi NGO representing sexual and gender minorities.^{cxlv} In the same year, Argentina became the first country in South America to include in their national census a question on if gender identity differed from sex assigned at birth, and gave several options for currently identified gender including 'woman' 'man' and 'non-binary' (neither man nor woman).^{cxlvi} The New Zealand national census of 2023 will include questions on differences between sex assigned at birth and gender identity, after consultation with community organisations on how to do so.^{cxlvii}

Population size estimates

73. Historically, 55 countries have reported estimates of size of transgender populations to UNAIDS. Of these, 15 countries' estimates are recent (2017-2021), covering the whole country and based on probabilistic methods. These include among others Armenia, with an estimate of 1,000 transgender people, Mexico 123,000, Philippines 205,000, South Africa 179,000, and the USA 1 million. A global online survey by Statista found that 2% of respondents from twenty-seven primarily high- and upper-middle income countries identified as transgender or in some way gender diverse.^{cxlviii}

Transgender people and HIV

74. In some settings, up to 58% of transgender women are living with HIV.^{cxlix} Despite HIV incidence rates decreasing among all women by 23% between 2010 and 2019, they did not decrease among transgender women.^{cl} Of countries reporting recent survey data to UNAIDS on transgender people:^{cli}
 - 32 countries reported HIV prevalence among transgender people from surveys. Most reported only on transgender women. Prevalence ranged from 0.5% in Sri Lanka (transgender women only) to 58% in South Africa (transgender women only) with a median of 20.8%
 - 29 countries reported transgender people's awareness of HIV positive status or having been tested in the past year and received their results, ranging from 7.3% in Antigua and Barbuda to 100% in Mali, with a median of 68.4%
 - Only 3 countries reported antiretroviral therapy coverage among transgender people from surveys, ranging from 19.5% in Nigeria (17.6% for transgender men and 19.6% for transgender women), to 97.9% in India, with the median being 34.4% in Indonesia (transgender women only)

- 20 countries reported the percentage of transgender people receiving at least two HIV prevention services from surveys in recent years, ranging from 16% in Guatemala (transgender women only) to 100% in Samoa and in Panama (for both transgender women and transmen), with a median of 54.9%
- Only 4 countries reported in recent years the percentage of transgender people experiencing stigma and discrimination from surveys, ranging from 44% in New Zealand to 91.3% in Azerbaijan (transgender women only).
- 11 countries reported avoidance of health care due to stigma and discrimination among transgender people in recent years from surveys, ranging from 5.5% in Sri Lanka to 67.7% in Azerbaijan, with a median of 8.4% (both aggregates of all transgender people).

Transgender people in all their diversity

75. Transgender people have specific needs and challenges in relation to HIV prevention, treatment, retention and care. They may have feelings of alienation from the sexed bodies they were born with, which means language to communicate about safer sex and prevention needs to be sensitive and appropriate. They may undergo gender affirming surgeries and need tailored advice on healthy sexualities and safer sex.^{clii} If they are taking hormones, PrEP, PEP and ARVs given need to be compatible.^{cliii} They may need gender-affirming care⁸ and prioritise this over HIV. Or they may require no hormones, surgery or medical interventions, but face pressure to undertake these in order to get legal recognition, or to fit gender stereotypes around the gender with which they identify.^{cliv clv}
76. Gender stereotypes, structural obstacles and health services discrimination need to be tackled to enable effective treatment and retention. Universal health coverage should be made available and be inclusive of people who do not conform to expected gender identities and expressions. Gender affirming health care options,^{clvi} mental health support, and harm reduction needs to be integrated with HIV services.
77. Where data exists, it shows high HIV infection rates and low life expectancy in several countries.^{clvii} Lack of data inhibits a comprehensive understanding of why this is the case, and of an evidence-based response. However, it is clear as described above that structural obstacles, criminalization, stigma, discrimination, and violence all play a role. Transgender women also have high levels of involvement in sex work due to work discrimination in education and workspaces, and demand by clients who fetishize transgender women. Transgender sex workers face intersecting stigma and discrimination both for being transgender and for selling sex.^{clviii} Transgender women involved in sex work are more likely than transgender women not involved in sex work to face stigma, violence and abuse, as shown by a study in the Dominican Republic.^{clix}
78. There are particular gaps around data on transgender men,^{clx} who are marginalised in the HIV response.^{clxi} Transgender men are as diverse as other men. Their sexual orientations are diverse, they may have anal or vaginal sex with people of various genders, with or without condoms. Stigma and discrimination can exacerbate their risk of acquiring HIV and other sexual health complications. Mental health issues, social isolation, substance use and low self-esteem are highly prevalent among transgender

⁸ Gender-affirming care can include any of the following: hormone therapy; upper (for example, face, chest, breast) surgery; and/or lower (for example, vaginoplasty, phalloplasty, metoidioplasty, etc.) surgery. ([WHO Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations](#), 2022, p.54)

men. Those factors, along with a perceived need for gender affirmation (seeking social recognition and support for one's gender identity or expression), may make it more difficult for transgender men to negotiate safer sex practices with their partners.^{clxii}

79. Non-binary and gender diverse people who do not identify as either women or men may be absent in HIV data.^{clxiii} In some contexts, non-binary people face pressures from health services and societies to fit stereotypes, either those associated with their sex assigned at birth, or by transitioning to a different gender. These pressures may obstruct access to health care, including HIV. In other contexts, such as South Asia, where non-binary identities such as 'hijra' existed in precolonial times and continue today, there is some legal recognition of genders other than 'woman' or 'man', however discrimination persists.^{clxiv}

Transgender people and intersectionalities

80. Often transgender people have multiple intersecting identities, more than one of which is criminalized. For example, while South Africa's Constitution entrenches the right to housing, some municipal laws effectively criminalize homelessness, exacerbating the impact of stigma and criminalization of other identities. One example of these laws is the Cape Town Streets, Public Places and the Prevention of Noise Nuisances law^{clxv}. Among homeless individuals reporting police abuse to a community organization, a majority were using drugs, a majority were LGBT, over one third were living with HIV, and over one third were selling sex. A testimony from a homeless transgender woman in South Africa is cited below.^{clxvi}

It was on a Friday morning that it happened; the 10 July 2021. Law enforcement came to break down my place that I call home. They came without warning and confiscated my stuff and I couldn't take anything, not even my personal belongings. They surrounded us like we were a bunch of criminals who were on the run. And they just started to confiscate our things. It happened under a bridge. They called us names like 'Moffies' [homophobic insult], and they said we are men, and they will treat us like men. Why do they act this way? They don't know the emotional harm they bring to us by doing and saying all those dehumanising words to us. I did not choose to be a transgender woman; I was born this way. Most of them don't even wear name badges, or they wear them back to front, so I can't even identify them.^{clxvii}

Transgender people in prisons and closed settings

81. High levels of criminalisation and marginalisation mean a disproportionate number of transgender people are in prison. Transgender people are disproportionately more likely to enter into sex work, and experiences of discrimination and "minority stress" lead to a higher rate of drug use among transgender people than the rest of the population. Both sex work and drug use are criminalized in the majority of countries and can lead to incarceration.^{clxviii}
82. Transgender people routinely face humiliation, harassment and abuse from prison staff and law enforcement personnel and fear retaliation should they seek redress.^{clxix} Most countries do not have protocols on how to manage transgender people in prison regarding housing, nutrition, showers, and toilets.^{clxx} No country yet has good practice on HIV and transgender people in prison. UNODC has received requests from some

countries on guidance on what to do. In response they have launched a technical brief on transgender people and HIV and work with GATE to build capacity support transgender people in prison.^{clxxi}

'They see you have breasts. They see you're a "trannie" and as far as they're concerned, it's their right' [to sexually abuse you]- a transgender woman in a prison in Australia talking about other prisoners^{clxxii}

Transgender youth

83. Families may reject children who do not behave according to expected norms of gender, which can impact on young people who are transgender, have same sex sexualities, or simply do not conform to stereotypes. In the USA, one in five transgender individuals have been homeless at some point in their lives. Family rejection, discrimination and violence are part of the cause, with LGBT identified youth making up 20-40% of the more than 1.6 million homeless youth.^{clxxiii} In India, more than 90% of transgender people leave their homes or are thrown out by the age of 15 years. Many live on the street with no money or education, often relying on sex work.^{clxxiv} All these factors can increase risk and impacts of HIV.
84. The key population organisation Youth LEAD partnering with the Asia Pacific Transgender Network conducted a recent situation analysis on transgender youths' access to healthcare in Indonesia, Thailand and the Philippines. More than half (52%) the study participants strongly agreed that they worried about being negatively judged because of their gender identity or sexuality when accessing care. Leo Villar, Youth LEAD's Communications and Project Officer explained that in the face of unfriendly health providers "*The study showed that young people seek knowledge from peers and undergo do-it-yourself treatments. This could lead to incorrect healthcare information and the misuse of hormones or HIV drugs.*"^{clxxv}

I am on hormone treatment, but I don't have a regular health checkup or go to the hospital for diagnoses or blood tests. Often, I must buy it online or through friends without any prescription. I have to switch to a new brand of testosterone since the previous one I have been using was limited in availability because the hormone seller could not travel outside of Vietnam to bring it into the country. The person who has been helping me to inject hormones also went back to his province because of lockdown so I did not have the shot injected on time. – 24 year old Transgender Man, Medical Student, Vietnam^{clxxvi}

Indigenous transgender people

85. Exclusion of indigenous people in settler societies such as USA, Canada and Australia^{clxxvii} compounds discrimination against transgender people, resulting in high levels of violence and violent deaths,^{clxxviii} ^{clxxix} social determinants of ill-health and HIV risk, and higher levels of HIV for indigenous transgender people compared with other transgender people.^{clxxx} Settlers suppressed traditional forms of gender expression and identity, including among Native American/Alaska Native peoples, such as 'two-spirit',⁹ an alternative identity to woman or man. Some indigenous people are reclaiming these identities as a strategy for empowerment and survival.^{clxxxi} ^{clxxxii} In Canada, a project

⁹ Traditionally, Native American two-spirit people were male, female, and sometimes intersexed individuals who combined activities of both men and women with traits unique to their status as two-spirit people. In most tribes, they were considered neither men nor women; they occupied a distinct, alternative gender status. (Indian Health Service, the Federal Health Program for American Indians and Alaska Natives <https://www.ihs.gov/lgbt/health/twospirit/>)

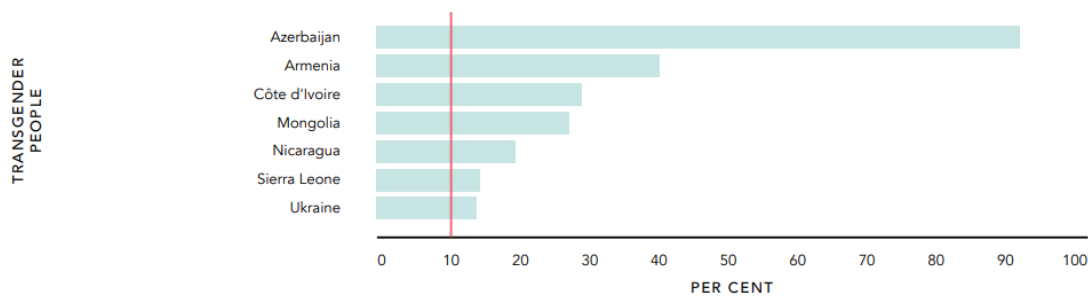
instigated by indigenous elders and academics convened ceremonies, gatherings, reflection sessions, and activities to build kinship and cultural connections and support the self-determination and leadership of Indigenous gender and sexuality-diverse youth.^{clxxxiii} Such strategies are echoed in some post-colonial societies such as Peru, with reclaiming of pre-colonial non-binary identities as part of a broader affirmation of pre-Hispanic cultures.^{clxxxiv}

Transgender people face violence, stigma and discrimination

86. Transgender people around the world face extreme levels of violence which may be on the rise in some contexts.^{clxxxv clxxxvi} They are often bullied at school, rejected by their families, pushed out onto the streets, and denied access to employment. When they are racial or ethnic minorities, or are migrants, living with HIV, or sex workers, they are particularly at risk of violence, including of killing, beatings, mutilation, rape and other forms of abuse and maltreatment. In health care settings, they may be denied care, or subjected to forced psychiatric evaluations, unwanted surgeries, sterilization or other coercive medical procedures, often justified by discriminatory medical classifications. Transgender people can be particularly vulnerable to human rights violations when their name and sex details in official documents do not match their gender identity or expression.^{clxxxvii}

The biggest hurdle we face is for our identity, mostly hospitals and health care centers are doing COVID-19 testing on the basis of citizenship card on which our gender is assigned as male; they don't register us as transgender. If we get a positive result for covid-19, we don't have a quarantine center for us. They put us in male quarantine centers, or they don't admit us at all. The nurses don't give us proper attention and the male patients present in the quarantine center have this weird look on their faces. The discrimination makes us feel depressed and sad. Basera Samajik Sansthan, India^{clxxxviii}

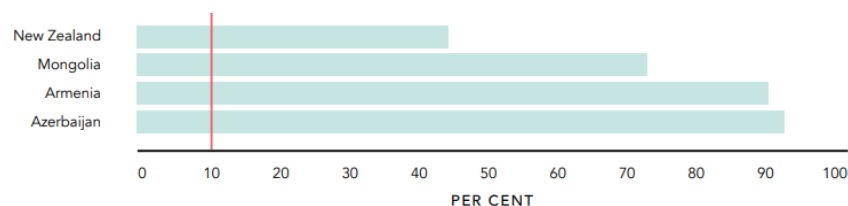
Transgender people reporting having experienced physical and/or sexual violence in the last 12 months, countries with available data, 2017–2021^{clxxxix}



Source: UNAIDS Global AIDS Monitoring, 2022 (<https://aidsinfo.unaids.org/>).

Transgender people reporting experience stigma and discrimination in the last six months, countries with available data, 2017–2021^{cx}

TRANSGENDER
PEOPLE



Source: UNAIDS Global AIDS Monitoring, 2022 (<https://aidsinfo.unaids.org/>).

87. As well as being perpetrated by family or intimate partners, violence takes place within institutions including police,^{cxci} prisons, schools and health services, as shown in these accounts by transgender people from different contexts.

I was slapped in the face by the deputy director of [my] technical college. I can still remember it to this day. He hit me so hard that I fell backwards. He did not only hit me once, you know? It was in front of my friends and a number of teachers were standing by ... He wanted to ridicule me ... ‘You don’t like to be a good man?’, he shouted, and then he hit me: Slap! Slap! Slap! ... He said, ‘Why can’t you behave in a more masculine way?’ That day broke my heart. I lost all motivation to study. Nok, aged 28, Thailand ^{cxcii}

A transgender woman in rural South Africa was gang raped and beaten by five men because of her transgender identity. A friend helped her get to the hospital to receive treatment and preventative HIV care, but the nurse refused to help her after looking at her identity document book and ‘told me to go home and take off my dress’.^{cxci}

Transgender sex workers in Bogota, Colombia tell of murders by paramilitary and violence by police. One woman narrates the extreme strategies they resort to for survival. *I did like this, watch [showing us how she cuts her arm] ... “Touch me and I’ll give you AIDS.” ... The saying is that we trans are the ones who have AIDS ... so you cut yourself, they see you bleeding and no one touches you, they let you die.*^{cxci}

Human Rights

88. The rights of transgender people are established in international human rights law. States have an obligation under international human rights law to protection against discrimination on the basis of gender identity and expression, including protection against discrimination when accessing health services. They must also provide for the legal recognition of a person’s self-identified gender, including for non-binary persons, without additional requirements that may violate human rights, such as surgery.^{cxcv} Where chosen by individuals, they should also have access to gender affirming care^{cxvii} ^{cxviii}. This includes removing laws that criminalize or are used to target people based on their gender identity. Twelve United Nations agencies have called for the removal of HIV-related discrimination in health-care settings.^{cxix}
89. Some progress has been made. The depathologisation of transgender identities is of huge importance. In 2019, the World Health Assembly adopted the eleventh revision of the International Classification of Diseases (ICD-11), which removed transgender related categories from the chapter on mental and behavioural disorders. This reflects current knowledge that transgender related and gender diverse identities are not conditions of mental ill-health, and that classifying them as such can cause enormous stigma.^{cc}

90. Steps forward have also been taken at regional and national levels. The Caribbean Court of Justice ruled in November 2018 that a colonial era law in Guyana, which made it a criminal offence to appear in a public place dressed in the clothing of the opposite sex, is unconstitutional, after a challenge brought by four transgender women in Guyana.^{ccci} Several countries have put in place laws that recognize diverse gender identities and expand the rights of transgender people, such as Uruguay in 2018.^{ccii} Countries like Canada, Chile, Germany, India, Nepal, South Africa reported recognizing a third gender^{cciii}.
91. 22 countries across 7 UNAIDS regions have reported having gender recognition laws or policies enabling legal change of gender. As a requirement to change gender 7 of those countries ask for gender reassignment surgery or application processes, 9 countries only require self-declaration (no medical evidence required), 3 ask for sterilization and 6 ask for a certificate of psychological assessment.^{cciv}
92. In 2012, Argentina became the first country in the world to allow people to officially change their name and gender without requiring permission from a judge or doctor; and without undergoing sex reassignment surgery, hormone therapy or psychological evaluation. The law also establishes the right of all adults to access, should they wish to, partial or comprehensive hormonal treatment and surgery to adjust their bodies, in line with their gender identity, as part of their right to comprehensive health, and on the basis of their informed consent.^{ccv} In 2020 a law was instated that one percent of public sector jobs would be reserved for transgender people.^{ccvi}
93. In addition, some private sector companies also implement transgender inclusion initiatives.^{ccvii}

Community leadership

94. Transgender people are disproportionately affected by poverty and marginalisation and excluded from basic rights such as education, employment, healthcare and sanitation.^{ccviii} Transgender movements have limited access to financial and organizational resources.^{ccix} The information that is currently available suggests that considerable work is needed to achieve the 80% community-led service delivery target for HIV prevention services for key populations. Across countries with available data for 2019–2021, key population-led organizations reached 37% of transgender people (17 countries) with prevention interventions that were designed for them.^{ccx} An analysis of the inclusion of transgender people in HIV national strategic plans found substantial gaps in the inclusion of transgender populations.^{ccxi} To build capacity to provide services, structural obstacles need to be tackled, and transgender people's organisations strengthened.
95. There are important international and regional organisations led by transgender people which tackle structural obstacles as well as working specifically on HIV, many of whom are engaged with UN and global fund processes and provide technical support to HIV programming. Global Action for Trans Equality (GATE) is one of these. They train and mentor trans, gender diverse and intersex activists and organizations on sustainability, organizational development and fundraising,^{ccxii} as well as producing research and advocating for inclusion of transgender people, including transgender men, in the HIV response.^{ccxiii} IRGT, a global network of transgender women and HIV, builds capacity of transgender organisers to contribute to universal health movements^{ccxiv}. At regional levels, organizations such as The Asia Pacific Transgender Network,^{ccxv} Redlactrans,^{ccxvi} ^{ccxvii} in Latin America and the Caribbean, and TGEU in Europe and Central Asia, conduct research, build capacity of transgender organisations and service providers,

and advocate for transgender rights, universal access to health care, and economic inclusion.

V. Examples of what is working and can lead the response for the achievement of the 2025 targets for key populations, especially transgender people

96. The Global AIDS Strategy, 2021–2026 provides a clear, evidence-informed blueprint for getting the AIDS response on track. The world’s governments have pledged to take concrete steps to translate this blueprint into action. No miraculous “silver bullet” is needed: using the tools already at its disposal, the global community needs to translate its commitments into concrete results for people. There is momentum on which to build. Communities of people living with HIV and key populations are generating the context that compels political leaders to take bold and courageous action. ^{ccxviii}
97. To end HIV among key populations we need to: ^{ccxix}
- Address gaps in the data and use the data for an evidence-based response.
 - Optimally resource and scale-up tailored and effective HIV interventions to combat inequalities.
 - Ensure sufficient and sustainable financing for key populations, including supporting and effectively resourcing community-led responses.
 - Address gender inequality, stigma and discrimination, end violence in all its forms, realize human rights and decriminalise.
 - Understand anti-gender movements and their impact on HIV and key populations and support joined up strategies to counter these movements.
 - Address inequalities in HIV prevention, testing and treatment access and outcomes, and close the gaps that exist in specific localities and for and within certain groups.
 - Integrate HIV services with broader health services tailored to and inclusive of key populations.
 - Integrate health and social protection and take whole person approaches which address economic factors and structural obstacles as well as health.
98. Case studies submitted by UNAIDS Programme Coordinating Board members are presented below to illustrate these strategies. No case studies were submitted on countering the anti-gender movement, so these have been drawn from elsewhere. The case studies presented use diverse labels to describe gender and sexual identities, reflecting the diversity of contexts.

Addressing data gaps and using the data for an evidence-based response

99. Quality data is needed for an evidence-based response. Governments need to collect data on key populations. Participatory research by members of key populations can also provide vital and influential information. This section presents case studies of state monitoring of the HIV response for key populations in Morocco, and data collection by a transgender organization in Uganda.

Germany – robust research on sexual health of trans and non-binary communities

100. The Robert-Koch Institut and Deutsche Aidshilfe conducted the ‘Sexual health and HIV/STI in trans and non-binary Communities’ study to generate robust data on the sexual health of these communities, published in May 2023. Results showed barriers

and gaps in the access to medical services in general and to HIV services in particular for trans and non-binary people.

101. The research showed these communities face violence, minority stress, gender dysphoria, and internalized transnegativity impacting on sexual negotiation skills and vulnerability. Consensus and communication in sexuality as well as body affirmation, self-awareness, transition processes, supportive partners and connection to the community have a positive effect on sexual health. Respondents lack trust in medical services due to negative experiences, including obstacles to gender affirming care, as well as assumptions that particular kinds of care are needed, or that transitions must follow a fixed pattern..
102. Recommendations of the study included the need to consider these factors in planning prevention campaigns and (medical) consultations. There is a need for both peer counseling and also training of medical and consulting personnel.

Uganda - Transgender network's needs assessment leads to inclusion in national HIV/AIDS and health sector plans

103. In 2018, Tranz Network Uganda (TNU) conducted a needs assessment in different regions of the country, aimed at providing information and data on challenges transgender people face in accessing SRHR and other health and social services. The needs assessment contributed to a shift in the Ministry of Health to greater recognition of transgender people. The subsequent Uganda AIDS Commission National Key Population Size Estimate Report references the needs assessment study. Transgender specific health data is now being captured in the National Health Management Information System, allowing for more evidence-based engagement with the transgender community. The needs assessment also had a significant impact on HIV/AIDS programming in the country. A revised National HIV/AIDS Strategic Plan 2020/21-2024-25 of the Uganda AIDS Commission and the new Uganda Health Sector Development Plan (HSSIP) 2020/21 – 2024/25, now include transgender people as a key target group for HIV/AIDS interventions.

Morocco - A unique identifier number system enables better monitoring of the HIV response for key populations

104. The national program for the fight against drugs in Morocco (PNLS) has developed, with the support of UNAIDS and the Global Fund, an information system based on each person being given a unique identification code (UIC), for monitoring the coverage cascade of combination prevention programs for key populations. Instead of giving their name, they can give their UIC, which responds to their concerns about confidentiality. Key populations are often hidden and mobile due to the stigma and discrimination they experience. The CIU makes it possible to monitor anyone who has benefited from a prevention or testing, or referral to legal services and human rights bodies. These services offered by 11 NGOs in different regions of Morocco have reached more than 100,000 people since 2014. This system is operational on a web platform, and allows data to be collected on a desktop computer, a tablet or a mobile

phone. The introduction of the UIC since 2014 has strengthened the monitoring capacities of combination prevention programs and improved the quality of data. Actors are able to identify the beneficiaries as well as the services received and to make a cross and precise follow-up of the services provided by the different service providers and in different geographical areas.

Community-led responses

105. Community led responses include community-led advocacy, education, service delivery, monitoring, research and evaluation, empowerment programming, and measures to achieve social enablers. Investing in key population networks is vital to enable these responses and to reach the 30-80-60 targets by 2025.¹⁰ This section presents case studies of transgender advocacy in Ukraine, and global interventions led by women who use drugs, focusing on Kenya and Spain.

Kenya and Spain – Community led integrated and intersectional responses for women who use drugs

106. The Women and Harm Reduction International Network (WHRIN), established in 2009, and led by women who use drugs, works globally on HIV and harm-reduction. In recent work in Kenya, a shelter was provided for women who use drugs to meet the urgent needs of the community as identified by local partners. While not a direct HIV prevention or treatment measure, this shelter meets urgent needs and provides an initial point of interaction to distribute harm reduction and SRHR information and materials. WHRIN together with the Kenyan organization Women Nest, conducted recent research on sex workers who use drugs, including transgender women sex workers. This is ground-breaking in the context of exaggerated siloing of services that do not match the intersectional realities of people's lives. In Spain, an integrated service provides harm reduction interventions within a holistic framework for women in all their diversity to engage in safer drug use practices, as well as providing a community space for personal development. The provision of SRHR services together with harm reduction services provides a rounded approach to HIV prevention where people are not siloed by key population group or type of intervention enabling, for example, trans people who use drugs and sex workers who use drugs, to access harm reduction services along with other forms of HIV prevention they need.

Ukraine - Transgender advocacy for more inclusive health services

107. Since 2021 the Ukrainian transgender people's organization "Cohort" has conducted national level advocacy, with the support of the Alliance for Public Health and with financing from the Global Fund. They advocate for the approval and change of relevant legislation, practices and policies, and the introduction of transgender competent medical services and services. Results to date include a representative of the transgender community being elected to the National Country Coordinating Mechanism

¹⁰ Adopted by member states in the Global AIDS strategy and 2021 HLM Political Declaration – that by 2025, communities will deliver 30% of testing and treatment services, 80% of HIV prevention services and 60% of programmes support the achievement of societal enablers.

(CCM); a working group on the needs of the transgender community being created in the National CCM; conferences with doctors on the topic of transgender competent medical care being held and a database of doctors created; The Standards of Care for Transgender People from the World Professional Association for Trans*People Health (WPATH) being translated into Ukrainian for use in the creation of new protocols by the Ministry of Health.

Building social enablers

108. Societal enablers are structural and systemic factors, including legal, cultural, social and economic, that are critical to the effectiveness of the AIDS response, including law reform, access to justice, protection from stigma, discrimination, violence and harmful gender norms. Implementing them removes barriers in access to health services and enable individuals and communities to better protect their health and well-being.^{CCXX} This section presents case studies which make state benefits and protections more inclusive in Indonesia and Colombia, and respond to human rights crises, murder and death threats faced by sex workers in Peru.

Indonesia – Enabling transgender people to access id cards and citizenship rights

109. In Indonesia, many transgender people leave their homes undocumented at a youthful age due to family rejection. They lack the necessary administrative documents to obtain a citizenship ID card, which is needed to access public services, such as national health insurance and social protection, and to open a bank account. In April 2021, several civil society organizations successfully advocated to the Citizenship and Civil Registry Department of the Ministry of Home Affairs to provide transgender individuals with equal opportunities to obtain citizenship documents, who agreed to assist in the administration registry of the transgender population. In different regions, enthusiastic community focal points helped peers engage with offices, and coordinated with bureaucracies, and the Indonesian government reached out. In July 2021, the responsible department of the Ministry of Home Affairs issued a Circular Letter regarding registration and citizenship documents for transgender people. This letter was sent to all Indonesian provincial and district population and civil registry offices. By the end of 2022, a total of 897 transgender individuals in seven provinces had obtained an ID Card, 116 individuals had registered with the employment security fund, and 20 individuals had registered with national health insurance. This is an ongoing initiative and it is likely that these numbers will rise.

Colombia – Venezuelan transgender migrants regularize immigration status

110. The Temporary Protection Statute for Venezuelan Migrants (ETPMV) allows Venezuelan migrants who wish to remain in Colombia to regularize their immigration status and access rights and services, enhancing processes of social, economic and cultural integration. Allowing transgender people to use their chosen name and gender in registering for immigration regularization facilitates access to health and protection services, including diagnosis and treatment of HIV infection. UNFPA - with the Ministry of Justice, the Presidency of the Republic, Colombia Migration and the Superintendence of Notaries and Registration - designed a guide for notaries that

provides education on sex, gender, and transgender identity. It outlines the procedure that must be carried out to allow transgender migrants to access the ETPMV with their name and gender identity. However, lack of resources creates a bottleneck limiting capacity to carry out social mobilization and education around the document, both for key populations as well as immigration offices.

Peru – An emergency response for sex workers facing death threats

111. Since January 2023, more than 10 Peruvian and migrant sex workers (cis and transgender) have been victims of sexual violence, torture, murder, kidnapping, and extortion by mafia that is taking control of the sex trade in the downtown streets of Lima, conducting a territorial dispute, which is extending to other Peruvian provinces, and crossing borders to Ecuador and Colombia. All assassinations had the same modus operandi, the killers filmed the murders using the victim's cellphone and sent the video to other sex workers in her social networks with life-threat messages. This is compounded by persecution by local authorities and national police, even though independent sex work is not illegal in Peru.
112. UNAIDS with sex workers' leaders put in place an emergency strategy to save the lives of those sex workers under threat, establishing an emergency fund, jointly managed by two transgender and sex worker networks, to relocate them to safe places and attend their basic needs. Additionally, WFP-UNAIDS activated an emergency cash-based transfer program (CBT) to attend their food insecurity and protect the adherence to ART of those living with HIV. A medium term response includes a protocol jointly developed between the Defender's Office of the Ministry of Human Rights and Justice and sex worker leaders, aiming to train Public Defenders to provide services tailored to their special needs. A case to denounce the systemic gender-based violence transgender and cisgender sex worker communities are victims of in Peru has been submitted to the Inter American Commission on Human Rights.

Understanding and countering anti-gender movements

113. Anti-gender movements are having serious impacts on key populations as well as societies more broadly, and undermining the social enablers which give strength to the HIV response. Several institutions and organisations are engaged in efforts to understand the anti-gender movement's impacts, and to join up strategies to counter these movements. These include the United Nation's Independent Expert on Sexual Orientation and Gender Identity, European Parliamentary Forum,^{ccxxi} Sexuality Policy Watch, Global Philanthropy Project, Open Democracy, Political Capital, Projekt:Polska, the Global Network of Sex Work Projects, and Global Action for Trans Equality as well as academic institutions such as the London School of Economics and Political Science. Two of these efforts are presented below.

We must seriously ask ourselves why we have failed to foresee what was coming? Why we have been repeatedly taken by surprise? Although there may be many other responses for this question, one of them seems to be that, by and large, we had not entirely realised the scope and scale of the 'conservative revolution' and how gender and sexuality are indeed...at the core of its political project. Sonia Corrêa, Sexuality Policy Watch, Brazil^{ccxxii}

Global Philanthropy Project – Donor collaborations and cross-movement alliances needed to counter anti-gender movements^{ccxxiii}

114. In early 2020, Global Philanthropy Project developed two related pieces of research: 1) a report mapping the funding of the global “anti-gender ideology” or “anti-gender” movement, and 2) a report mapping the progressive philanthropic response. They find that progressive movements and their philanthropic partners are being outspent by hundreds of millions of dollars each year, and the institutions providing anti-gender funding have developed sophisticated and coordinated systems to learn, co-fund, and expand their influence. The philanthropic community is called to recognize the scale of the fight and to work together and engage in collective learning, spending power, and institutional knowledge. An explicit strategy is needed to counter anti-gender movement, which will require collaboration between donors, and between movements – women’s rights, LGBTI, SRHR, and youth, as well as outreach to technology, journalism, economic justice, democracy and governance.

Global Action for Trans Equality (GATE) - Increasing capacity of trans, gender diverse and intersex communities to respond to anti-gender movements^{ccxxiv}

115. Across the globe, trans, gender diverse and intersex (TDGI) people are being targeted by anti-gender movements operating at the social, political and institutional level. GATE has published 8 reports on anti-gender opposition and the impact on transgender and LGBT Movements. GATE’s analysis shows that anti-gender movements are growing in power and geographical reach and becoming more successful in pushing back against the hard-won gains by the LGBT communities. GATE is focused on increasing the capacity of trans, gender diverse and intersex communities to respond to anti-gender movements operating at the international, regional and national levels. GATE draws upon international human rights laws and policies to build a strategy to protect trans, gender diverse and intersex communities. GATE’s report *The Impact of Regional and International Human Rights Mechanisms on Trans Rights: A Review*^{ccxxv} outlines positive progress in transgender rights. Looking at how human rights mechanisms are dealing with gender identity-related issues, it is designed to assist activists, policymakers, and other stakeholders in understanding how international and regional human rights standards can be an asset in their fight against anti-gender actors and their narratives.

Reducing inequalities in HIV services

116. This section presents two case studies which tailor services to key populations and make broader health care systems friendlier and more accessible – both of which can contribute to reducing inequalities in HIV services.

India – HIV services tailored to transgender and hijra people and men who have sex with men

117. The Samarth civil society programmes, since 2016, run community based clinics and outreach to gathering sites such as community brothels, hostels, private party venues, hourly rented places and massage parlours. People coming to the clinics are offered early HIV tests and immediate linkages to treatment and are also able to access a variety of harm reduction, hepatitis, sexual and reproductive health rights services,

along with legal support. This intervention has contributed to establishing a service network distinctive to the needs of MSM (men who have sex with men) and TGH (transgender and hijra) people with sexualized substance use history. The project has linked HIV positive people from these communities to national care systems helping them obtain transgender certificates and ID cards needed to access government supported services, such as health insurance and educational scholarships. From April 2022-March 2023; under Samarth program phase 3, 2641 individuals (1862 MSM and 779 TGH) were tested for HIV and among them 248 (200 MSM and 40 TGH) were found reactive. 241 PLHIV were linked with ART treatment (202 MSM and 39 TGH) with a low lost to follow up rate. Additionally, 68 individuals (59 MSM and 9 TGH) were linked with harm reduction programmes.

Zimbabwe – Lesbian and bisexual women, trans men, and non-binary people access health care

118. Queer women and other female bodied persons (QWF-bP) are excluded from sexual and reproductive health information which assume all female bodied people are heterosexual and cisgender. Many QWF-bP avoid gynaecological check-ups because they find these distressing and service providers discriminate. Reproductive tract infections remain untreated, and they also face health service barriers regarding HIV, hepatitis, HPV and cervical cancer. In 2021, Zimbabwe's Rise Above Women Organisation (RAWO), a civil society group, started hosting SRH clinics, specifically designed for QWF-BP to access friendly, gender sensitive, people centered and comprehensive HIV/SRH. These have reached a total of 400 QWF-bP, 80% of whom were under 25 years of age and had never presented for SRH services before. RAWO also trained healthcare workers. The Zimbabwe National AIDS Council is now facilitating a Memorandum of Understanding with key clinical service providers to apply a lesbian, bisexual and queer women lens. RAWO participated in the National AIDS Council Needs Assessment to establish the gaps surrounding service delivery to QWF-bP. Data will feed into the National strategies and policies on HIV and healthcare programming.

Integrating HIV and broader health services

119. Key populations often face stigma and discrimination barriers to health access. HIV specific programming may address some health care needs, but they may remain excluded from broader health services. Without compromising differentiated service delivery and tailoring, HIV services need to be better integrated with primary health care, pandemic preparedness, sexual and reproductive health services, harm reduction and gender-affirming and inclusive care into HIV services. Two case studies which seek to make broader health services more inclusive of key populations and their HIV needs are presented below.

Jamaica – A National Transgender Health Strategy for trans-competent and trans-friendly public health services

120. UNFPA Caribbean collaborated with Transwave Jamaica, a trans-led, trans-focused civil society organisation, to develop a National Transgender Health Strategy. The transgender population reported substantive barriers to healthcare, housing, and

access to basic social amenities because of discrimination against their gender identity or expression. Almost one-third had some form of disability and one-third were living with HIV. The Transgender Health Strategy aims to make public health services more trans-competent and trans-friendly and aligns with the National HIV National Strategic Plan for HIV/STI 2020 -2025, as well as with the UNAIDS 2025 targets. Initial results include building of trans-competence capacity among mental health service providers, and more trans-inclusive referral pathways for social protection and gender-based violence services. An Accompanying Advocacy Strategy was developed to influence human rights based legislation and social, educational, health and economic policies.

Kenya – Making universal health coverage more inclusive of transgender people and men who have sex with men

121. Kenya has adopted Universal Health Coverage (UHC) with an aspiration that all persons in Kenya will be able to use the essential services they need for their health and wellbeing through a single unified benefit package without the risk of financial catastrophe. This includes the Transgender community. HIV and AIDS People Alliance of Kenya (HAPA) uses peer outreach together with county public health service providers, to deliver information and services to virtual and physical hotspot sites where men who have sex with men and transgender people meet partners. HAPA does home visits to support adherence for transgender people living with HIV. HAPA works with social workers and mental health counsellors to provide psychosocial support group for PLHIV. HAPA reached 254 transgender and 5289 MSM individuals with a defined package of service by March 2023, supporting them to test, treat, initiate PrEP, report human rights violations, and engage in income generation activities.

Brazil - Establishing channels for delivery of healthcare services to transgender and travesti¹¹ people in the state of São Paulo

122. Brazil recognizes people's rights to change their name and gender without requirements of surgery, hormone therapy or psychological evaluation. They also recognize gender affirming health care as a right, and this is provided free under the public health care system. In 2023, the state of Sao Paulo in Brazil established 30 new comprehensive health services in 26 cities targeting transgender and travesti. These services are integrated into a network comprising primary healthcare, specialized services in STI/AIDS, endocrinology, mental health, laboratory and pharmaceutical services, as well as surgical gender transition services, and combined strategies to prevent and diagnose STIs and HIV, including through PEP and PrEP. This network has provided gender transition services to 2,633 transgender and travesti people, of whom 1,247 are transgender women, and 1386 transgender men. An additional 25 cities are in the process of implementing new services and organizing channels for the delivery of these services.

¹¹ Some people in Latin America who are assigned male at birth and have a feminine gender identity identify as *travesti*

123. The expansion of comprehensive healthcare services to transgender and travesty people contributes to reducing their vulnerability to STIs and HIV, in addition to reducing the psychological suffering resulting from exclusion.

Integrating health and social protection

124. Whole person approaches are needed which address economic factors as well as health and structural obstacles, and which integrate social protection with the HIV responses. Two case studies which begin this integration are presented below.

Guyana – Combining public assistance with HIV services for people living with HIV

125. One of the key programs that provide public assistance to PLHIV in Guyana is the National AIDS Programme Secretariat (NAPS) under the Ministry of Health. Through NAPS, PLHIV can access free antiretroviral therapy (ART) and other essential medicines, as well as receive counselling and psychosocial support services. In addition to NAPS, several NGOs in Guyana deliver public assistance to PLHIV. The Society Against Sexual Orientation Discrimination (SASOD), is one of the NGOs providing public assistance, helping public assistance programming to better include LGBT. In one year of the programme, over 3500 people applied for public assistance, 2150 received assistance of US\$75/ month including children, key populations and other vulnerable groups. All Children are given a one-time grant of \$500.

Luxembourg – Holistic support for drug users stems HIV outbreak

126. In 2014 an outbreak of HIV infections among people who inject drugs (PWID) started in Luxembourg. Despite one supervised drug supervision facility, several harm reduction agencies, and free access to opioid substitution therapy and needle/syringe exchange in the country and including in prisons, 68 new diagnosis of HIV infection among PWID occurred between January 2013 and December 2017. Injecting cocaine was found to be a key risk factor related to HIV infection in PWIDs. Women were highly represented in cocaine users (38%) reporting trading sex for drugs or money. 30% of cocaine users had no social security coverage, and 28% were homeless.
127. An outreach program combined with several structural interventions and policies were launched under the umbrella of the national HIV action plan to test PWID for infectious diseases and link to care. Community-based projects to expand hepatitis C testing and access to treatment for drug users were conducted at drug treatment sites and in prisons. Luxembourg was the first country to reach the WHO target of 200 syringes per PWID per year in 2019. The By Pass center was opened in 2020 to allow PWID and especially women sex workers to have access to safer use/safer sex material and hygiene and care products. A housing facility dedicated to women was open in 2023 and another one will be restored to accommodate PWID for medical care by 2024. Community-based testing and linkage to holistic care have successfully stemmed the outbreak among drug users.

VI. Ways forward - Recommendations for reducing health inequities through tailored and systemic responses for key populations, especially transgender people.

128. **Use strategic information to guide action** - Address gaps on population size estimates and expand disaggregated data on key populations including the particular

gaps on transgender populations. Support community-led data generation and use data effectively to guide an evidence-based response. Use data to identify where stigma and criminalisation obstruct access to services by key populations.

129. **Optimally resource and scale-up tailored and effective HIV interventions to combat inequalities.** Increase substantially prioritization and investments in combination HIV prevention packages for key populations. Scale-up HIV prevention, testing and treatment programmes and services that are tailored to address the diverse needs, circumstances and preferences of key populations, especially transgender people.
130. **Ensure sufficient and sustained funding for key populations** - Increase funding for the HIV response for key populations. Prioritize funding for most effective interventions based on evidence and human rights. Scale up existing effective interventions. Establish mechanisms to increase and facilitate funding and establish sustainable financing for community-led organizations, including for those led by key populations.^{ccxxvi}
131. **Support community-led responses** - Increase the proportion of HIV services (prevention, testing and treatment and for societal enablers) led by key populations (30/80/60 targets), especially for HIV/STI prevention. Include key populations especially transgender people in governance mechanisms and decision making for health. Support community-led monitoring and research considering context and needs of each key population. Integrate community-led responses to national HIV responses. Build capacity of key population communities, supporting intersectional work and solidarity. Invite their organisations to build capacity of HIV responders.
132. **Understand and counter anti-gender movements** - Build on and support the research within institutions, NGOs and academia, including that led by communities, to better understand and anticipate this movement, and its impacts on HIV and key populations. Develop and fund collective strategies to counter anti-gender movements. Build donor coalitions, and cross-movement and cross-sectoral alliances, including with inclusive faith-based responses.
133. **Build societal enablers** - Address gender inequality, stigma and discrimination affecting key populations especially transgender people in all sectors. End violence in all its forms. Realise human rights. Review and reform harmful criminal laws and end punitive use of laws. Remove death penalties and forced sterilization of LGBT. Monitor progress on decriminalization and conversion therapy.
134. **Address inequalities and make health services inclusive, tailored and integrated** - Expand tailored HIV services for key populations. Address inequalities in HIV prevention, testing and treatment access and outcomes, and close the gaps that exist in specific localities and for and within certain groups. Tackle gender stereotypes in health services discrimination to enable effective treatment and retention. Improve health sector governance and integrate HIV services with other health services, including for sexual and reproductive health, STIs; gender-affirming care, harm reduction, occupational and mental health. Implement ICD 11's depathologisation of transgender.

135. **Integrate health services with social protection** - Take whole person approaches which address economic factors as well as health and structural obstacles. Integrate social protection with health and HIV responses. Make education, welfare, and social protection systems more inclusive of key populations, and people who do not conform to expected gender identities and expressions. Enable transgender people to access services, without discrimination, using their self-identified gender.

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