3
Services


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

What's in this chapter?

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

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

3.1 Introduction

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

Box 3.1

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

Essential health-sector interventions

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

Essential strategies for an enabling environment

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

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

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

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

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

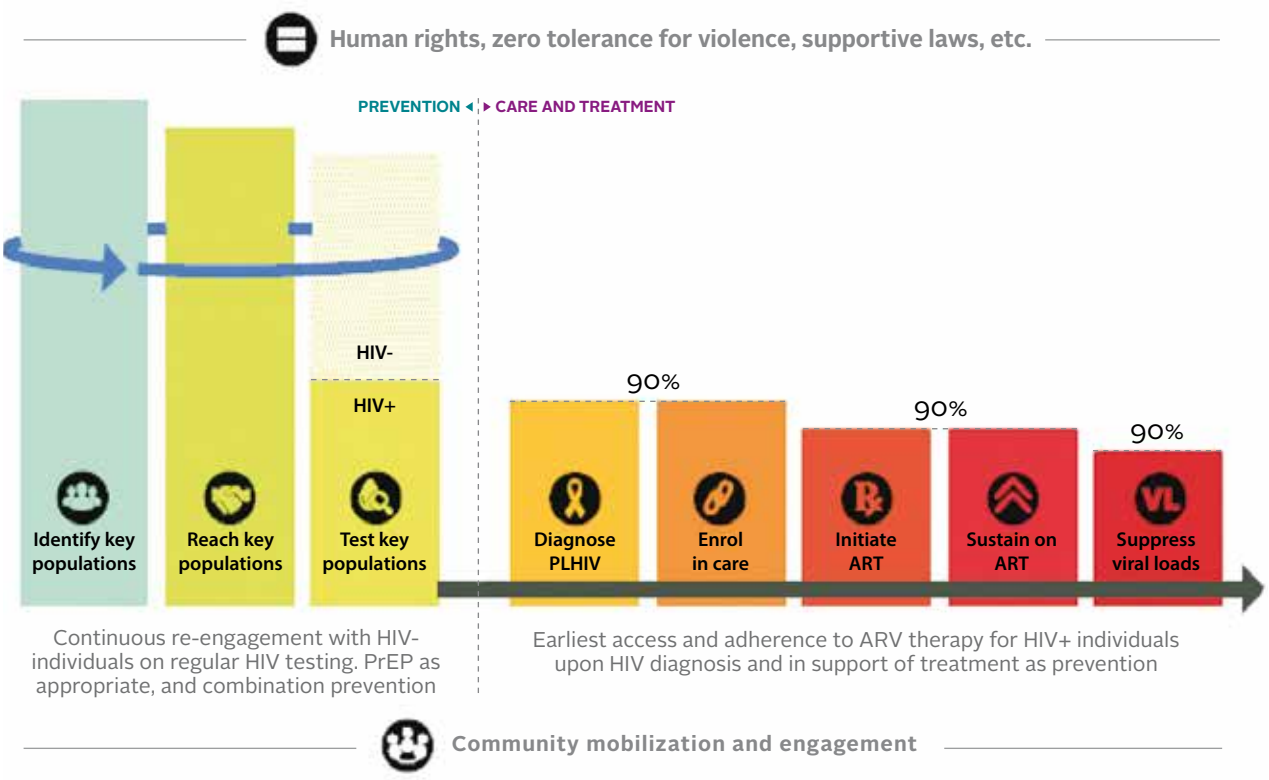
3.1.1 The HIV prevention, diagnosis, treatment and care continuum

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

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

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

Figure 3.1 HIV prevention, diagnosis, treatment and care continuum



Source: FHI 360/LINKAGES

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

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

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

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

3.2 Trans-competent health services

3.2.1 Principles for providing trans-competent health services

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

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

3.2.2 Primary care

2014 Key Populations Consolidated Guidelines[5]

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

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

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

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

Box 3.2

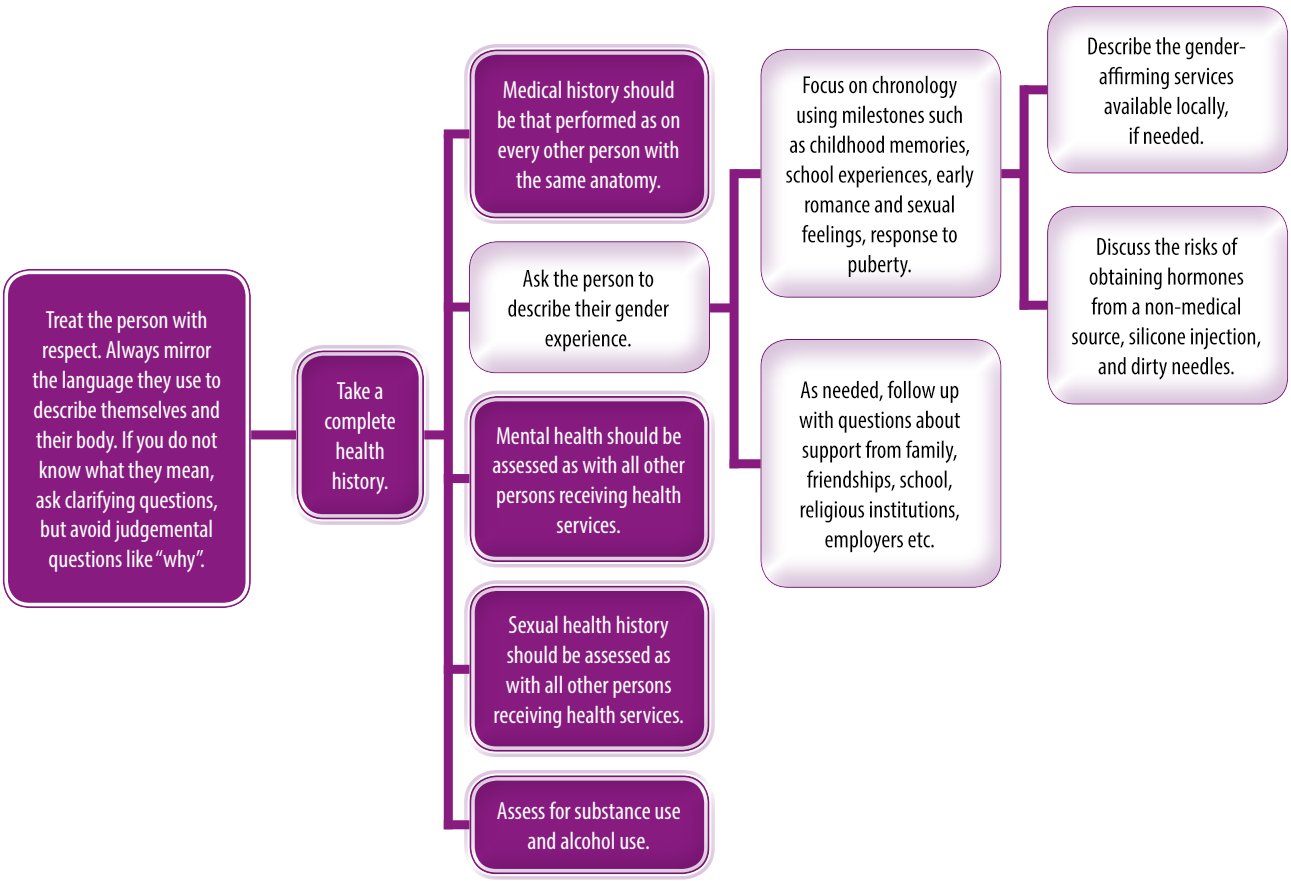
Recommended treatment protocols and guidelines for trans-competent health care

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

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

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

Figure 3.2 Flowchart for a trans-competent health assessment



3.2.3 Gender-affirming health services

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

Box 3.3

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

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

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

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

www.cliniq.org.uk

Hormone therapy

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

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

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

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

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

Surgical procedures

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

Table 3.1 Gender-affirming surgeries

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

3.2.4 Coding

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

Box 3.4

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

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

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

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

3.2.5 Life course

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

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

Childhood

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

Adolescence

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

Adulthood

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

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

Older adults

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

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

Surgical procedures for gender affirmation may not be feasible for older trans persons due to physical wellness requirements. Older trans people desiring surgical procedures should discuss specific procedures, physical requirements and recovery periods with the surgeon to ensure safety and efficacy.

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

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

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

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

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

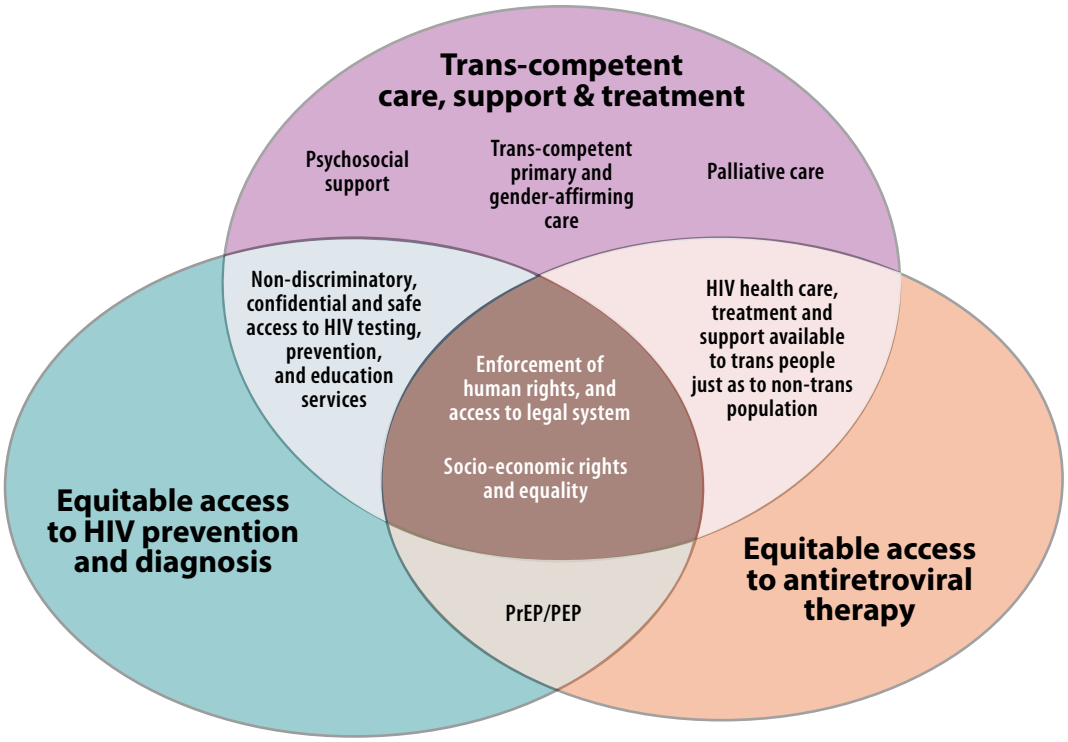
Source: WHO, 2014; WHO, 2013; WHO, 2012; WHO, 2008.

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

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

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

Figure 3.4 Ecosystem of care, support and treatment



Box 3.5

Case example: Integrating clinical and community services in El Salvador

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

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

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

3.3.1 Condoms and lubricants

2014 Key Populations Consolidated Guidelines

ALL KEY POPULATIONS

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

TRANS PEOPLE

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

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

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

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

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

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

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

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

3.3.2 Pre-exposure prophylaxis (PrEP)

2015 ART and PrEP Guidelines[11]

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

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

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

Implementation considerations

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

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

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

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

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

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

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

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

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

3.3.3 Post-exposure prophylaxis (PEP)

2014 Key Populations Consolidated Guidelines

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

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

WHO Recommendations for PEP[13]

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

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

PEP is not indicated when:

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

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

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

Treatment regimen

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

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

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

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

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

3.3.4 Harm reduction interventions

2014 Key Populations Consolidated Guidelines

ALL KEY POPULATIONS

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

TRANS PEOPLE

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

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

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

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

Soft-tissue fillers

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

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

Botox

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

Hormones

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

Box 3.6

Case example: A self-injection workshop in the USA

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

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

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

www.callen-lorde.org

Alcohol and substance use

2014 Key Populations Consolidated Guidelines

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

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

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

Box 3.7

Substance use screening tools

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

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

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

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

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

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

3.3.5 Sexual and reproductive health

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

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

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

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

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

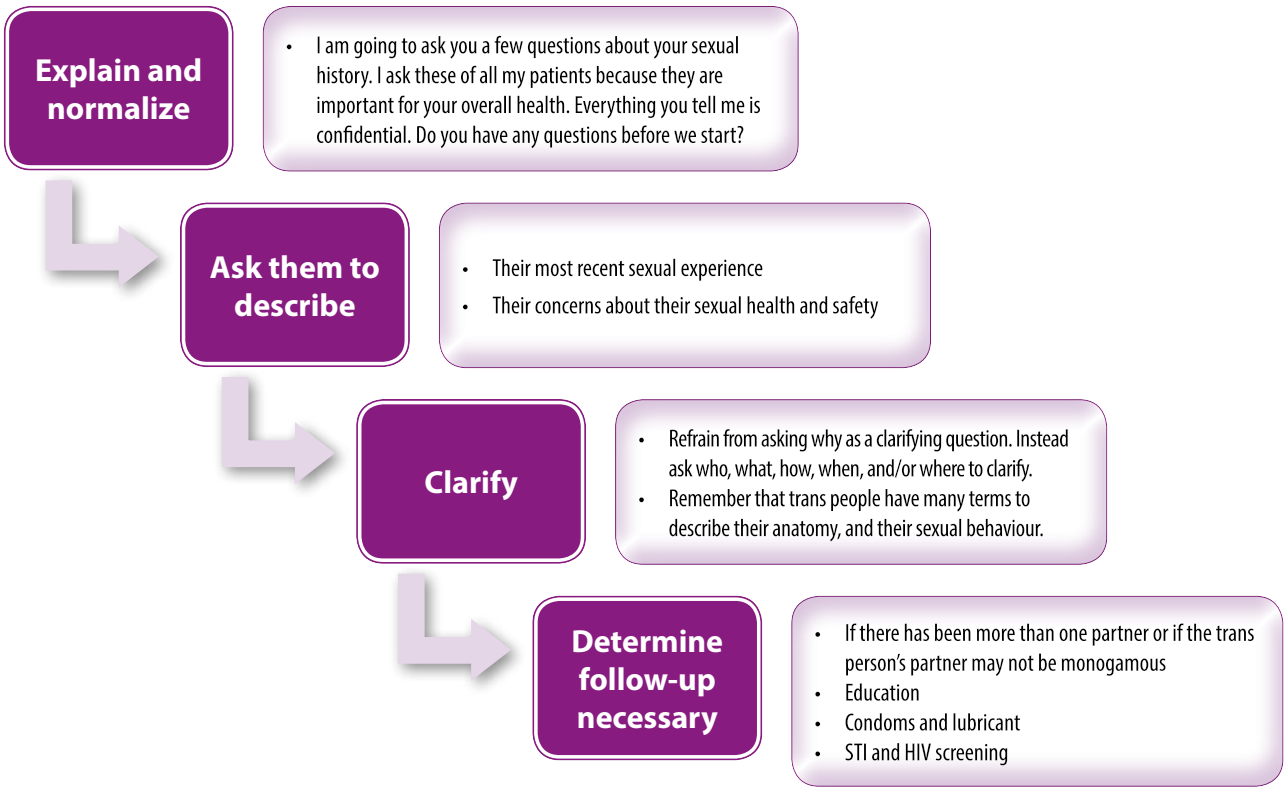
Sexual-health history

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

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

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

Figure 3.5 Sexual-health history taking



Fertility considerations

> **2014 Key Populations Consolidated Guidelines**
>
> It is important that contraceptive services are free, voluntary and non-coercive for all people from key populations. *(p.81)*

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

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

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

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

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

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

Hormonal contraceptives

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

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

Box 3.8

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

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

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

www.nzpc.org.nz

3.3.6 Sexually transmitted infections

2014 Key Populations Consolidated Guidelines

ALL KEY POPULATIONS

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

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

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

TRANS PEOPLE

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

Screening

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

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

Box 3.9

STI treatment guidelines

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

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

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

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

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

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

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

3.3.7 HIV testing services

2015 WHO HIV Testing Services Guidelines[16]

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

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

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

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

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

Box 3.10

The range of HIV testing services

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

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

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

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

Box 3.11

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

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

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

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

Box 3.12

Case example: Self-testing in China

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

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

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

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

Box 3.13

Good practices in linking HIV positive clients to treatment and care

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

3.3.8 HIV treatment and care

2015 ART and PrEP Guidelines

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

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

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

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

Specific considerations for trans clients and ART

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

3.3.9 HIV and hormonal therapy

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

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

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

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

Antiretroviral drugs may interact with the hormones found in oral contraceptives (ethinyl estradiol particularly) which trans women often use for feminization, especially where safer formulations of estrogen (17-β estradiol) are unavailable or more expensive. These interactions have the potential to alter the safety and effectiveness of either drug. In particular, when ethinyl estradiol is used in combination with ARV drugs there may be an increased risk of blood clots. However, current WHO contraception guidelines conclude that no drug interactions between hormonal contraceptives and currently recommended ART or PrEP are significant enough to prevent their use together.

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

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

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

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

Viral hepatitis

2014 Key Populations Consolidated Guidelines

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

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

When treating viral hepatitis among trans people taking hormones for gender affirmation, it is important to screen for interactions between hormone therapy and hepatitis medications. Due to

the more rapid progression of hepatitis-related liver diseases in people infected with HIV, treatment for hepatitis and HIV should be prioritized in people who are co-infected.

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

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

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

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

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

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

Tuberculosis

WHO HIV and TB Recommendations

ALL KEY POPULATIONS

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

TRANS PEOPLE[18]

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

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

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

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

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

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

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

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

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

Violence

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

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

Box 3.14

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

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

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

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

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

Mental and psychosocial health

2014 Key Population Consolidated Guidelines

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

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

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

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

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

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

Box 3.15

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

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

www.lgbtihealth.org.au/mindout

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

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

Box 3.16

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

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

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

www.transfeminists.org

Trauma

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

Box 3.17

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

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

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

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

Depression and anxiety

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

Box 3.18

Screening tools for depression and anxiety

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

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

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

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

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

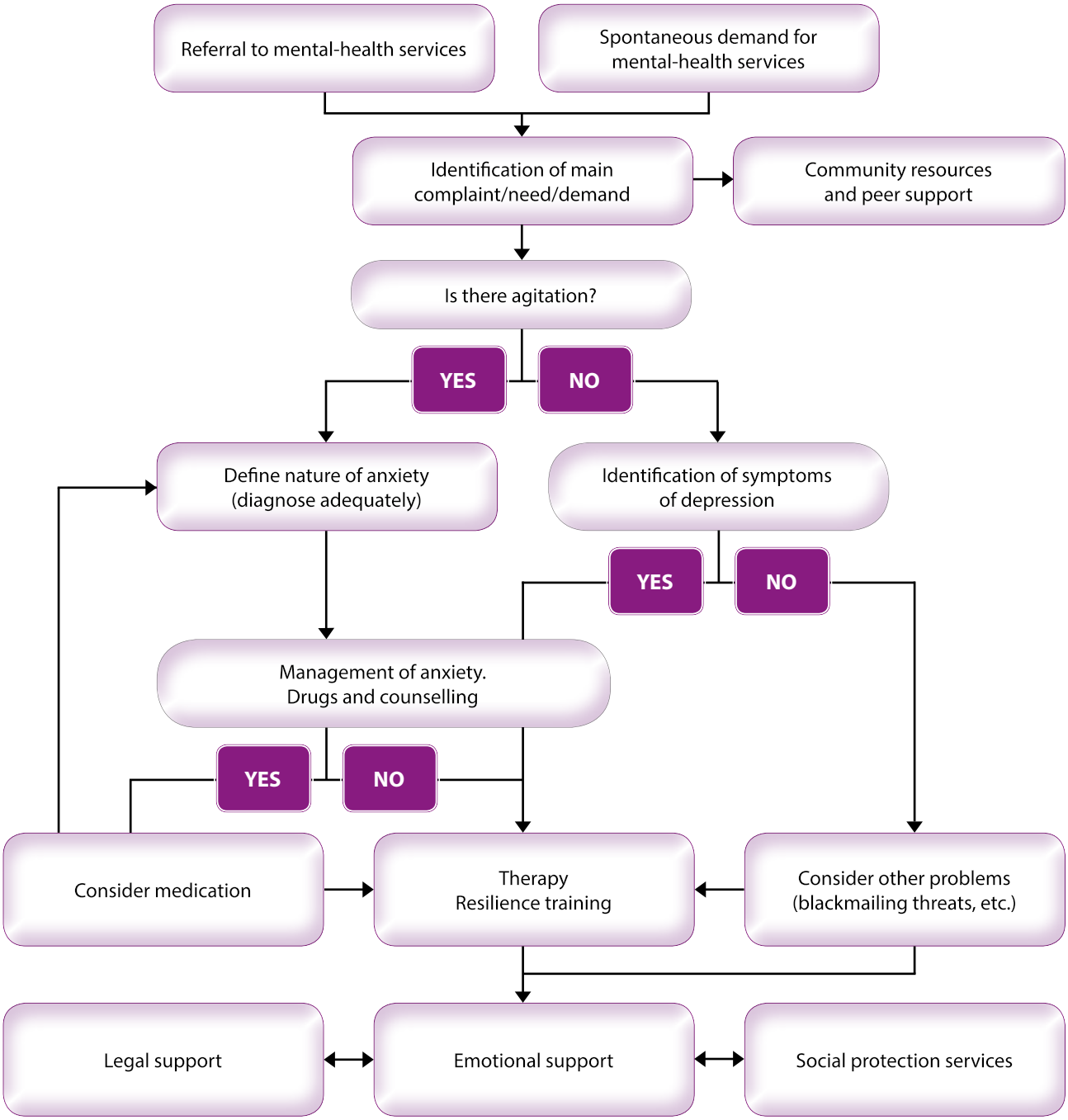
The **Beck Anxiety Inventory (BAI)** is a well-accepted self-report inventory to measure the severity of anxiety in adults and adolescents. It is available at:

http://www.pearsonclinical.com/psychology/products/100000251/beck-anxiety-inventory-bai.html

Minority stress

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

Figure 3.6 Management of minority stress



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

3.4 Resources and further reading

General

1. Policy brief: transgender people and HIV. Geneva: World Health Organization; 2015. http://www.who.int/hiv/pub/transgender/transgender-hiv-policy/en
2. Blueprint for the provision of comprehensive care for trans persons and their communities in the Caribbean and other Anglophone countries. Arlington (VA): John Snow, Inc.; 2014. http://www.who.int/hiv/pub/transgender/blueprint-trans-paho/en
3. Por la salud de Las personas trans Elementos para el desarrollo de la atención integral de personas trans y sus comunidades en Latinoamérica y el Caribe. Washington (DC): Pan American Health Organization; 2014. http://www.paho.org/arg/images/gallery/Blueprint%20Trans%20Espa%C3%83%C2%B1ol.pdf
4. Blueprint for the provision of comprehensive care for trans people and their communities in Asia and the Pacific. Washington (DC): Futures Group, Health Policy Project; 2015. http://www.asia-pacific.undp.org/content/rbap/en/home/library/democratic_governance/hiv_aids/blueprint-for-the-provision-of-comprehensive-care-for-trans-peop.html
5. Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach. Geneva: World Health Organization; 2011. http://www.who.int/hiv/pub/guidelines/msm_guidelines2011/en
6. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2014. http://www.who.int/hiv/pub/guidelines/keypopulations/en
7. Reisner SL, Lloyd J, Baral SD. Technical report: the global health needs of transgender populations. Arlington (VA): USAID's AIDS Support and Technical Assistance Resources, Task Order 2 (AIDSTAR-Two); 2013. http://www.aidstar-two.org/upload/AIDSTAR-Two-Transgender-Technical-Report_FINAL_09-30-13.pdf
8. Hormonal contraceptive methods for women at high risk of HIV and living with HIV. Geneva: World Health Organization; 2014. http://www.who.int/reproductivehealth/publications/family_planning/HC_and_HIV_2014/en

Primary care

9. Primary care protocol for transgender patient care. San Francisco (CA): Center of Excellence for Transgender Health, University of California, San Francisco; 2011. http://transhealth.ucsf.edu/trans?page=protocol-00-00
10. Standards of care for the health of transsexual, transgender and gender nonconforming people, Version 7. World Professional Association for Transgender Health. http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351

Hormone protocols

International

11. Refer to WPATH Standards of Care (10 above).

Europe

12. UK (NHS): Guidance for GPs, other clinicians and health professionals on the care of gender variant people. London: Department of Health; 2008. http://www.gires.org.uk/assets/DOH-Assets/pdf/doh-guidelines-for-clinicians.pdf
13. UK (NHS): Interim gender dysphoria protocol and service guideline 2013/14. London: Department of Health; 2013. http://www.england.nhs.uk/wp-content/uploads/2013/10/int-gend-proto.pdf

Canada

14. Guidelines and protocols for hormone therapy and primary health care for trans clients. Ontario: Sherbourne Health Centre & Rainbow Health Ontario; 2015. http://www.trans-health.com/2015/rainbow-health-guidelines
15. Endocrine therapy for transgender adults in British Columbia: suggested guidelines. Vancouver (BC): Transcend Transgender Support and Education Society & Vancouver Coastal Health; 2006. http://www.shb-info.org/sitebuildercontent/sitebuilderfiles/guidelines-endocrine.pdf

USA

16. Refer to Center of Excellence Primary care (9 above).
17. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2009;94(9):3132–3154. http://press.endocrine.org/doi/pdf/10.1210/jc.2009-0345
18. Protocols for the provision of hormone therapy. New York (NY): Callen Lorde Community Health Center; 2014. http://issuu.com/callenlorde/docs/tg_protocols_2014_v.5/1?e=8526609/10794503
19. Tom Waddell Health Center protocols for hormonal reassignment of gender. San Francisco (CA): Tom Waddell Health Center; 2013. https://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransGendprotocols122006.pdf
20. Transgender cross-sex hormone therapy use. Washington (DC): Veterans Administration; 2012. http://www.pbm.va.gov/clinicalguidance/clinicalrecommendations/transgendercarecrosssexhormonetherapyfeb2012.doc

Asia Pacific

21. Refer to Asia Pacific Blueprint (4 above).
22. Gender reassignment health services for trans people within New Zealand: good practice guide for health professionals. Wellington: Ministry of Health; 2012.

http://www.health.govt.nz/system/files/documents/publications/gender-reassignment-health-services-for-trans-people-in-nz-v3oct14.pdf

Caribbean

23. Refer to Caribbean Blueprint (2 above).

Latin America

24. Refer to Latin American Blueprint (3 above).

South Africa

25. Sexual and reproductive health for transgender and gender non-conforming people: guidelines for health care workers in primary care. Cape Town (South Africa): Gender DynamiX; 2013.
http://www.genderdynamix.org.za/wp-content/uploads/2013/06/GDX-HCW-Bklt-for-Web.pdf

PrEP and ART

26. Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015.
http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en

27. WHO technical update on pre-exposure prophylaxis (PrEP). Geneva: World Health Organization; 2015.
http://www.who.int/hiv/pub/prep/prep-technical-update-2015/en

28. Guidelines on post-exposure prophylaxis for HIV and the use of co-trimoxazole prophylaxis for HIV-related infections among adults, adolescents and children: recommendations for a public health approach. December 2014 supplement to the 2013 consolidated guidelines on the use of antiretrovirals drugs for treating and preventing HIV infection. Geneva: World Health Organization; 2014.
http://apps.who.int/iris/bitstream/10665/145719/1/9789241508193_eng.pdf?ua=1&ua=1

29. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. Geneva: World Health Organization; 2013.
http://www.who.int/hiv/pub/guidelines/arv2013/en

Harm Reduction

30. Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence. Geneva: World Health Organization; 2009.
http://www.who.int/hiv/pub/idu/opioid/en/

STIs

31. HIV, sexually transmitted infections and other health needs among transgender people in Asia and the Pacific: joint regional technical brief. Geneva: World Health Organization; 2013. http://www.wpro.who.int/hiv/documents/docs/HIV_STI_Other_Health_needs_among_transgender.pdf

32. The time has come: enhancing HIV, STI and other sexual health services for MSM and transgender people in Asia and the Pacific. Training package for health providers to reduce stigma in health care settings. Geneva: United Nations Development Programme; 2013. http://www.thetimehascome.info

HIV testing

33. Consolidated guidelines on HIV testing services. Geneva: World Health Organization; 2015. http://www.who.int/hiv/pub/guidelines/hiv-testing-services/en

34. A short technical update on self-testing for HIV. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2014. http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/JC2603_self-testing_en.pdf

35. Report on the first international symposium on self-testing for HIV: the legal, ethical, gender, human rights and public health implications of self-testing scale-up: Geneva, Switzerland. 8-9 April 2013. Geneva: World Health Organization; 2013. http://www.who.int/hiv/pub/vct/self_test/en

Viral hepatitis

36. Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection. Geneva: World Health Organization; 2015. http://www.who.int/hiv/pub/hepatitis/hepatitis-b-guidelines/en

37. Guidelines for the screening, care and treatment of persons with hepatitis C infection. Geneva: World Health Organization; 2014. http://www.who.int/hiv/pub/hepatitis/hepatitis-c-guidelines/en

39. Guidance on prevention of viral hepatitis B and C among people who inject drugs. Geneva: World Health Organization; 2012. http://www.who.int/hiv/pub/guidelines/hepatitis/en

TB

39. WHO policy on collaborative TB/HIV activities: guidelines for referral programmes and other stakeholders. Geneva: World Health Organization; 2012. www.who.int/tb/publications/2012/tb_hiv_policy_9789241503006/en

Violence

40. Egremy G, Betron M, Eckman A. Identifying violence against most-at-risk populations: a focus on MSM and transgenders. Training manual for health providers. Washington (DC): Futures Group, Health Policy Initiative, Task Order 1; 2009. http://www.healthpolicyinitiative.com/Publications/Documents/1097_1_GBV_MARPs_Workshop_Manual_FINAL_4_27_10_acc.pdf

Mental health

41. Guidelines for psychological practice with transgender and gender nonconforming people. American Psychological Association; 2015. http://www.apa.org/practice/guidelines/transgender.pdf

Further reading

42. Bauer GR, Redman N, Bradley K, Scheim AI. Sexual health of trans men who are gay, bisexual, or who have sex with men: results from Ontario, Canada. Int J Transgend. 2013;14(2):66–74.

43. Boyce S, Barrington C, Bolaños H, Arandi CG, Paz-Bailey G. Facilitating access to sexual health services for men who have sex with men and male-to-female transgender persons in Guatemala City. Cult Health Sex. 2012; 14(3):313–327.

44. Bradford J, Reisner SL, Honnold JA, Xavier J. Experiences of transgender-related discrimination and implications for health: results from the Virginia transgender health initiative study. Am J Public Health. 2013;103(10):1820–1829.

45. Brennan J, Kuhns LM, Johnson AK, Belzer M, Wilson EC, Garofalo R, Adolescent Medicine Trials Network for HIV/AIDS Interventions. Syndemic theory and HIV-related risk among young transgender women: the role of multiple, co-occurring health problems and social marginalization. Am J Public Health. 2012;102(9):1751–1757. doi:10.2105/AJPH.2011.300433.

46. Buchbinder SP, Glidden DV, Liu AY, McMahan V, Guanira JV, Mayer KH, et al. HIV pre-exposure prophylaxis in men who have sex with men and transgender women: a secondary analysis of a phase 3 randomised controlled efficacy trial. Lancet Infect Dis. 2014;14(6):468–475.

47. de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. J Sex Med. 2011;8(8):2276–2283. doi:10.1111/j.1743–6109.2010.01943.

48. Deutsch MB, Green J, Keatley J, Mayer G, Hastings J, Hall AM, et al. Electronic medical records and the transgender patient: recommendations from the World Professional Association for Transgender Health EMR Working Group. J Am Med Inform Assoc. 2013;20(4):700–703. doi: 10.1136/amiajnl-2012-001472.

49. Gooren LJ, Sungkaew T, Giltay EJ, Guadamuz TE. Cross-sex hormone use, functional health and mental well-being among transgender men (toms) and transgender women (kathoeys) in Thailand. Cult Health Sex. 2015;17(1):92–103.

50. Grant RM, Anderson PL, McMahan V, Liu A, Amico KR, Mehrotra M, et al. Uptake of pre-exposure prophylaxis, sexual practices, and HIV incidence in men and transgender women who have sex with men: a cohort study. Lancet Infect Dis. 2014;14(9):820–829.

51. Hendricks ML, Testa RT. A conceptual framework for clinical work with transgender and gender nonconforming clients: an adaptation of the minority stress model. Prof Rsycho-Res Pr. 2012; 43(5):460–467.

52. Hunt J. Why the gay and transgender population experience higher rates of substance use: many use to cope with discrimination and prejudice. Center for American Progress, March 9, 2012.

53. Liu A, Cohen S, Vittinghoff E, Anderson P, Doblecki-Lewis S, Bacon O, et al. Adherence, sexual behavior and HIV/STI incidence among men who have sex with men (MSM) and transgender women (TGW) in the US PrEP Demonstration (Demo) Project. Oral abstract at the 8th International AIDS Society Conference on HIV Pathogenesis, Treatment & Prevention (IAS 2015) in Vancouver, Canada. Program number TUAC0202, track C. Presented July 21, 2015.

54. Lombardi E. Varieties of transgender/transsexual lives and their relationship with transphobia. J Homosex. 2009; 56(8):997–992. doi:10.1080/00918360903275393.
55. Melendez RM, Pinto RM. HIV prevention and primary care for transgender women in a community-based clinic. J Assoc Nurses AIDS Care. 2009;20(5):387–397.
56. Nuttbrock L, Bockting W, Rosenblum A, Hwahng S, Mason M, Macri M, et al. Gender abuse, depressive symptoms, and substance use among transgender women: a 3-year prospective study. Am J Public Health. 2014;104(11):2199–2206.
57. Nuttbrock LA. Culturally competent substance abuse treatment with transgender persons. J Addict Dis. 2012;31(3):236–241.
58. Operario D, Nemoto T, Iwamoto M, Moore T. Unprotected sexual behaviour and HIV risk in the context of primary partnerships for transgender women. AIDS Behav. 2011;15(3):674–682.
59. Poteat T, Reisner SL, Radix A. HIV epidemics among transgender women. Curr Opin HIV AIDS. 2014;9(2):168–173.
60. Poteat T, Wirtz AL, Radix A, Borquez A, Silva-Santisteban A, Deutsch MB, et al. HIV risk and preventive interventions in transgender women sex workers. Lancet. 2014; 385(9964):274–286.
61. Reisner SL, White JM, Mayer KH, Mimiaga MJ. Sexual risk behaviors and psychosocial health concerns of female-to-male transgender men screening for STDs at an urban community health center. AIDS Care, 2014;26(7):857–864.
62. Schneiders M. Values and preferences of transgender people: a qualitative study. Geneva: World Health Organization; 2014.
63. Sevelius JM, Patouhas E, Keatley JG, Johnson MO. Barriers and facilitators to engagement and retention in care among transgender women living with human immunodeficiency virus. Ann Behav Med. 2014;47(1):5–16.
64. Sevelius JM, Saberi P, Johnson MO. Correlates of antiretroviral adherence and viral load among transgender women living with HIV. AIDS Care. 2014;26(8):976–982.
65. van Griensven F, Na Ayutthaya PP, Wilson E. HIV surveillance and prevention in transgender women. Lancet Infect Dis. 2013;13(3):185–186.
66. van Griensven F, Phanuphak N, Srithanaviboonchai K. Biomedical HIV prevention research and epidemic control in Thailand: two sides of the same coin. Sex Health. 2014;11(2):180–199.
67. Williamson C. Providing care to transgender persons: a clinical approach to primary care, hormones, and HIV management. J Assoc Nurses AIDS Care. 2010;21(3):221–229.
68. Wilson E, Pant SB, Comfort M, Ekstrand M. Stigma and HIV risk among Metis in Nepal. Cult Health Sex. 2011;13(3):253–266.