RED LACTRANS

SUGGESTED GUIDELINES FOR THE PROVISION OF COMPREHENSIVE HEALTCHARE FOR TRANS WOMEN IN LATIN AMERICA AND THE CARIBBEAN

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SUGGESTED GUIDELINES

FOR THE PROVISION OF COMPREHENSIVE HEALTHCARE

FOR TRANS WOMEN IN LATIN AMERICA AND THE CARIBBEAN

“The average life expectancy of a trans woman in the region is 35 years. Without comprehensive health, there are no equal rights quality nor true democracy”.

Marcela Romero
Regional Coordinator
REDLACTRANS

1. Presentation: purpose and scope

The right to health is a human right and, as such, is unalienable. The States are required to uphold this fundamental right through national laws, agreements, treaties and international conventions. However, most people are still not entitled this right.

Trans women[1] are consistently denied most of their rights. In Latin America and the Caribbean, trans people experience the systematic violation of their human rights. Historically, "the constant lack of legal recognition that trans people have endured for years largely contributes to preventing them from fulfilling their needs"[2]. A proof of such failure to recognize trans people's human rights is the restriction, obstruction or interruption of access to health through barriers and conditionings imposed in both public and private services.

The pathologization of our identity across the medical sciences, the layout of physician's offices or waiting rooms, clinic hours, the refusal to call us by our names, the prejudice about our (employment, sexual and intimacy, among others) practices and care habits are some barriers to equity of access to quality and ongoing health care services.

Overt or covert discrimination, prejudice, stigmatization, the presumption about our activities and the violations to our autonomy are customary practices we have to combat all together. A survey conducted by the Argentine Association of Transvestite, Transsexual and Transgender Persons (ATTTA), Fundación Huésped and UNAIDS in Argentina in 2014 showed that although Gender Identity Law, HIV Law and several anti-discrimination measures were enacted in such country, "discrimination by health providers, either due to the trans identity or HIV status, is extremely high"[3].

In some countries in Latin American and the Caribbean (such as Argentina, Bolivia and Uruguay) where a gender identity law has been enacted, trans rights are increasingly enforced and, consequently, the access to and continuity of health care services. This exerted a positive impact on health care provision, as well as the treatment provided by health care workers.

In the context of heteropatriarchy in which we live, which places and prioritizes men in positions of power and organizes society from a heteronormative standpoint, women, both trans and nontrans, are liable for healthcare. This involves two joint processes:

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[1]We will use the term "trans" to name and include all the people whose gender identity differs from the sex assigned at birth. The term "trans women" represents us since we are people with female gender identity.
[2]*Gender Identity Law and transgender people access to health care in Argentina* (2014). ATTTA, Fundación Huésped and UNAIDS, page 9.
[3]*Gender Identity Law and transgender people access to health care in Argentina* (2014). ATTTA, Fundación Huésped and UNAIDS, page 12.

On the one hand, trans people are responsible for their own health and that of their families (dependent children and elderly parents). Far from being based on "natural grounds", a patriarchal society does not assign household work and reproduction to men but rather to women (in all our diversity).

On the other hand, living in an unfair society founded on discrimination, women, especially trans women, live physical and psychological situations that expose them and make them vulnerable.

Therefore, we have to adopt measures to protect health.

Trans women, throughout their lives, face health issues derived from stigma, discrimination and violence, as well as a set of problems related to health care services and providers.

Purpose

These guidelines are designed as a tool to improve access to health care services for trans women. They were prepared as a practical and quick review to provide health care workers with the necessary information to address trans people's health in a comprehensive manner (and abiding by human rights). The main purpose is to serve as a source of information for people working in, organizing or planning health care services.

We also believe that they may be useful for all trans women as an essential empowerment tool with a political impact and as a manner of claiming friendly health care services that address their specific needs. We hope these guidelines are used by trans women across Latin America and the Caribbean to access health care services and work with its personnel to ensure a comprehensive and decent approach.

Finally, we expect they offer recommendations and advice on how to accompany trans people properly regarding their health and gender identity.

We believe that, as mentioned in the report from the 2013 United Nations Development Programme (UNDP)[4], ensuring a health care service that is trans women-friendly, which understands health from an holistic and human rights-based approach, entails working on training

[4]*Consultorios amigables para la diversidad sexual. Informe ejecutivo* (2013). United National Development Programme, page 4.

health care referents, agents and providers and "reordering existing resources (betting on long-term sustainability) focused on the specific characteristics and needs of this population".

Health care workers, in the different organizational and administrative facilities and types, have much to learn about trans people's bodies and lives. Thus, we believe that we need to be allies to address this pressing need to remove existing obstacles and guarantee that trans people get involved in, access and stay at health care, which would quickly enhance public and individual health.

Structure

Section two reviews terminology to share a common code to communicate without discrimination, stigmatization or other forms that violate the right to identity.

Section three compiles existing material to account for prior work from other areas and lay the foundations for our recommendations.

Section four addresses the components of a holistic health care system, including prevention, care, support and assistance. We describe the structural elements related to the physician's offices, waiting rooms, the building layout and elements specifically related to trans people's health.

These guidelines may also be used to trigger communication and debate. Section five deals with the alternatives to make contacts and establish dialogue since we aim at setting up networks and dialogue strategies on the understanding that trans women's comprehensive care is strictly related to the political, social and legal context, so we can constantly improve health care services and the comprehensive perspective we assign to them.

Finally, we will list the recommendations to conclude our proposal.

We hope these guidelines are used and consulted on an ongoing basis by trans women and health care workers across Latin America.

The Latin American and Caribbean Network of Trans People (REDLACTRANS) appreciates the technical support provided by UNAIDS and International HIV/AIDS Alliance in preparing these guidelines.

REDLACTRANS

September 2017

“United and organized for a Gender Identity Law in Latin America and the Caribbean”

2. Basic concepts on identity, gender and sexuality

When discussing *identity*, we are not thinking about a final and unchanging characteristic, but rather a long-life process of creating a sense of belonging. Forging an identity follows a practical purpose since such identification allows some actions and makes others impossible, as well as a cognitive end because it makes the world intelligible for social subjects.

Gender identity is a dimension of this identity or identification process. When discussing a person's *gender identity*[5] we refer to the social and cultural distinctions between male and female. It is a cultural construction related to a certain historical context that interprets body use according to sexual differences. However, there is a considerable difference between sex and gender, and sexuality and gender identity.

Gender identity is a cultural construction and, as such, is shaped by other dimensions, such as social class, ethnical differences and the prevailing ways of seeing the world. In this context, people adhere to male and female categories, without this leading to a certain sexual "orientation".

In the societies in which we live, gender identities determine the possible world for people by establishing roles, representations and expectations. All these categories are assumed individually but built collectively. In the process of identifying gender, self-perception is influenced by how others perceive us. This process never ends: we can understand gender identity as a continuum of potential, diverse and variable identities.

The imposition of rigid and binary gender categories (female/male) is understood as *heteronormativity*. This term is related to the matrix of power devices that position heterosexuality as normal in our culture and as the basis for setting rules for human behavior. This "normality" provides (only one) sense to social belonging, parentage, affinity and family relationships. It is spread though devices such as institutions, thought structures and practices, among others. Heteronormativity is, then, the establishment of a sense of what is "right" in terms of gender and sexuality, leaving out and stigmatizing the relationships and identities that deviate from heterosexual parameters. The document prepared by ATTTA, REDLACTRANS and the National University of Santiago del Estero (UNSE) in

[5]Gender refers to the "group to which the human beings of each sex belong understood this from a sociocultural point of view instead of exclusively biological" (Royal Spanish Academy's Spanish dictionary). The number of sexes also differs from the heteronormative binary described in the following page.

2016 states that: “Thus, those people who do not adjust to or refuse to belong to this system are silenced or made invisible, since the system denies, rejects and punishes discrepancies. This is how many people who live outside heterosexuality are excluded by a portion of the society, as is the specific case of the community of trans women”[6].

As it will be discussed later, the construction of prevailing gender categories –in Latin America and the Caribbean, male and female– was historically related to the definition of rules of conduct for the use of genitalia. Sexuality is a social construction related to everything linked to sex (that is, biological conditions), but also to the rules used to regulate such sex: loyalty, marriage, reproduction, motherhood and fatherhood, among others.

Hence, sexual identity is an identification process that involves the person’s gender identity and sexual orientation. It is one’s own internal frame of reference built throughout life. Sexual identity comprises physical characteristics, gender identity, gender expression and sexual orientation. Sexual identities include a broad variety of possibilities and representations.

People’s sexual orientation is the capacity to feel emotional, affective and sexual attraction to people of the opposite gender (heterosexual), the same gender (homosexual), both genders (bisexual) or regardless of gender (pansexual).

Sexual orientation is a personal characteristic in spite of gender identity and expression. Therefore, a person’s gender identity or expression allows for no assumptions to be made regarding his/her sexual orientation.

Sex, gender identity, gender expression and sexual orientation are four separate characteristics. They refer to independent definitions and may show up in a broad range of potential combinations. The dominant binary heteronormative system in Latin American societies proposes the identification of two gender options and matches these identifications with expected sexual and identity behaviors.

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[6] *Situation assessment of PLWHA trans women with regard to the adherence to ART in Argentina* (2016). ATTTA, REDLACTRANS and UNSE, 2016, page 5.

The first definition is made at birth and is external: a medical team usually looks at the baby's genitals and defines its sex. This sex is then ratified in the civil registry office by registering the name chosen by the parents or legal guardians. Throughout their lives, many people build their identity from that initial imposition, whereas others build other gender or sexual identities.

However, regardless of the sex assigned at birth and the subsequent registration, a person may identify as female and present its gender in a masculine manner, or as a male since the person may adopt female manners of expressing gender. Moreover, gender nonconformity either at gender identity or gender expression level is not necessarily related to a specific sexual orientation. Notwithstanding the gender expression and identity and irrespective of society's expectations related to the sex assigned at birth, a person may feel attracted to people of the opposite gender, the same gender, more than one gender or regardless of gender.

The medical field offered and adopted strict definitions on male and female genitals, female and male mannerisms and man and woman identity. These ideas were naturalized and upheld as common sense, imposing a sex-gender binary (that is, the identification between one certain sex and a specific gender identity) that classifies diverse human behaviors into narrow definitions. These definitions also maintain the hierarchical division between men and women.

Medicine, psychiatry, psychology and sexology have traditionally associated human diversity to two genitals directly related to two sexual and gender identities from a paradigm that promoted reproduction as people's core interest. Everything that did not fit into this pattern was pinpointed as abnormality, abnormal, illness, syndrome or pathology. The persecution, punishment, repression and even the administration of treatments to "cure" some of the gender identities or expressions have been historically justified from these binary and narrow standards of female and male. Trans women cope with social, economic and institutional stigma and discrimination daily. This binary classification is supported by the difference established between trans and nontrans people, or intersex and nonintersex people, among others.

These determinations define what is normal and leave out everything considered abnormal from the legal framework. The people that do not fit in the accepted definitions are legally vulnerable and exposed to civil exclusion, institutional persecution and violence. We witness, once and again, the deterioration of their health, imprisonment and even death.

In agreement with the Yogyakarta Principles, section of Law No. 26,743 establishes that "gender identity is understood to refer to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body, which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means and other expressions of gender, including dress, speech and mannerisms"[7].

However, body diversity and the different experiences, perceptions, expressions and identities in terms of genders and sexualities challenge this biological, psychological and medical reduction. People live gender in particular ways. There are several gender identities and expressions. Trans people are entitled to build their own gender identity and express it freely. This right should be safeguarded.

Respecting people's decisions and representations should outweigh the conditionings imposed by health organizations. Institutional conditionings are a barrier to accessing health care. In the countries where free gender identity is recognized by law (Argentina, Bolivia, Uruguay and the City of Mexico, though with major differences between them), these conditionings go against the law and may entail legal penalties for health care institutions or workers that fail to meet their obligations.

Under the legal framework recognized by people's rights to define and express their gender, health care institutions and teams are liable for comprehensively addressing the medical needs of transgender people by understanding the importance of acknowledging gender identity through every aspect of life.

We need to advocate for systems in which health care professionals do not impose their own ideas, expectations or moral or religious standards. We need to dismantle the classifying system that stigmatizes and hierarchizes trans identities. We need to move past our own ideas to listen and recognize people's decisions. Active listening is the only way of offering accurate, timely and understandable information. This information

[7] *Atención de la salud integral de personas trans. Guía para equipos de salud* (2015). Program of Sexual Health and Responsible Procreation of the Argentine Ministry of Health.

should facilitate a free and informed decision-making process.

The use of the term "trans" (abbreviation for transgender or transsexual chosen by REDLACTRANS to represent trans people's identity because it is both broad and accurate) is used to refer to the people who identify or embody a gender that contravenes the societal expectations associated to the sex given at birth and even challenge these expectations, as trans women do. Therefore, "trans" may be opposed to "cis" or "cisgender", which is sometimes used supplementary to refer to people whose gender expression matches the sex assigned at birth. Trans identities encompass different processes of identifying, expressing and embodying the sex-generic parameters.

Trans people have general and specific medical needs. We have always found barriers to accessing competent services to meet these needs. Trans people's specific needs involve assistance to match body and gender identity, including the medical interventions to feminize or masculinize a body. The general needs comprise primary care, including a sexual health that considers the diversity of gender identities, gender expressions, anatomy, sexuality and sexual practices among this population.

2.1. Some important definitions to understand trans women's diversity

Gender nonconformity

It is a phenomenon in which a person's gender expression does not conform to traditional social standards and expectations, the sex assigned at birth or his/her gender identity.

Transition or construction

It is the period of time when trans women change the gender role associated with the sex given at birth to a different gender identity. The construction, as we would rather call it in REDLACTRANS, may or may not include body feminization (changing one's genital characteristics) through hormones and other medical procedures.

Trans

Throughout these guidelines, "trans" is used to refer to women whose gender identity and/or expression contravenes the societal expectations traditionally associated to the sex given at birth. Trans women are trans people who identify as women, despite being assigned male at birth.

Transgender

It refers to people who have not changed or who do not wish to change the

sexual conditions or characteristics with which they were born, but whose gender identities differ from the sex they were assigned at birth.

Transsexual

Term used in the medical field to refer to people who desire to assume or have changed their sexual characteristics at birth and/or secondary sexual characteristics through medical interventions (such as the application of hormones and/or the performance of surgeries) to feminize or masculinize their bodies.

Transvestite

This term has the broadest number of meanings across the region. In some Latin American and Caribbean countries, it is used to refer to persons assigned male at birth who go to great length feminizing their body and appearance and prefer female pronouns, without typically considering themselves women or desiring to alter their natal primary sexual characteristics through genital surgery.

In other countries it refers to people who use clothes or gender expressions culturally associated with the opposite sex to that assigned at birth. Some terms that are used include: drag queens, transformers, drags or cross-dressers (in the case of men assuming a female role) and drag kings or painted women (in the case of women assuming a male role.

Other gender categories

There are gender identifications that challenge the gender binary. These identifications do not conform to a binary, mutually exclusive understanding of gender in terms of man or woman, male or female. These may comprise terms such as “queer” and “trans-queer”, and may include individuals who identify as both man and woman (bigender, pangender, omnigender), as a third or other gender (intergender), or as without gender (genderless, agender or neutral).

Alternative genders/Third genders

Among some aboriginal and native peoples, gender systems may not be binary (for example, masculine-feminine), but include additional categories. Some examples of these social constructions for gender categories are muxes among Zapotecs in Mexico or tidawinas among Warao in Venezuela. There are studies which have shown that

Within the context of a medical appointment or health approach, what we call ourselves is the only thing that matters. If the profile of a trans woman in a consultation may be associated, for example, with a “queer” but she would rather be called transvestite, her decision should be supported. This defines whether we continue in treatment and return to health care services.

some aboriginal groups in Latin America recognized up to five genders within their ethnic groups before the Spanish conquest.

2.2. The sex-generic binary as a construction and imposition

The gender categories that support people identification are created by the people who comprise the different cultures. As practical categories, they allow us to know and understand the world from interpreting people based on whether they belong to a category or another. These categories also allowed for differentiating and organizing people into hierarchies; in other words, they were used to prioritize some persons at the expense of others. Consequently, what belongs to a "normal” and “hegemonic” social group has priority over diversity. Division between men and women is the first hierarchy of citizenship from establishing a correspondence between genitalia (male/female) and a social role (masculine/feminine). Therefore, differentiated ways of dressing, walking and thinking, professions, trades, domestic roles, places of participation and circulation, and interests were set forth arbitrarily for those who identify themselves and appear as men and those who identify themselves as women.

These ways of understanding and experiencing gender restricted to feminine and masculine show the traditional social roles. The practices deemed final and unmistakable related to these roles vary historically and geographically. Anyways, these categories function as ideals since people never meet all the traits assigned to one gender or another, but rather take in some and discard others in a strenuous process.

However, the classification into masculine and feminine has been questioned as *sex-generic binary* and the need to recognize the diverse ways in which gender may be expressed was raised, mainly fueled by transgender-rights organizations. We also sustain that gender identity is independent from sexual orientation. Trans women may identify as heterosexual, gay, lesbian, bisexual, pansexual or queer, among others.

Thus, if gender experiences and expressions are as varied as people exist, the ways of living sexuality are multiple. People do not always adjust to the definitions accepted in a culture at a certain time and propose changes

or cause tensions to get out from those systems or propose new ones. Anyways, the trans experiences of the bodies and the sexualities are still conditioned by the hetero and heteronormative models.

The term "transgender" made it possible to move away from the psychological and medical connotations of "transsexuality" and "transvestism". This proposal allowed us to move away from heteronormativity and reassign under the umbrella term "trans" our self-perception by building gender identity over and above the surgical interventions and hormonal and cosmetic modifications.

From this standpoint, the term "trans" assumes a political sense since it identifies "transsexuals", "transvestites", "transgender" and other forms of expression and self-determination. The term "trans" allows us to show the process of identity self-determination, which differs from the traditional psychological and medical terms. Therefore, "trans" refers not only to the people that live a different gender from the one assigned at birth, but also the persons whose gender is not fixed or who do not identity with any particular gender, notwithstanding whether they have performed hormonal or surgical modifications.

Looking for and creating ways of calling trans people based on their own gender experience exceed pre-established categories and respond to ways of tailoring and politicizing references.

2.3. About the legal framework[8]

Thanks to the great political incidence and the systematic and long-term work carried out by activists and organization that, like ours, fight for sexual and gender rights , international agencies such as the WHO depathol-

> *We are not "men who have sex with men", as we have been called for many years in studies on HIV/AIDS and STIs. We are TRANS WOMEN.*

ogized trans identities, which were formerly categorized as "mental disorders".

This led to recognizing the importance of depathologizing gender expressions and trans identities and resorting to the judicial system for these purposes, which also means

[8]For additional information, please refer to the baseline health status prepared by REDLACTRANS (2017).

understanding these experiences not as pathologies or abnormalities but rather as forms of expressing and naming from diversity. As such, it is essential to recognize and secure their expression within the human rights paradigm.

Under Argentine Gender Identity Law No. 26,743 enacted in 2012, the State is required to enforce trans depathologization. In the medical field, this law entails ensuring comprehensive care for trans people focused on a rights-based model according to each person's needs[9], fostering equity in the provision of health care services.

Gender Identity Law has many major precedents, even in Latin America and the Caribbean. As from the 1970s, different laws were enacted in several countries to provide trans identities with state recognition. Such was the case in Sweden (1972), Germany (1980), Italy (1982), Holland (1985), Australia (1988 and 1993), Turkey (1988), New Zealand (1995), Finland (2002), South Africa (2003), the United Kingdom (2005), Spain (2007), Belgium (2007), Mexico City (2008), Uruguay (2009), Bolivia (2016) and Portugal (2011).

The main difference with these precedents is that they only authorize the change in registration for the persons who undergo psychological and medical assessment protocols and self-perceived gender diagnosis. These laws establish that it is mandatory to adjust to the physical characteristics that are recognized as socially typical for each gender. With slight differences, they propose prior requirements to change name and sex designation that include sterilization, genital modification and hormone intake.

There are international precedents of major changes that reflect the debates and struggles fought by activists and organizations. There is a new paradigm that recognizes a person's gender expression and identity since the moment the person asserts his/her autonomy in the decisions concerning his/her body as fundamental human rights that should not be violated.

The Yogyakarta Principles were signed in 2007 by the United Nations Organization to establish the basic rights to be enforced by international agencies and member states to ensure the protection of human rights of LGTBI persons. In addition, reports such as *Human Rights and Gender Identity* (2009) by

[9] Argentina is an example of the positive and direct impact exerted by gender laws on improving access to and continuity of health care services. For additional information, please refer to *Gender Identity Law and transgender people access to health care in Argentina*. (2014) ATTTA, Fundación Huésped and UNAIDS.

Thomas Hammarberg, the Commissioner for Human Rights of the Council of Europe, as well as a European Parliament Resolution on Human Rights, sexual orientation and gender identity at the United Nations (2011) requested the WHO to stop considering trans expressions and identities as "mental disorders"[10].

The enactment and implementation of laws and regulations catering for trans people's specific needs vary significantly. While some countries obtained major legislative accomplishments, in other countries trans people face daily struggles and challenges[11].

South America

In Argentina, Gender Identity Law No. 26,743, as amended, establishes the right to have an identity and guarantees access to comprehensive health care for trans people. A set of accompanying laws were also amended or enacted to ensure access to social, political, economic and cultural rights.

Bolivia also has a set of laws that benefited the trans population, such as the constitution itself, a human rights plan and several specific decrees that grant rights and define the trans community as a specific group to ensure protection and nondiscrimination. In May 2016, it enacted Gender Identity Law No. 807, thus joining the other countries within the region that had enacted this essential regulation.

The legal situation in Chile is changing since although it had some breakthroughs (decriminalizing "sodomy" in 1999, approving bills to curb and end violence against the LGBTI population and enacting regulations addressing health care for trans people, among others), there are still major gaps (there is no gender identity law). As from 2012, trans people are allowed to change sex designation and name.

Paraguay lags well behind its neighboring countries in accepting and enforcing the international treaties that are aimed at ensuring LGBTI's rights. It has no gender identity law or any law penalizing discrimination

[10] *Atención de la salud integral de personas trans. Guía para equipos de salud* (2015). Program of Sexual Health and Responsible Procreation of the Argentine Ministry of Health.

[11] An analysis of current legislation may be found in *The night is another country* (REDLACTRANS, 2012).

against LGBTI persons. The Paraguayan legal system rejects the concept of gender identity and all attempts to enact laws that provide for the situation of specific groups or women's rights are systematically amended by the Chambers. There are no specific public laws for the community and the few developments made are ministerial resolutions.

Uruguay, like Argentina, has achieved dramatic progress in consolidating the rule of law for trans people. It penalizes violence, discrimination and hate crime, and enacted Gender identity Law No. 18,620 in 2009. Related legislation was amended and several public policies were drafted to prevent the violation of human rights affecting the trans community. In Uruguay's case, the incidence of the Uruguayan Trans Association (ATRU) was tantamount to improve legislation and trans women's specific needs.

Ecuador has no gender identity law. It passed a reform to Organic Law of Identity Management and Civil Data, which establishes that sex may be changed by gender in the ID voluntarily only once after 18, with two witnesses. However, there were some regulatory improvement concerning the LGBTI community. The constitution recognizes the right to health for all people and enforces another set of rights essential to human development. Although some progress was made in respecting sexual orientation, legislation set to ensure trans human rights is still needed.

Mexico, Central America and the Caribbean

Mexico has a mixed reality since the City of Mexico is one of the states that has more legislation seeking the development of trans people. The Mexican constitution includes the right not to be discriminated against on the basis of sexual preference. In addition, there are many regulations to ensure health care for the trans community. In the City of Mexico, trans people, after filing the case in court, are legally recognized their identity. As from 2008, sex changes are recognized legally. In July 2017, Michoacán became the second state after the City of Mexico to grant gender change full legal recognition. The regulation read as follows; "gender identity shall be understood as the personal and internal conviction, each person's self-perception, which may or may not match the sex assigned in the birth certificate". Thus, surgical interventions, therapies or psychological diagnosis are no longer used to evidence the gender identity of trans people.

This was a long-awaited triumph of the trans movement fight against pathologization and the "veracity" control implemented by the medical faculty.

In July 2017, the state of Nayarit became the third city in the country to grant full legal recognition the trans identity.

The most important achievement of the reform is that the request to amend the certificate for gender identity is an administrative formality handled by the state civil registry offices.

El Salvador, like the rest of Central America and the Caribbean, has poor legislation. There are ministerial provisions and some regulations with a narrow scope that seek to fight discrimination and improve access to health for LGBTI persons. Although El Salvador penalizes hate crimes on the basis of sexual orientation, the general regulations do not address the trans community specifically, thus creating a considerable difficulty in accessing basic and fundamental rights.

The situation for the trans community in Panama is also very precarious since there is no specific legislation against any act of aggression or to protect human rights. As from 2000, there are specific health plans, especially concerning HIV prevention and treatment. Sodomy was decriminalized in 2008 and since then, trans people are able to change their names after a sex reassignment surgery.

Belize is one of the most hostile countries for trans people. It was not until 2016 that the Supreme Court of Justice rendered the illegality of nonheteronormative relationships null. Although we expect this decision to improve living conditions, related regulations have not been updated accordingly so the trans community is still stigmatized.

Something similar occurs in Guatemala since regulations do not recognize the specific characteristics of the trans community and fail to implement special policies to ensure the protection of trans rights. Guatemalan laws do not recognize the right of trans people to gender identity and although the right to health is ensured by law, they encounter difficulties and obstacles upon accessing health due to identity issues. The Guatemalan trans base has been promoting a public policy to ensure trans health. The government of Guatemala approved the Strategy for Comprehensive and Differentiated Health Care for Trans People in Guatemala 2016-2030. It still has to be implemented and provided with resources for full compliance.

In Costa Rica, despite the constitutional safeguard, no gender identity law or specific law against discrimination or hate crimes were enacted.

Honduras neither recognizes gender identity nor has any law to protect trans people against discrimination or hate crimes, but prohibits sex-based discrimination.

"We advocate to ensure access of trans people to all social, economic, cultural and political rights".

3. Background information: comments on trans women's health in Latin America and the Caribbean

This section reviews prior experiences from manuals, guides or researches that propose methods for approaching health care for trans women. We were able to identify similarities between the documents and add new suggestions. We include the outstanding topics of the documents reviewed. We supplement this information

The survey conducted by the INDEC highlights the importance of the public health care system since 80% of trans people surveyed had no statutory health care organization, private healthcare insurance or state plan. This figure is confirmed by a study conducted in Chile, which showed that 86% of trans people surveyed used the public health care system. Out of this percentage, 34% stated that they suffered discrimination at these places.

with specific data from the countries within the region aimed at filling certain bibliographical gap at regional level.

To propose a new health care system based on a new approach that acknowledges access to health for all people, especially trans women, it is essential to be acquainted with the situation in Latin America and the Caribbean. The health of Latin American trans women is, undoubtedly, the result of a long history of stigma-driven discrimination suffered from the pathologization of the trans identity. The hegemonic interpretation of trans women in the health care system has hindered their access to a comprehensive health care and contributed to consolidating stigmatization against us in other fields.

A new health care model for trans women should include us and other diverse subjectivities. Health care should accompany, recognize and strengthen the person's autonomy. Health care should boost trust and respect, leaving exclusion and discrimination practices aside.

There are a few initiatives to gather information on the situation of trans women in Latin America and the Caribbean. The lack of information regarding their health across the region is evident. No general survey was conducted to record, neither quantitatively nor qualitatively, the health care status and whether trans people access, stay in and return to health care services. Therefore, we compiled this information from different documents, research papers and outreach programs from international organizations, among others.

The States have not launched ambitious efforts to know how trans women live; instead, the most popular initiatives belong to trans rights organizations that wish to know the status of its members.

The survey on trans population in Argentina, conducted between 2011 and 2012 by the Argentine Statistics and Census Institute (INDE) and the Argentine Institution against Discrimination (INADI) is an updated source of information on trans women. It consisted in the implementation of a survey as a first initiative introduced by the Argentine government to survey, systematize and gather social demographic information to make decisions and design public policies. Although Argentina has a distinctive legal framework, the data from the survey allow us to explore situations repeated in every country across the region. This survey agrees with the analysis of trans women in Argentina conducted by the Argentine Ministry of Health in the document entitled "*Atención de*

la salud integral de personas trans. Guía para equipos de salud"[12], published in 2015 through its Program of Sexual Health and Responsible Procreation. This guide is aimed at medical teams and continually refers to Gender Identity Law No. 26,743 enacted in Argentina in 2012. After an overview of the law and a definition of the medical and common sense concepts of sexuality, gender identity and transition, the guide analyzes the situation of trans people in Argentina based on the findings of the survey on trans people in Argentina (conducted by the INDEC and INADI in 2012).

The guide prepared by the Argentine Ministry of Health proposes strategies to address trans persons' health pursuant to effective regulations in Argentina. Some strategies are mentioned herein. The legal framework limits the scope of such guide since it can hardly be used by health care teams of other countries. Besides, such guide considers several transitions other those of trans women, which is the sole purpose of this document[13].

The document prepared by the Pan American Health Organization (PAHO) in 2012[14] includes data on trans women from other Latin American countries. Though the information included allows to address the situation of trans people in Latin America, it is based on data taken from private research that show a fragmentary portrait of the trans population. The document accounts for this information void and highlights the importance of obtaining such data to make decisions and draft public policies. The approach adopted by this document is extremely interesting since, not being restricted to the legal framework of a specific country, it deals with a fundamental factor: the determinants of health[15] and the legal, cultural and economic obstacles faced by trans women upon accessing health care services. Focusing on the determinants of health entails accepting that "the vulnerability of many trans women in Latin America is worsened by poverty, age, ethnic origin, nationality, migratory status, disability and serologic status, among others" (REDLACTRANS, 2012: 14).

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[12] Available at http://www.msal.gob.ar/images/stories/bes/graficos/0000000696cnt-guia-equipos-atencion-Salud%20integral-personas-trans.pdf

[13] The creation, drafting and enforcement of Gender Identity Law in Argentina and the subsequent improvement of health care services for trans women are examples of the best practices. To review these practices, please refer to *Gender Identity Law and transgender people access to health care in Argentina* (2014). ATTTA, Fundación Huésped and UNAIDS.

[14] Available at http://www.paho.org/arg/images/gallery/Blueprint%20Trans%20Espa%C3%83%C2%B1ol.pdf

[15] We understand the determinants of health as "the circumstances in which people are born, grow up, live, work and age, including the systems put in place to deal with illness" and that explain the inequality of access to health across populations. In 2005, the WHO institutionalized its work about the determinants of health as an advisory strategy for the States to mitigate the consequences of these determinants. More information at http://www.who.int/social_determinants/es/ (last accessed August 26, 2017).

The document does not specifically address health care teams; hence, it advocates for the enactment of laws that acknowledge the identity of trans people in Latin American countries. However, having a broader audience, the recommendations concerning health care lose some centrality. Chapter 9 gathers recommendations on health care, prevention and support for trans people, which will be mentioned herein.

We also considered a document prepared jointly by the PAHO and the Argentine Ministry of Health in 2008, *Salud, VIH-SIDA y sexualidad trans. Atención de la salud de personas trans y travestis. Estudio de seroprevalencia de VIH en personas trans (health care for trans persons and transvestites)*[16]. The document deals with some conceptual issues regarding transsexuality and proposes some considerations to provide health care for trans people, as well as hormone treatments. The second part of this report shows the outcomes from *Estudio sobre seroprevalencia de VIH en personas trans (travestis/transexuales/transgéneros* (study on HIV seroprevalence in trans people) conducted in 2006 by the Argentine AIDS Program, with the involvement of ATTTA and Fundación Buenos Aires SIDA.

We also include in this review the documents filed by ATTTA and REDLACTRANS. One of these documents, S*ituation assessment of PLWHA trans women with regard to the adherence to ART in Argentina*, prepared jointly by both organizations and the National University of Santiago del Estero (2016) shows the economic conditions, educational level and access to health of trans women in Argentina

The document published by the PAHO (2012), aimed at building a comprehensive health care system for trans people in Latin America, based on the systematization of the data collected from different countries, mentions the **main problems experienced by trans women**:

- high frequency of mental disorders caused by external causes;
- high prevalence rates of HIV and other STIs;
- high use of alcohol and other psychoactive substances;

[16] Available at http://www.msal.gob.ar/images/stories/bes/graficos/0000000145cnt-2013-06_salud-vih-sida-sexualidad-trans.pdf

- negative effects of self-administered hormones, injectable soft tissue fillers and other methods to modify the body, including complications caused by sex reassignment malpractice, and reproductive health issues;
- other health issues, mostly derived from the high levels of exposure to verbal, emotional and physical violations, including fatal attacks (hate crimes).

All the documents reviewed mention cases of discrimination and violence in public institutions, including medical facilities. According to the document prepared by the Argentine Ministry of Health and the PAHO[17], trans people wait too long to seek health care, when they are really sick or have a much deteriorated health.

As to health care providers, the survey conducted by ATTTA and Fundación Huésped (PAHO, 2012) points that the parties surveyed suffered discrimination both by other service users and different members of the medical team, especially medical and administrative personnel. Discrimination in health care settings directly lead to abandoning medical treatments, even avoiding medical care altogether due to the discrimination encountered on the basis of gender identity.

The study conducted by USAID in Central America[18] collected experiences of stigmatization and discrimination in the form of jokes, offensive comments, disrespect of the patient's privacy and long waits at the physician's office. Health care quality was rated as bad, lacking knowledge and resources. In line with this, health promotion is not a regular practice; in fact, trans people go to the doctor in case of emergency (evident pain or illness). The report published by REDLACTRANS in 2014[19] entitled "*Report on the economic, social and cultural rights of the transgender population of Latin America and the Caribbean*" shows the results of a research involving trans women in the region and discloses that when asked what was the main obstacle faced by the trans people in accessing healthcare in the countries surveyed, the almost unanimous response referred to the lack of preparation, sensitivity and training of the personnel and professionals to provide the trans community with health care. The report also showed that: "the treatment is not focused on

[17] *Salud, VIH-SIDA y sexualidad trans. Atención de la salud de personas trans y travestis. Estudio de seroprevalencia de VIH en personas trans* (2008). Argentine Ministry of Health and PAHO.
[18] *Diagnóstico situacional de estigma y discriminación relacionado a la homofobia, transfobia, comercio sexual y personas con VIH en Centroamérica* (2011). USAID.
[19] Available at http://redlactrans.org.ar/site/wp-content/uploads/2015/03/Informe%20DESC%20trans.pdf.

human rights and in most cases trans people's gender identity or name is not respected. In addition, they are refused comprehensive care and referred to areas of HIV and STIs without further formalities"[20]. The gravest consequence of stigmatization and discrimination against trans women is hate crime. The PAHO[21] shows that one of the most immediate threats on trans persons' health is the alarmingly high levels of physical violence. Latin America has an extremely high homicide rate of trans people: the PAHO mentions that 80% of recorded murders of trans people in 2011 took place in Latin America. Violence due to transphobia[22] (understood as individual and group attitudes and behaviors of rejection, disdain, scorn and violence to trans people) is made invisible by the means of communication by portraying them as "score settling" or "crimes of passion" and usually remain unpunished. *The night is another country*, a document prepared in 2016 by REDLACTRANS with the support of International HIV/AIDS Alliance and What's preventing Prevention, includes systematized information and testimonies that discuss the crimes that go unpunished and the treatment afforded at state level. This document summarizes the high number of extrajudicial murders and killings, and claims that "criminalization deters people from seeking medical services, undermining the efforts to prevent HIV and affecting the right to health" (REDLACTRANS, 2012: 5). Ignoring these crimes and failing to solve them makes the State liable since it legitimizes the stigmatization and discrimination suffered by trans women in Latin America and the Caribbean. We highlight that public health policies that ensure trans women's access to health care services are tools to protect their basic human rights or, on the contrary, they can be instruments that hinder the exercise of their basic rights. A certain level of physical and mental health is needed in order to be able to exercise all human rights, which will lead to the enjoyment of genuine physical and mental wellbeing. The

> The potential mental health consultations are related to social elements and life in society rather than gender iden-

[20] *Report on the economic, social and cultural rights of the transgender population of Latin America and the Caribbean* (2014). REDLACTRANS, page 35.
[21] *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* (2012). PAHO.
[22] REDLACTRANS discourages the use of the term "transphobia" and opts to use "gender violence" or "transfemicide" that best describe the situation faced by trans women in the region and incorporate their demands to the broad feminist movement. However, we understand that it is a term that may appear in the related literature or that some trans women may use.

document prepared by the UNDP and other UN agencies in 2016 presents an interesting proposal to reinforce trans women's capacities as a strategy to improve access to health. It is a collaborative guide to implement health programs, especially related to HIV/AIDS. This document highlights the threat posed to the strategies implemented by the discrimination, violence and criminalization of trans people. These situations not only harm mental and physical health but also clearly limit access to health. The document stresses the importance of community empowerment as a way of building mutual trust to form alliances and collaborations between the parties involved. Thus, it proposes that the national, regional and global networks of trans people get involved in these programs because they have broad experience and essential technical knowledge.

3.1. Mental health

Even when we aim at eradicating the pathologization –arising from considering our gender identity choice an abnormality– of trans women, the rejection we cope with and the stress caused by discrimination and social exclusion may be a source of severe unease and distress. The adversity of the surroundings and societal difficulties may affect the emotional and mental health of trans people throughout their lives. Trans people often suffer restlessness, anxiety and depression, as well as suicidal ideations. These conditions are not always considered upon the consultation and our concerns are dismissed.

Trans women are entitled to receiving discrimination- and prejudice-free psychological care because they have to face complex life situations and be part of a social, political, legal and cultural system that stigmatizes them and tries to isolate them.

Firstly, in the event of a physical consultation, it is important to consider the need to conduct a mental health consultation or at least to look for signs of depression or anxiety due to the discrimination and violence we suffer. Medical teams should listen to our consultations with respect and offer decent treatment to ease our concerns. Like everybody else, we want to receive psychological services that do not pathologize our gender identity. Having assumed our identity freed and empowered us.

Some successful experiences include hiring trans women to support us in case of crisis, or even to make us feel more welcomed when starting the psychological treatment.

3.2. HIV and other STIs

The identification of trans people as men who have sex with men (MSM), a health category that reinforces the pathologization of women challenging the gender identity assigned at birth, has severely restricted the availability of specific statistics about the prevalence of HIV/AIDS and other STIs. The document prepared by the PAHO[23] (2012) mentions that the epidemiological data concerning trans women's health in Latin America and the Caribbean are very scant, especially in the case of trans men. The special vulnerability of trans women to HIV/AIDS is revealed in studies that show that the prevalence of HIV in trans women may be forty times higher than the rate for the general population and even twice as high in the case of men who have sex with men. Several studies claim that trans women are the population with the highest prevalence of HIV/AIDS in Latin America, with an average rate of 35% (REDLACTRANS and International HIV/AIDS Alliance, 2012).

Other studies (ATTA-REDLACTRANS, 2007; Asociación Panambi, 2011; Bolivia Red Trébol, 2012[24]) report HIV prevalence rates ranging from 26 to 35%.

A study conducted in 1996 in Brazil[25] sought to identify patterns of discrimination and imprisonment and researched the prevalence of HIV in trans women and men in prisons. The data found shows that the discrimination and violence that turned trans people to crime also shaped their relationship with their bodies and determined high rates of HIV infection among trans persons incarcerated (78% of the 82 persons interviewed tested positive for HIV). Prior sex work and the continuity of such activity inside the prison were the salient factors. Practicing sex work in Latin

[23] *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* (2012). PAHO.
[24] *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* (2012). PAHO.
[25] *HIV infection among Brazilian transvestites in a prison population*, Varella, D. et al. Published in AIDS Patient Care STDS, Vol. 10, No. 5.

American prisons may be a way of surviving or avoiding physical abuse; however, it exposes them to STIs.

Although the research paper was published 20 years ago, the data is undeniably current and many trans women's organizations report this.

Existing studies document alarming HIV prevalence rates among trans women ranging from 15% to 33% (Universidad del Valle de Guatemala, 2010a/b; Hernández et al, 2010; Tabet et al, 2002[26]). This is even more revealing when compared with the data for the general Latin American population: showing a concentrated HIV epidemic, by the end of 2013 a total of 1.6 million people lived with HIV in the region accounting for a prevalence of 0.4%, which may be considered low (Global Fund, 2014). The concentration of the HIV epidemics explains the high prevalence in key populations, such as men who have sex with men, trans women and female sex workers. In Latin America, trans people are affected 28 to 198 times higher than the general adult population, and 2 to 3 times higher than men who have sex with men (Global Fund, 2014). These differences between populations are also seen in countries with low prevalence rates among the adult population, which confirms we are more vulnerable.

These figures show that trans women are almost two times more likely to get HIV-infected than men who have sex with men (prevalence rates ranging from 2.5% to 18% in the same studies). The studies focused on trans women who engage in sex work showed even higher prevalence rates ranging from 28% to 63%, confirming sex work is a considerable risk factor for trans women.

Syphilis prevalence rates also show high rates for trans women ranging from 6% to 51% (Universidad del Valle de Guatemala, 2010 /b; Hernández et al, 2010; Tabet et al, 2002[27]). A study conducted in Argentina shows hepatitis B prevalence averaged 42% among trans women sex workers.

A total of 97% of the trans women sex workers surveyed for the study conducted by the PAHO tested positive for HPV. In addition, three studies assessed the prevalence of HSV2 (herpes) among trans women in El Salvador, Nicaragua and Peru. This study revealed rates between 71%

[26] *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* (2012). PAHO.
[27] *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* (2012). PAHO.

and 81% (Hernández et al, 2010; Universidad del Valle de Guatemala, 2010a/b; Silva-Santisteban et al., 2011).

In a research conducted across Central America in 2012, financed by USAID and undertaken by Iris Group International[28], we found that HIV prevalence in Central America is stable and it is concentrated in key populations, except for Belize, in which case it is still generalized.

According to a study carried out at regional level[29], the Latin American Caribbean is the second region with the highest HIV prevalence rate. A total of 1% of its adult population is affected by the virus, while in other countries such as Belize the rate amounted to 2% in 2008. It included trans women, who constitute the most vulnerable social group to HIV in Belize. HIV infection also particularly affects trans persons and sex workers in the Andean region. This survey shows that, for example, in Peru, almost 55% of men who have sex with men (a category we reject, but it is the one used in the report) interviewed were HIV positive. The study showed that Argentina and Brazil execute a successful HIV prevention and treatment campaign mainly supported by the ongoing relationship between health care agents and the base communities and their organizations. It also highlighted the weakness of the health care and information systems implemented in Paraguay.

In 2015, Samudio, Vesga, Cohenca, Jacobs and Brezzo published a paper on the incidence of HIV in the adult population of Paraguay[30], which shows that the new infections and incidence rates are greater among men who have sex with men, followed by persons who have heterosexual sex.

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[28]Iris Group International (2012). *Diagnóstico de situación en el ámbito de políticas relacionadas con VIH en Centroamérica*. USAID.

[29] *HIV Biennial Report. 2008-2009*. PAHO.

[30]Samudio, Margarita; Vesga, Juan Fernando; Cohenca, Beatriz; Jacobs, Marjolein y Brezzo, Clarisa, *Estimación de la incidencia de VIH en población adulta de Paraguay con el modelo matemático MoT* (2015). Revista Panam Salud Pública, Vol. 37, No. 3. Washington.

According to the *Informe Nacional Sobre los Avances realizados en respuesta al VIH y al SIDA en el Paraguay* (national report on the progress made in response to HIV and AIDS in Paraguay) published in 2014[31], there are 12,564 persons living with HIV, which is higher in men than in women. As in prior years, sexual transmission prevails by 98.48%.

It also reports that the prevalence of HIV and syphilis among the trans community stood at 26% and 12%, respectively, in 2011.

According to the prevalence study of HIV/syphilis in the trans population conducted in Paraguay in 2011[32], 46% of the trans community surveyed admitted to using drugs and almost 68% of that percentage did cocaine.

A total of 89% of the trans people surveyed in 2011 reported that they engage in sex work and 21.7% of that group is HIV positive.

Out of the trans population surveyed, 26% is HIV positive and 12% has syphilis, whereas 6% has both HIV and syphilis.

A study published by Fundación Igualdad LGBT of Santa Cruz[33] in 2008 reported that in the mid-1990s, the Bolivian health system underwent a severe crisis, which directly affected public health and its services concerning HIV prevention and treatment, violating the right of all people under treatment. This boosted the creation of several LGBT groups to urge the State to fulfill its obligations. From 2008 onwards, Bolivia improved its HIV plans and health care for trans people drastically; however, the weakened general health care system negatively affects trans women.

A report conducted in 2012 in Lima[34] showed that trans women are the most vulnerable population to HIV/AIDS in Peru. Out of the 450 trans women surveyed, 64% engaged in sex work; 30% tested positive for HIV; 79% suffered herpes, and 25% had syphilis.

Belize has a high HIV prevalence rate, and according to a report prepared by UNAIDS in 2014[35], it is caused by a selective use of the condom and early sexual intercourse with no sex

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[31] *Informe Nacional Sobre los Avances realizados en respuesta al VIH y al SIDA en el Paraguay* (2014). UNAIDS, Pan American Health Organization and Paraguayan AIDS/STDs Control Program.
[32] E*studio de Prevalencia del VIH/Sífilis y comportamientos, prácticas y actitudes de la población trans en el Paraguay* (2011). PRONASIDA, CIRD, Fondo Mundial, Panambi, ParaGay
[33] Vargas, Pablo C., *Derechos Humanos de Lesbianas, Gays, Bisexuales y Trans (LGBT) en Bolivia: Diagnóstico y Antecedentes* (2008). Fundación Igualdad LGBT of Santa Cruz for Red LGBT del MERCOSUR. Bolivia.
[34] Silva-Santisteban, A et al. *Understanding the HIV/AIDS epidemic in transgender women of Lima, Peru: results from a sero-epidemiologic study, using respondent driven sampling*. Published in AIDS Behav, Vol 16, No. 4.
[35] UNAIDS (2014) *Global AIDS Country progress Report 2014*. Belize

education on prevention and gender violence. In 2012, a survey was conducted to determine population-specific HIV status; however, trans people were not included as such. The survey targeted female sex workers, persons living with HIV and men who have sex with men. A total of 13.85% of the latter group lives with HIV.

In Argentina, a study was conducted to compare HIV/AIDS prevalence among trans and nontrans people who went to Hospital Ramos Mejía in the Province of Buenos Aires between 2002 and 2006[36]. The outcomes show that the trans population was less educated than nontrans people; almost 90% earned low income and 27.6% had a positive HIV serology (which stood at 6.2% for nontrans persons). Moreover, 54.5% of the trans community had a history of STIs as compared to 16.9% in the case of nontrans people.

The data provided by the Uruguayan Ministry of Health[37] show an HIV/SIDA prevalence rate of 28%, which stands at 0.42% for the general population. This rate increases to 36.54% for trans women sex workers.

Moreover, a research conducted in Nicaragua[38] showed that about 22.6% of trans people interviewed in Managua had never been tested for HIV and the remaining 77.4% had. This was mainly due to the massive awareness and sensitivity campaigns launched by trans rights organizations targeting trans women and decision makers.

This same survey shows the problems arising from the negotiation of condom use, an issue that affects both trans and nontrans women who engage in sex work and have intercourse with their romantic partners. A research undertaken in Chile[39] demonstrates that only 67.2% of trans women surveyed used condoms in all sexual relations, whereas the remaining 32.8% did not use condoms

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[36] Toibaro, J. et al. (2009), *Sexually transmitted infections among transgender individuals and other sexual identities*. Published in Medicina Vol. 69, No. 3.

[37] TRANSFORMA 2015. *Diversidad sexual y derecho a la salud: El acceso de las personas trans*. Base document. Published by the Human Rights Division, the Uruguayan Direction of Social and Cultural Promotion (DNPSC) and the Uruguayan Ministry of Social Development (MIDES). 2015.

[38] *Encuesta Centroamericana de Vigilancia de Comportamiento Sexual y Prevalencia de VIH e ITS en poblaciones vulnerables (ECVC) Nicaragua*. Research conducted in 2009. Results published in 2010.

[39] *Caracterización de la vulnerabilidad individual y grupal de personas Trans de la Región Metropolitana, con énfasis en aquellas que ejercen el Comercio Sexual* (2009). CES and MUMS.

consistently. Moreover, only 22% reported using condoms in all the sexual relations with stable partners. The percentage increases when asked about using condoms with their customers: 85.5% reported using condoms in all sexual relations.

According to the Chilean report on AIDS (2014)[40], HIV is mainly transmitted sexually (99.2%), which, in the case of men who have sex with other men is the main reason mentioned. This report does not break down the population into trans people and trans women. As is the case with the two abovementioned studies conducted in Chile, the cases of HIV prevalence and infection for trans women in Costa Rica are difficult to obtain since the statistics do not analyze trans people separately.

Also, a research undertaken in Ciudad Juárez (Mexico) and Santo Domingo (Dominican Republic) in 2006 showed that successful strategies on condom use by female sex workers (both trans and nontrans) with customers and romantic partners were implemented.

Condom use is highly related to access to condoms (usually related to the relationship with the ministries of health and public health institutes) and health care services. Although a high percentage of trans sex workers reported using a condom with the last customer (95.8% in Argentina and 95% in Bolivia), this percentage dropped dramatically when asked about noncommercial partners since only between 37% and 78% reported using a condom (Global Fund, 2014[41]).

The data about behavioral strategies for infection prevention are also very scarce in Latin America and the Caribbean. The scant evidence regarding the scope of prevention programs shows that there is still a high number of trans persons that are not provided with these strategies. REDLACTRANS asserts that in Bolivia, for example, only 47% of trans people undergo prevention programs, whereas 7 out of 10 has already taken an HIV test (Global Fund, 2014).

In the edition published in 2013, Sevelius highlights that health care agents should have accurate and updated information to ensure quality. Therefore, using the right terminology is essential, especially upon planning a long-term therapy or treatment, particularly HIV treatments, which was their object of study.

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[40] *Informe Nacional de Progreso sobre SIDA en Chile* (2014). UNAIDS and Chilean Ministry of Health.
[41] In this section we refer to the data included in the concept note submitted by REDLACTRANS to the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2014.

In addition to considering the ways in which trans women follow treatment on an ongoing or intermittent basis or suspend or resume treatment, we should also think of the ways in which the different health care systems in Latin America and the Caribbean design and adopt strategies to make us feel part of the community and welcomed in health care institutions.

3.3. Use of alcohol and other psychoactive substances

Although there are studies on substance use among trans people, this topic has not been discussed as much as other issues (such as HIV and hormone replacement therapies). The document published by the PAHO refers to reports that suggest that alcohol and other substance use is very high. This practice is much more frequent among sex workers.

According to this document, such use would not be related to recreational uses but rather to hostile sex conditions (a source of discrimination and institutional violence in Latin America and the Caribbean). Many trans women sex workers are forced to use substances to promote customers' use in the workplace. For example, they are forced to use alcohol at night clubs so that customers also buy alcohol and the owners of the bars and sex work venues boost their profits.

Alcohol and other substances may reduce the capacity to negotiate the conditions of the sexual encounter, which increases vulnerability and raises the chances of getting HIV and other pathogens.

Besides, substance use may be related to the living conditions of trans women and the rejections they encounter since a young age. Many of us are forced to work since we are teenagers, especially as sex workers, after being expelled from our houses, public spaces and schools, among others. Such exposure and vulnerability may lead to psychoactive substance use.

The Central American survey of sexual behavior and HIV/STI prevalence among vulnerable populations conducted in Nicaragua in 2009[42] showed that about 82% of the trans people interviewed in Managua had used alcohol within the last 30 days and almost 20% used drugs.

[42] *Encuesta Centroamericana de Vigilancia de Comportamiento Sexual y Prevalencia de VIH e ITS en poblaciones vulnerables (ECVC) Nicaragua*. Research conducted in 2009. Results published in 2010

In 2009, according to a study focused on trans-friendly health care in Buenos Aires, Argentina[43], 68% of the trans people that went to the hospital used alcohol and 76% used drugs as compared to 8.8% and 7%, respectively, for nontrans persons.

That same year a study was conducted in the Metropolitan Region of Chile[44] and revealed that 85.9% used drugs. Out of that group, 56.4% randomly used drugs; 27.3% almost always used drugs, and 16.4% always used drugs.

In addition, substance use may also be related to the social discrimination and stigma faced daily by trans women. This type of emotional suffering may lead to using antidepressants or other drugs to alleviate anxiety, neglect or unease. The guidance to trans health care prepared by the PAHO[45] mentions the lack of studies confirming this relationship, though they refer to a research (conducted by Tobairo et al. in 2009) that indicates the frequent use of alcohol in trans women sex workers. Substance use seems to be related to the need to endure a violent and hostile environment. It also acknowledges the existence of situations related to sex work in which trans women are forced to use alcohol with their customers.

3.4. Negative effects of the self-administration of hormones and other body modifications

Using hormones to initiate transition processes to feminize bodies, as well as the application of injectable substances is usually performed outside the health care system with no medical monitoring or subsequent medical support.

The document prepared by the PAHO[46] mentions that in the case of hormones used to feminize bodies (estrogens and antiandrogens), the collateral effects may include: thromboembolic disease, hepatic failure, hypertension, gallstones, migraine, fluid retention and other conditions related

[43]Toibaro, J. et al. (2009). *Infecciones de transmisión sexual en personas transgénero y otras identidades sexuales*. Published in Medicina Vol. 69, No. 3.
[44] *Caracterización de la vulnerabilidad individual y grupal de personas Trans de la Región Metropolitana, con énfasis en aquellas que ejercen el Comercio Sexual* (2009). CES and MUMS.
[45]*Por la salud de las personas trans. Elementos para el desarrollo de una atención integral de personas trans y sus comunidades en Latinoamérica y el Caribe* (2012). PAHO.
[46]*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* (2012). PAHO.

to the employment of high doses of estrogens, such as alterations in the production of the lactogenic hormone, insulin resistance and the development of hormone-dependent cancers.

In addition to hormone administration, many trans women inject soft tissue fillers (most commonly, silicone fluid or methacrylate) to modify part of their bodies. The information available suggests that trans women use substances to alter the shape of their breasts, buttocks, legs, lips or cheeks.

Soft tissue fillers are usually injected by unqualified personnel under poor hygiene conditions and bad aseptic and antiseptic measures, with chemical contamination of the fillers (with linseed oil or mineral oil) and bacterial or fungal contamination.

In addition to the complications derived from these conditions, the practice of injecting industrial silicone (polydimethylsiloxane) or liquid paraffin directly to the subcutaneous cellular tissue or the cheeks may have sever medical consequences, such as lung embolism and fatal consequences[47]. There were also cases of granulomatous hepatitis, acute kidney failure, ulcers, cellulitis, scars, abscesses and infections.

In Uruguay, 38% of trans people wish to undergo a sex reassignment surgery but the State does not meet their demand and a significant number of trans persons are administering hormones without medical control and with no clear information on its negative consequences (Transforma report, 2016).

> *Although not every trans woman is a sex worker, many of us are. Thus, it is important that we are asked about it and that our responses are assessed without judging or stigmatizing us.*

Hormone and physical transition therapies should be conducted in a health care facility that advises trans people, offers the best procedure and contemplates the particularities of each case while understanding health as a comprehensive process.

These practices are performed outside the system due to the abovementioned reasons. Another reason is the inexistence of a gender law that ensures our rights; these procedures are not

[47] *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* (2012). PAHO.

gratuitous in some countries; therefore, conducting them within the medical system entails disbursing lots of money that many trans women do not have. In addition, health care services do not follow inclusive health care protocols and the experiences lived by trans women are usually characterized by mistreatment, stigmatization and discrimination, among others. Another problem is that clinic hours tend to be incompatible with our jobs or the availability of appointments is very small to meet the demand.

These problems vary in the different countries in the region and are drastically lower in the countries that, having enacted a gender identity law work, have been working towards ensuring comprehensive health care for trans people.

3.5. Other health issues

All the papers and narratives include different health issues derived from sex work (which involves most trans people) and general situations.

- Dermatological problems (rashes, itching, pustules, parasitic infestation) caused by the use of clothes and fillings made of synthetic fibers, excessive sweating and lack of basic hygiene services.
- Genital infections caused by providing sexual services in poor hygiene conditions.
- Leg and back pain caused by standing for long periods.
- Dental problems, caries, herpes and infections.
- Sleep disorders or insomnia.
- Eating disorders, including anorexia, bulimia and malnutrition.
- Respiratory diseases, congestions caused by working in the streets in cold temperatures.
- Wounds, including those caused by sexual and institutional violence.
- Physical and psychological consequences of bullying, discrimination, harassment and transphobia. Paranoia, anxiety and personality disorders, among others.

3.6. Trans women's determinants of health

From a comprehensive health paradigm, health is a state of complete physical, mental and social wellbeing rather than the mere absence of disease. This definition is based on a complex interaction of biological, ecologic, cultural, economic, political and social phenomena. From this

perspective, factors such as the access to education and housing, the economic situation and social inclusion are deemed determinants of a healthy life.

Therefore, it is essential upon analyzing the health status of trans women in Latin America and the Caribbean to consider that our lives have been exposed to institutional exclusion, basic rights violation, discrimination and violence.

Exclusion, stigmatization, discrimination and violence

According to the Bolivian survey published in 2011 of TLGB persons [48] conducted in La Paz, Cochabamba, Santa Cruz, Oruro, Tarija, Sucre, Trinidad, Potosí and Cobija, 91.7% of the trans people surveyed reported suffering from discrimination and mistreatment by the medical personnel (nurses and doctors) and even 29.2% reported that they were denied access to a hospital or health care center. A total of 82.4% did not have medical insurance.

The Bolivian health care system creates dynamics of exclusion that affect the entire population and intensify the already existing barriers for trans people. A study published in 2011 by Ledo, Soria, MC, MSP and AS[49] also highlights this problem and explains the Ministry of Health's incompetence to regulate the different health care subsystems from a sanitary, administrative and financial standpoint.

In the first case study about the living conditions, social inclusion and human rights of LGBTI persons in Ecuador conducted in 2013, a total of 2,805 persons belonging to the LGBTI community were surveyed: 31.10% were trans; 29.20% were gays; 23.60% were lesbians, and 15.90% were bisexuals. Out of the total persons surveyed, 55.8% reported having encountered discrimination in public spaces; 71.4% were expelled from public spaces, and 65.6% suffered violence in public

[48] *Encuesta Nacional de Situación de las poblaciones TLGB en Bolivia* (2011). Series Estudios e investigaciones. Conexión-Fondo de emancipación.
[49] Ledo, Carmen; Soria, René; MC; MSP and AS (2011). *Sistema de Salud en Bolivia*, article published in Salud Pública de México, Vol. 53, No. 2.

spaces in Ecuador. The study shows that 58% of the LGBTI population did not have access to social security or any other type of health insurance.

The report prepared by Transforma (2016) revealed that 45% of the trans people surveyed in Uruguay had suffered violence on the basis of gender identity.

According to a publication by Asociación Panambi de Paraguay in 2014[50], the failure to recognize the trans people category makes it impossible to produce accurate statistics on the murder of trans women. Following the same line, it explains that discrimination, prejudice and stigma interfere in the performance of unbiased and independent investigations to identify the murderers. As a result, murders go unpunished and murderers are prosecuted for "traffic accidents" or "altercation in a public space", which do not reflect the characteristics of the hate crime or transphobia.

Based on the national survey on sexual diversity performed in 2013 by the Chilean Homosexual Movement of Integration and Liberation (MOVILH)[51], we are aware that in Chile 74.5% of the LGBTI population suffered discrimination on the basis of sexual orientation or gender identity sometime in his/her life and 92% has never reported the discrimination lived. However, we are unable to know many of these are trans people since the data is not broken down.

Obstacles in accessing education

The survey conducted by the INDEC and INADI in Argentina in 2011[52] showed that one of the greatest difficulties encountered by trans people is access to education. According to the survey, only 64% of the trans population surveyed finished primary education; 20% finished secondary education, and only 2% ended tertiary or university studies.

The fight by LGBT organizations has shown the exclusion of trans women in the educational system and the discrimination suffered due to our gender identity while studying or when we are

[50] *Olvidadas hasta en la muerte. Asesinatos a personas trans durante el período democrático en Paraguay* (1989-2013) (2014). Asociación Panambi. Asunción, Paraguay.
[51] *Primera Encuesta Nacional. Diversidad Sexual, Derechos Humanos y Ley contra la Discriminación* (2013). Chilean Homosexual Movement of Integration and Liberation (MOVILH).
[52] *Atención de la salud integral de personas trans. Guía para equipos de salud* (2015). Program of Sexual Health and Responsible Procreation of the Argentine Ministry of Health.

looking for a job. REDLACTRANS reveals in one of its documents that 65% of trans people in Latin America has suffered violence at school[53].

The paper prepared by ATTTA, REDLACTRANS and UNSE explains that "the school environment has a thorough geometry of the heteronormed bodies; that is, a set of rules and indications on how to be a boy or a girl. This situation reinforces stereotypes and cause trans women to be victims of discrimination, stigma and even physical violence because they do not match the parameters that education establishes for men and women"[54]. The document prepared by REDLACTRANS in 2014[55], *Report on the economic, social and cultural rights of the transgender population of Latin America and the Caribbean*, also states that "the nonrecognition of gender identity by students, teachers and authorities results in violence, bullying and harassment, which make it hard for transgender people to remain in the education system"[56].

Limitations in accessing formal employment

In Uruguay, like in other countries in the region, the severe discrimination at school and the workplace keeps trans people away from well-compensated jobs (Transforma report, 2016).

Access to the job market is another point mentioned in the documents reviewed. The survey performed by the INDEC and INADI in Argentina revealed that 20% of the trans population surveyed does not conduct any compensated activity[57]. The remaining 80% engaged, at the time of the survey, in activities related to prostitution and/or sex work, or other casual and informal jobs. The survey administered by ATTTA and Fundación Huésped[58] confirm these tendencies and assert

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[53] *Report on the economic, social and cultural rights of the transgender population of Latin America and the Caribbean* (2014). REDLACTRANS.
[54] *Situation assessment of PLWHA trans women with regard to the adherence to ART in Argentina* (2016). ATTTA, REDLACTRANS and UNSE.
[55] *Report on the economic, social and cultural rights of the transgender population of Latin America and the Caribbean* (2014) REDLACTRANS.
[56] *Report on the economic, social and cultural rights of the transgender population of Latin America and the Caribbean* (2014) REDLACTRANS, page 32.
[57] *Atención de la salud integral de personas trans. Guía para equipos de salud* (2015). Program of Sexual Health and Responsible Procreation of the Argentine Ministry of Health.
[58] *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* (2012). PAHO.

that 71% of trans women are self-employed, whereas 13% are payroll employees. Out of the total persons surveyed, 61% engages in prostitution or sex work.

According to the Transforma report (2016), based on the first center of trans people in Uruguay, the number of trans people who engaged in sex work at the time of the survey (2016) or in the past stood at 64.9%.

Access to formal employment was hindered by a complex combination of factors, including the lack of personal documentation matching the self-perceived gender identity and social prejudice. Even those who manage to penetrate the formal employment market find it difficult to fit in because they are bothered and pestered by peers and bosses[59].

Every time a trans woman is called from a doctor's office with a male name, the possibility of her joining the health care system is lost and she becomes another victim of discrimination.

Poverty and access to decent housing

According to a study conducted by Colafranceschi, Failache and Vigorito in 2013[60], the trans population in Uruguay is poorer than the rest of the population.

Working conditions faced by trans women exert a direct effect on housing. According to the aforementioned survey conducted in Argentina, 50% of trans people surveyed live in deficient houses[61]. The report prepared by the PAHO[62] concurs and states that in Buenos Aires trans women are usually denied housing, who are forced to pay astronomically expensive rent for inadequate houses with no access to their own kitchen (49%) or bathroom (48%). The discrimination and rejection suffered by many trans women from their own families heightens the risk of ending up on the streets since they are young. In fact, the report filed by the Uruguayan Ministry of Health[63] indicates that between 15% and 20% of trans people in Uruguay are homeless.

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[59]*Report on the economic, social and cultural rights of the transgender population of Latin America and the Caribbean.* REDLACTRANS.
[60]Colafranceschi, Marco; Failache, Elisa y Vigorito, Andrea (2013). *Desigualdad multidimensional y dinámica de la pobreza en Uruguay en los años recientes*, El futuro en Foco: Cuadernos sobre desarrollo humano. UNDP. Uruguay.
[61]*Atención de la salud integral de personas trans. Guía para equipos de salud* (2015). Program of Sexual Health and Responsible Procreation of the Argentine Ministry of Health.
[62]*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* (2012). PAHO.
[63] TRANSFORMA 2015. *Diversidad sexual y derecho a la salud: El acceso de las personas trans* (2015). Base document. Published by the Human Rights Division, DNPSC (Uruguayan Direction of Social and Cultural Promotion) and

The report filed by REDLACTRANS in 2014, which explores housing conditions, finds that in the countries surveyed in this regard most trans women surveyed do not have their own house and deal with many difficulties to rent. Like in the rest of the documents reviewed, it mentions that "the main difficulty encountered in access to housing, land, or credit is the inability to demonstrate financial solvency, with no formal employment record. And of course, pervasive stigma and discrimination add complexity to the situation and create difficulties even in the few cases where there are usually guarantees required".[64]

In addition to sex work, life on the streets and substance use, poverty is a risk factor which raises trans women vulnerability to infections and health issues.

Hence, it is no wonder that trans women consider the health care institutions as highly discriminatory places where they only go in case of emergency. Failing to recognize our identity and ignoring our decisions regarding our lives and identity contributes to preventing trans women from receiving health care and, therefore, prevention or early intervention.

Below we include materials, examples and tools so that the different medical teams and health care workers people involved in health care may get acquainted with the strategies to provide all trans women in Latin America and the Caribbean with a human rights-based approach to high-quality long-term comprehensive care.

4. Comprehensive health: prevention, care and support[65]

Uruguayan Ministry of Social Development (MIDES).

[64] *Report on the economic, social and cultural rights of the transgender population of Latin America and the Caribbean* (2014). REDLACTRANS, page 39.

[65] The recommendations included herein arise from dialogues with trans women that face several obstacles upon accessing health care services. We also considered the studies referred to in the first section of these guidelines that tackle the issue from a medical or social science standpoint. Finally, to supplement the information contained in some sections we used the information included in the following materials: *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*, published by the PAHO; *Atención de la salud integral de personas trans. Guía para equipos de salud*, published by the Program of Sexual Health and Responsible Procreation of the Argentine Ministry of Health in 2015; *Consultorios amigables para*

Trans women in Latin America and the Caribbean are affected by social factors and the surroundings. We speak different languages, belong to different ethnics, some are aboriginals, others afro-descendants, some have immigrated, others migrated and some have immigrant grandparents. Some are homeless while others were able to buy or occupy the places where they live. Many have stable romantic partners whereas others have multiple sex partners, or are married to men or women (trans and nontrans) with whom they plan to have or adopt children. Some speak Spanish because they learned it at school while another language was spoken at home. Some are thin, others obese and other wear wigs. Some have undergone surgery or plan to have it while others have no interest at all and would rather not undergo surgery or hormone therapies. Some trans women in Latin America and the Caribbean are religious, whereas others are not; through we believe in God, we do not trust churches.

Some are sex workers, others engage in different work and professional activities, both compensated and not compensated. Some have family dependents, others were rejected by our families or live with them in an environment of acceptance.

Our gender diversity is supplemented by the multiple social, religious and cultural differences of the societies in which we live. Therefore, the doctor's visit or medical treatment should be based on respect, attentive listening and sufficient time to discuss our situation.

It is essential that a depathologizing approach is adopted, which acknowledges gender identity as one of the multiple expressions of human diversity rather than a disease or pathology.

The Center of Excellence for Transgender Health recommends eight best practices for HIV prevention among trans people:

1) Ground your proposal in the trans people community and its recommendations.
2) Incorporate racial and ethnic issues that are specific to trans people.
3) Use multidisciplinary approaches to HIV prevention that focus not only on the strict definition of health but also on wellbeing, and consider the friends, families, social networks and communities.
4) Share accurate information to assess and improve the situation.

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la diversidad sexual. Informe ejecutivo, published by the United Nations Development Programme in 2013; *Guía de Buenas Prácticas para la atención sanitaria a personas trans en el marco del sistema nacional de salud*, published by the Red por la Despatologización de las Identidades Trans del Estado Español (Spanish network to stop trans pathologization) in 2010, and *Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions*, edited by the United Nations Development Programme, and others.

5) Look in all the right places while planning and implementing prevention actions; for example, by bringing health care services to trans people in their neighborhoods and places of work, among others.

6) Increase health care access to trans people by having locations with easy access to public transportation; provide services in those countries where the trans population is characterized by immigration, among others.

7) Invest in developing and supporting the staff engaged in the prevention proposal, which will shape the method of communication with the trans persons who attend the health centers of prevention campaigns.

8) Advocate for structural and systemic change on behalf of trans people.

Trans women are entitled to comprehensive health care that considers their mental and physical health, personal circumstances, social and economic context and environment. Health care should not only focus on HIV prevention or health care in case of emergency; instead, it should adopt different medical approaches that consider community health, training on health, treatment and support, active listening and depathologized psychological follow-up, among others. Moreover, this provision should be competent, safe, confidential, respectful and destigmatized.

Our first recommendations are related to the places where health care begins. As already mentioned, many times there is no need to create new spaces, but rather reorder and restructure existing resources, services and infrastructure.

These guidelines are also aimed at reintroducing the discussion on universal access to care by upholding our right to undergo treatment and health promotion and prevention services. Universal Access to Health and Universal Health Coverage entails that all people and communities have access, without any kind of discrimination, to comprehensive, appropriate and timely, quality

health care services determined at national level according to needs, as well as access to safe, affordable, effective, quality medicines. Latin America adheres to these definitions, but we are aware that universal access ignores a considerable portion of the population[66].

Institutional responses to ensure long-term approaches

Trans women's health care issues are covered by well-intended specialists, professionals and agents who try to counteract poor structure operation with hard work.

Service quality cannot depend on the isolated performance of some professionals or group of people that, once disintegrated or left short of funds, end up cancelling the service provision.

A comprehensive health care service needs to be formalized through action protocols, stages and stable strategies agreed by consensus. This will ensure a comprehensive health care system that works properly regardless of the goodwill displayed by certain people.

Waiting rooms, shared spaces and public toilets

Waiting rooms should be places of tolerance, coexistence and diversity.

There were many cases in which the waiting rooms of different medical specialties not exclusively related to trans women care (ER, traumatology, dermatology, and endocrinology, among others) led to conflicts characterized by verbal and physical violence, harassment, mistreatment or discrimination.

In many cases, the spatial distribution (a few chairs, small spaces and overcrowding) makes people nervous and ill-disposed, and trans people are made scapegoat of the situation and abused, as is the case in other social spaces.

Waiting rooms should have information about diversity (which may be, for example, signs displayed on walls and consultation brochures, among others) and statements to demand respect from all users.

[66]For additional information on universal access to health care, please visit the PAHO's site: http://www.paho.org/hq/index.php?option=com_content&view=article&id=9392%3Auniversal-health&catid=6253%3Auniversal-health-coverage&Itemid=40244&lang=es (last accessed on September 5, 2017).

Also, the toilets that respond to the "woman-man" binary system make many trans women feel an outcast. It is high time we authorized women's bathrooms that embrace diversity since trans women should go to women's toilets and feel accepted.

Trans-friendly health care should consider the violence and intolerance that characterizes the political, social and economic context of each country and city. When going to a toilet for nontrans and trans men, for example, men should also feel protected from other men's attacks. There were cases in which trans women and men were attacked by other users in the toilets or waiting rooms of the medical facilities and many of these aggressions were fostered by the lack of personnel available to get involved in these situations or their lack of experience.

Clinic hours

> *It is high time we generate multiple signals that make us feel welcomed and understood. If there are no resources available, the existing signals may be intervened to make them more inclusive*

Several elements should be borne in mind regarding the time availability to render medical services. Many trans women are sex workers; therefore, rest and work schedules usually differ from other people. Therefore, to include trans sex workers, health care services should be provided in the afternoon.

We also recommend offering a broad schedule to add as many trans women as possible.

Persons involved in access to health care

Undoubtedly, in many cases, health care specialists, administrative staff, surveillance team, nurses, service and cleaning personnel and cooperatives were not given the possibility of joining a sensitivity program and undergoing training on diversity. However, they are the first persons we contact when entering an institution or service.

These employees (personnel engaged in administrative, surveillance and registration tasks, night watch persons, day and night care assistants, emergency admission personnel and nurses) should be trained and undergo sensitivity programs concerning trans women's health. When these employees treat us inadequately or violently, our vulnerability rockets, even above the levels experienced on a daily basis. This may have direct effects on our health and life.

For example, if we have a bad experience when we enter a hospital, may not come back and suffer the consequences of not having or interrupting treatment.

The guide *Por la salud de las personas Trans* (for trans people's health)[67] recommends that this training be extended not only to the medical personnel but also to officers in ministries, departments, customs and airports, among others.

Legal name and identity name

In the Latin American countries in which a gender identity law was enacted that allows trans people to obtain a legal name representing gender identity, the relationship between the legal name and the name preferred according to the identity does not cause major complications. However, in those countries in which no law has been approved, trans women bear the legal name that does not match their gender identity.

Many times trans women do not go into the physician's office because the medical care providers (physicians and nurses) call them by the names appearing in the ID instead of the name preferred based on their gender identity. The same happens with some noun and pronouns chosen ("this man" instead of "this women" or using "he" instead of "she", among others).

It is essential that trans people are called by their preferred name according to identity rather than the name appearing on the ID card when accessing health care services (in all its stages: reception, identification and care).

These forms of discrimination stigmatize us and keep us away from health care services. Therefore, the likelihood of not attending or continuing treatment increases since we fear (and avoid) contact with professionals if we are welcomed incorrectly.

4.1. First contact (initial care protocol)

[67] *Por la salud de las personas trans. Elementos para el desarrollo de una atención integral de personas trans y sus comunidades en Latinoamérica y el Caribe*. Original version: Bockting, W. and Keatley, J. Improved version: Pan American Health Organization and Regional Committee, 2011.

Due to ongoing discrimination, attacks, aggressions, mistreatment and physical and symbolic violence, trans women fear or avoid going to health care services. Hence, when a trans woman enters for severe or chronic cases, it is essential to try to display a comprehensive approach to her health.

As already mentioned, due to this generalized context of hostility against trans women, the first contact at the health care facility determines whether we will continue attending or not. Thus, front-line and second-line support personnel (depending on the country, it may be safety guards and the receptionists who record our names or administrative personnel and nurses, among other) should be necessarily trained in gender, sexuality and diversity from a human rights-based approach that fosters respect and quality. The religious, political and social practices of these people should not and cannot affect how they treat the trans people attending health care.

The patient intake form is essential. The name of the woman attending the consultation is registered in the form and it is fundamental that the countries that have not enacted a gender identity law register the preferred name in the form.

Both the current gender and the sex assigned at birth should be detailed to consider the identity, as well as the current anatomy. This is key since, if not asked explicitly, health care providers could make wrong assumptions concerning our health (for example, sexual and reproductive), about our sex practices and the potential diseases or problems we may encounter.

The approach should be respectful and based on dialogue or else we will not be willing to expose our bodies to examination by personnel who refuse to call us by our names or use the appropriate pronouns.

Respect to gender identity should be combined with a thorough examination of the organs present and biology. For example, in the case of trans women, depending on whether they underwent surgery to bring their body into greater congruence with their gender identity, it is essential to examine the breast, the prostate, the penis, the testicles, the anus and the vagina (in case of a male-to-female genital surgery), among others. Thus, a comprehensive approach can be adopted. These examination practices should be conducted in a setting of respect, with sufficient time since it

Removing the hierarchical distance between the "patient" and the "doctor" is possible if we are listened to carefully and without prejudice, we are provided with careful and accurate information and advised of the different actions and treatment available to make an informed decision.

may be very difficult for trans women to be examined. All women's relationship with their body is affected by the social and cultural context. The relationship with our own bodies is very complex as a result of the experiences of discrimination and stigmatization at the health care settings, the violence suffered, the attacks received in different situations and the stigmatization. Respect, attentive listening, goodwill and understanding should govern all consultations, especially when being examined. Another major factor to be considered is that sex, sex practices, eroticizing and sex roles are different for each trans woman. They are neither necessarily related to nor directly derived from the gender identity or sex assigned at birth. Any information not asked may support an incorrect assumption and lead to a wrong treatment. The most common cases (among others) are related to sex and reproductive health; for example, it is usually assumed that a trans woman does not use her penis in sex or only has sex with nontrans men. This incorrect assumption leads to informing incomplete or incorrect reproductive barriers or methods for preventing STDs. Thus, no assumptions should be made on the sex assigned at birth, the current gender identity, whether sex is practiced with women, men, trans women, trans men; whether she is a sex worker (and if this is the case, which services are provided) and whether she adopts any reproductive and sexual health care strategies. However, exotism should be avoided. This means that there is no need to go into detail about elements that are unrelated to our consultation. We want to receive, like anybody else, an excellent service that addresses our illness, offers a treatment or solves our doubts or problems that led us to the consultation in the first place. There is no need to inquire us about our experiences and elements that are not key to the consultation and that only make us feel uncomfortable. For example, if we go for dengue confirmed by blood tests, asking us about our sex practices or the reasons why we decided to undergo surgery or not is completely unnecessary and does not contribute to the development of a diagnosis.

A very successful strategy is having trans personnel to welcome trans women. This strategy may be adopted in the spaces that specifically address trans people.

In addition, the specialists and nurses should provide us with complete information in an accessible manner. Moreover, they should ensure a space to erase our doubts without fear of being mistreated by the questions we ask.

The comments on the processes to adjust our bodies to our gender identity are always negative, even when they are made to "admire" such body transformation.

Besides, the interventions to "recommend" us to undergo surgery or modify our bodies to meet the medical team's expectations on "how a trans woman's body should be" affect our perception on health care and hinder access, adding more difficulties to those already in place.

In an appointment for groin pain, a doctor said to a trans woman: "You are trans? How weird! You don't' look trans", as a "compliment". The woman felt very uncomfortable and was unable to create the bond of trust needed. She did not continue her treatment.

Feldman and Goldberg[68] (2007) explain that the ways of intervening trans women's bodies differ from one person to the other. Our clitoris, vagina, nipples and breast may have different morphologies and color. Moreover, our skin may react differently to medicine and treatment (acne, dryness and allergic reactions).

Professionals should never use us and our bodies or life as example in front of other people without our permission.

Finally, many international studies refer to dental health as a good space to begin contact with trans women. Due to the dental problems faced by the entire population (tooth decay, bite problems, orthodontia and acute pain) caused by work (excess of energy drinks, unprotected oral sex), bad habits and substance use (alcohol, tobacco and marijuana) and medicines and hormone use that generate gum problems, trans women go to on call dental urgent care or dental appointments much more frequently than to other specialties. Therefore, it is a proper place for specialists to approach us.

Health care services and providers should ensure confidentiality and privacy.

The lack of economic resources seriously limits our access to this specialty since all the implants, root canals and interventions to protect or heal the tooth are very expensive and are rarely included in the gratuitous services granted by the government. Even so, we need to be advised of existing options, the benefits and potential complications of each alternative and how they may affect other treatments.

[68] Feldman, JL and Goldberg, J. *Transgender primary medical care: Suggested guidelines for clinicians in British Columbia* (2006). Vancouver Coastal Health - Transgender Health Program.

Usually, the injuries to our gums, tongue, teeth and mouth are related to other problems and should be used as an indication of potential illnesses or infections.

Always ask:

- Reason for consultation
- Personal medical history
- Family medical history
- Psychological and social background and context (if appropriate)

4.2. STIs and HIV (treatment, counselling, and support)

As discussed in the previous chapter, trans women are particularly vulnerable to HIV and other STIs. Research on the topic showed the high prevalence rates of these infections across trans women in Latin America. Undoubtedly, such rates are related to the difficulties in negotiating condom use, mistreatment, violence and the systematic discrimination at the health care system.

This section focuses on the difficulties encountered to access HIV and other STI screenings, proper counselling to prevent contagion or accurate and timely information to access treatment.

The different research papers mentioned in the previous chapter show that trans women are less likely to conduct HIV and other STI testing than other at-risk groups, such as men who have sex with men. Although trans women have high prevalence rates of HIV and STIs, the trans community is concerned about the impact of positive HIV or STIs on access to hormone therapy and surgeries, in addition to the fear of how this diagnosis may affect social interactions since it is highly stigmatized.

It is fundamental to reinforce the systematic use of condoms and dental dams as strategies to prevent HIV and other STIs. It is also important to assess the need to use other methods of prevention, such as hepatitis A and B vaccinations.

In addition to sexual risk behaviors of unprotected anal intercourse, trans women may be at risk through sharing injection needles during drug, hormone, and soft tissue filler injections. Sometimes hormone use can result in mood swings and feminizing hormones may impair erections, making condom use more difficult. Sex workers

are at a higher risk for HIV, particularly when customers offer more money for unprotected sex. Also, trans women feel that they are not in a position to negotiate safer sex for fear of losing a partner. This happens to us, as well as the groups of women who are also affected by the patriarchal society in which we live.

Like other at-risk populations, the studies conducted show that trans women are more likely to practice unsafe sex with their main or stable noncommercial partners[69].

Trans women who test positive for HIV or other STIs face other challenges: access to and continuity of treatment. The studies analyzed in section 3 argue that access to HIV and other STI treatment is limited. This is so due to the lack of coverage and the need to avoid health care providers who lack the cultural tools required to handle our needs. Due to the fear of discrimination and poor prevention practices trans women delay seeking care, which leads to additional complications. Moreover, ensuring the continuity of treatment is challenging for a group of people who are constantly denied access.

Sexual health approach

Active listening and openness are essential to cater for trans women seeking health care. To detect the risks of contracting HIV and other STIs, information should be gathered on sex history: the number of current and past sexual encounters, as well as the gender of these romantic partners. It is also important to ask about "changes" in sexual orientation. "Sexual orientation" may change when transitioning to another gender, especially due to the use of hormones. Inquire about the use of condoms, lubricants and barrier products; prior STIs, history of sex abuse and potentially dangerous sex practices (for example, gags and bondage, S&M and autoerotic asphyxiation, among others). Explore the existence of self-destructive behaviors that might require referral to a mental health care service.

[69] *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* (2012). PAHO.

No assumptions should be made and it should be acknowledged that gender identity and sexual orientation are different categories, and trans women may have different sex practices. It is advisable to ask whether the person has had sex with men, women, trans people or all of the above rather than using labels such as homosexual, bisexual, pansexual or heterosexual. Follow-up questions may include specific sexual practices. For example, many trans women who have sex with men are versatile; that is, they do not always adopt a passive (receptive) position during anal sex. It is important to ask only the questions relevant to analyze the patient's health and not invade privacy and intimacy.

The best way of working on these fears is facing them. Active listening is the core of counseling to allow for informed decisions. It is not about building a specific office but rather making the time to address questions, fears and expectations. HIV counselling should be oriented to prevention and take into account trans-specific risk factors and cofactors.

Counseling should be based on confidentiality and address individual risk factors. We recommend supplying proper, timely and understandable information on HIV and STIs, focused on prevention.

There are some incorrect ideas on the interference of HIV treatment with trans-specific medical treatment (hormone therapy and surgery). The inaccurate information held by some health care professionals about the interference of the antiretroviral therapy with hormone treatments is a major barrier to access to HIV treatments.

Trans women with HIV can receive antiretroviral therapy like other HIV positive people. Trans women undergoing hormone treatment or who plan to pursue the treatment in the future can receive antiretroviral therapy as well, taking into account some special considerations. The simultaneous use of antiretroviral therapy and hormone therapy drugs may increase or decrease the level of hormones in the blood. Then, the professionals that monitor the hormone treatment should analyze whether the dose of hormones administered should be changed. There is no evidence on the impact of hormone therapy drugs on the effectiveness of the antiretroviral therapy.

The medical team should encourage trans women with HIV to access and follow HIV and STI treatment, for example, by combining this treatment with the hormone therapy desired, which is a top priority for many trans women.

Trans women who test negative for HIV and STI should undergo frequent tests.

4.3. Methods to bring our bodies into greater congruence with gender identity (surgical and hormone procedures and cosmetic treatments)

Injectable soft tissue fillers

There are many trans women who inject medical- and industrial-grade silicone, lubricant oil, mastic sealant, baby oil and a variety of other substances in their hips, buttocks, thighs, breast, lips or face. These injections may have been administered by medical staff who did not follow the protocols established or by other trans women. These procedures are usually performed with lack of appropriate sterilization in inadequate settings. The risks related to these procedures include local and systematic infections, clots, painful granulomas and even a systemic inflammatory response syndrome that may lead to death. When a trans woman states that she wants to change her body, it is important to assess the current or future risks of applying these soft tissue fillers, and she should be counselled appropriately. The complications from injections may require cosmetic surgery to repair damages.

The risks of undergoing dangerous body changes may be addressed in specialized counselling, in which hormone therapy and surgeries are properly discussed. Counselling should focus on these specific cases and adopt a harm reduction approach.

Hormone administration

The person who decides to begin a hormone therapy to transition from one gender to the other requires special attention. Although the transition grants the possibility of easing the pain related to gender identity, it makes this desire to change gender more visible to the rest. In other words, in addition to the medical process, the transition represents challenges with our loved ones, at school and at the workplace. This process could be much easier, in some cases, with the aid granted by mental health teams.

When starting hormone treatment, it is essential to assess the trans woman's capacity to thoroughly understand the risks and benefits of the treatment. It is important to build a space of dialogue to channel doubts and understand changes and the steps of the transition. The first consultations should also inquire about the prior use of cross-sex hormones, either prescribed by another health professional, obtained in a drugstore or through acquaintances or means that did not involve prior medical exams. Medical providers should ask about these prior experiences without making any judgment on the decisions and circumstances lived by trans women.

The hormone treatments that were administered independently by trans women may be continued. Medical personnel should abide by the harm reduction approach. When they are determined to continue taking medication even if it is not medically supervised, in general, the physician should deliver the medical care and prescribe the appropriate hormones. If a trans woman is denied care, she will likely continue the treatment on her own, probably to her own detriment.

When cross-sex hormones are prescribed for a woman who has never used them before, personnel should study preexisting physical and mental conditions to determine the preparation and dose to be prescribed. The professional is liable for monitoring the effects of the hormone treatments administered.

If a trans woman requests a hormone treatment and is already receiving hormones, health care providers should examine the current treatment and conduct a comprehensive health assessment. This assessment is used to determine whether it is advisable to change the dose or hormone preparation.

Relevant literature agrees that the only absolute contraindication to begin or continue estrogen or testosterone treatment is cancer sensitive to those hormones. Other conditions such as obesity, cardiovascular diseases and dyslipidemia do not prevent treatment provided that it with informed consent.

Baseline laboratory testing

Baseline laboratory testing should include a fasting lipid panel (if the patient takes estrogens orally). Potassium and creatinine should be tested for patients on spironolactone. Use female reference values for trans women taking estrogens. Creatinine clearance should be used as the clinic criterion along with muscle mass and body fat.

In addition, lab tests should consider family history, age, concomitant diseases, sexual activity and other relevant risk factors.

Fertility issues

The health provider who initiates therapy should discuss fertility issues with trans women.

Cross-sex hormones may reduce fertility and this may be permanent even if hormones are discontinued. Estrogen tends to reduce libido, erectile function and ejaculation. Testosterone tends to increase libido.

Facial and body hair

Some specific aspects should be borne in mind upon beginning a hormone treatment. The distribution of body hair is strongly affected by androgens, which are more abundant in people who are born men and cause hair to sparse across the body. The administration of female hormones to trans women does not remove facial or body hair if it grew during puberty. Therefore, many trans women have to deal with a masculine hair distribution, including a mustache and beard that need to be shaved or waxed and covered with makeup every day.

Waxing may be a solution if it is performed by qualified personnel, but it entails risks based on the color of the skin. Another option is laser hair removal, in which case it should be examined which service provider is best skilled and equipped to work on each type of skin.

Electrolysis is another alternative to remove body and facial hair, but it is an expensive, uncomfortable and lengthy process. It should be conducted by a qualified professional well informed on the procedure and follow-up care (for example, avoiding sun exposure and makeup, among others).

Skin care

Male skin has, in general terms, bigger pores and more sebaceous glands. The administration of female hormones contributes to changing these characteristics and the skin becomes much softer after the treatment.

Makeup applied in excess may obstruct the pores and inflame the sebaceous glands. Makeup with low oil content should be used according to each skin type.

Trans women should not share cosmetics, especially those applied in the eyelids and lips because it is a common way of spreading several infections. Decorative contact lenses should not be shared either because they spread eye infections or may cause severe damage to the cornea.

Skin can be irritated by some fabrics and materials. Tucking may also affect the skin.

Hormone therapies for trans women include the administration of estrogens, progesterone and antiandrogens. Below we include some specific considerations on these treatments:

- **Estrogen administration**

  Estrogens should be administered sublingually (the oral formulation is dissolver under the tongue instead of swallowing it), transdermally (patches) and intramuscularly rather than orally since they need to be metabolized. Oral estrogens increase the risk of thromboembolism in smokers aged over 35.

  Lower doses of estrogen are recommended after a gonadectomy. Periodic tests should be conducted and the doses should be increased or decreased according to each person's tolerance.

- **Progestogen administration**

  Some risks and benefits of progestogen administration are still unknown. Some suppliers found that it has positive effects on the areola around the nipple and libido. The effects on mood are ambiguous, they may be either positive or negative. Some women may gain weight and suffer emotional alterations like depression.

  Some studies that reviewed the use of oral progesterone in postmenopausal women (for example, the study conducted by the ***Women's Health Initiative*** *[WHI]) found that oral medroxyprogesterone may increase the risk of heart disease whereas intramuscular injections (for example, Depo-Provera) may reduce this additional risk.*[70]

- **Antiandrogen administration**

  The treatment is initiated with a single or divided dose with weekly lab tests. Younger and overweight or obese women may require higher doses. Since progesterone also has antiandrogen effects, it may be an alternative especially in those cases in which spironolactone is contraindicated.

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[70] *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* (2012). PAHO.

If the patient is balding, finasteride may be added supplementary (even at the beginning of the treatment). Hair implants may be useful.

Follow-up care

Most medical problems that arise in trans women are not secondary to cross-sex hormone use. This confirms the importance of adopting a comprehensive approach to trans women's health, including primary care and psychological and social support.

Follow up medically at 4 weeks, 3 months, 6 months and every 6-12 months thereafter. These appointments should be more frequent if other problems arise. Check blood pressure, side effects, emotional changes, sexuality, weight and quality of life (inquire about any risk behavior). Clinical evolution should be monitored by evaluating subjective and objective physical and emotional changes.

Consider giving calcium and vitamin D supplements should be analyzed pursuant to current osteoporosis management guidelines aimed at maintaining bone density.

First few follow-up appointments: 1 to 6 months

- Assess for desired and adverse effects of medication.
- Check weight and arterial pressure.
- Review overall health status.
- Perform a physical exam, if needed.
- Discuss social adjustment, libido, sexual behavior and quality of life. Assess new risk factors to hormone treatment.
- If on spironolactone (an anti-androgen medication), check potassium.

Half-yearly appointment

- Assess for desired and adverse effects of medication.
- Check weight and arterial pressure.
- Review overall health status.
- Perform a physical exam, if needed.

- Discuss social adjustment, libido, sexual behavior and quality of life. Assess new risk factors to hormone treatment.
- If spironolactone dose increased, check potassium. Testosterone is generally not checked unless patients have little evidence of feminization.

Annual appointment

- Assess for desired and adverse effects of medication.
- Check weight and arterial pressure.
- Review overall health status.
- Perform a physical exam, if needed.
- Discuss social adjustment, libido, sexual behavior and quality of life. Assess new risk factors to hormone treatment.
- Prolactin screening once at 1-2 years after beginning hormone therapy.
- Breast cancer prevention according to standard guidelines, assessing risk factors on a case-by-case basis and using algorithms based on current evidence.
- Annual rectal exam +/- prostate antigen according to national standards and considering the risk factors in personal and family history.

In the case of elderly trans women, a mammography is recommended. This exam should be included when patients have used estrogens for, at least, 30 years and are aged 50 or over unless there is a family history of early ovarian and breast cancer.

Primary health care providers should refer trans women to the related specialties to conduct the procedures for assessing overall health status. An urology consultation is appropriate for trans women.

They should also be cognizant of the effects of body modifications since they may offer postoperative care for women who underwent surgery.

Surgical transition for trans women

Orchiectomy

Orchiectomy is the removal of the testicles. Some trans women will have this procedure without a vaginoplasty or penectomy. Estrogen therapy may need to be adjusted post-orchiectomy;

orchiectomy may permit lower doses of estrogen therapy and eliminates the need for testosterone blockers.

Vaginoplasty

Vaginoplasty is the construction of a vagina using penile tissue or a colon graft. The procedure usually involves clitoro-labioplasty to create an erogenously sensitive clitoris and labia minora and majora from surrounding tissues and/or skin grafts, as well as a clitoral hood. Colon grafts do not require dilation and are self-lubricating; however, lubrication is present at all times and may be bothersome. Additionally, colon grafts must be screened for colon cancer and should be monitored by the surgical team if the patient develops inflammatory bowel disease.

Penectomy

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

Breast increase

If breast growth stimulated by estrogen is insufficient, augmentation mammoplasty may be indicated for adequate gender affirmation.

Chondrolaryngoplasty

It is the procedure to shave the thyroid cartilage (known as "Adam's apple").

Vocal cord surgery

It is an experimental procedure to raise pitch. Speech and language therapy is recommended.

Facial feminization

Facial feminization includes a broad range of cosmetic surgery procedures designed to change masculine face proportions. Some women need these procedures to facilitate social interaction.

Post-surgical monitoring

Examine for difficulties in healing. Post-operative complications may include bleeding, infection or impaired wound healing.

After pedicled penile flap technique vaginoplasty, the patient must dilate 3-4 times daily using progressively larger dilators. After the initial 6-12 month period, if the patient is having regular sexual intercourse, no further dilation is required. Otherwise, continue routine dilation once or twice per week. Lubrication is required to have sex.

Possible late complications include stenosis of the new urethral meatus. In case of infection or complication, refer to a surgeon with expertise.

Other controls

Breast cancer

All trans women should follow routine screenings, even if they have not undergone breast hormone treatments or surgical interventions. These screenings should follow the guidelines applicable to natal genitals and breast cancer family and own history.

Trans women aged 50 and over with past or current estrogen hormone therapies and other risk factors such as positive family history, combined use of estrogens and progestin for more than 5 years and/or high body mass index should perform a bilateral mammography. There is no evidence that testosterone either decreases or increases the risk of breast cancer so screening practices would not change due to the use of this hormone.

Upon conducting a mammography, it should be considered whether a mammoplasty was done to ensure proper procedures due to the risk of implant rupture and potential interference with the sensibility of the analysis.

Prostate cancer

As is the case with breast cancer, all trans women should also follow routine screenings, even if they have not undergone breast hormone treatments or surgical interventions. These screenings should follow the guidelines applicable to the genitals at birth and family and own history of prostate cancer.

Using antiandrogens appears to decrease the risk of prostate cancer, but the degree of reduction is unknown. Trans women aged 50 and over undergoing hormone treatments should perform frequent digital rectal exams to check the prostate. In these cases, PSA is not recommended as PSA levels may be falsely low in an androgen-deficient setting, even in the presence of prostate cancer.

Trans women who underwent male-to-female genital surgery should undergo prostate cancer testing because the prostate is not removed. Since the vagina is created from a virtual space between the rectum and the prostate, the proper exploration of the gland may require the performance of a pelvic exam.

Anal cancer

Some studies show an increase in anal cancer risk caused by human papillomavirus (HPV) among people who practice anal sex, mainly HIV-positive people and with a lower CD4 count or any other cause of immunosuppression, and a history of anal injuries caused by HPV. In these cases, anal cancer should be screened performing anal pap tests. However, there is scarce evidence on the natural evolution of anal intraepithelial neoplasia, the reliability of detection methods and response to treatment. To be able to recommend these tests, the medical facilities should have personnel specialized in anatomic pathology who can interpret annual pap smears. It is also important to identify the circuit to provide the patient with referral in the event of a positive pathology result since it will require the performance of a high-resolution anoscopy and follow-up by proctology or, otherwise, general surgery.

4.4. Substance use and abuse

As already mentioned, substance use may be related to living conditions and the number of rejections faced by trans women since early age and/or the criminalization and persecution of sex workers (which is the only work opportunity for many of us).

In addition to the possibility of feeding addictions and causing irreparable consequences to our bodies, alcohol and other substances may reduce the capacity to negotiate the conditions of the sexual encounter, which increases vulnerability and raises the chances of getting HIV and other pathogens.

In the case of consultation for substance use and others (allergies, problems affecting the GI tract and insomnia, among others), health agents should inquire about trans women's relationship with several substances. This is relevant to make an accurate diagnosis of the problem that gave rise to the visit and to prescribe and administer medication (considering incompatibilities, neutralizations and counter indications, among others). To such end, specialists should be updated on pharmaceutical and chemical information to detect drugs which may counteract or neutralize other drugs. Moreover, these drugs may interfere with other treatments (antiretroviral, antibiotic, antiallergic and hormone); therefore, health specialists need to be acquainted with all this information.

Inquire on substance use without prejudice and in a nonjudgmental way to allow for honest answers. Include questions on self-medication with over-the-counter medicines with no medical monitoring.

The medical team should also consider history of substance use, the amounts taken or used in combination with other drugs (cocaine and alcohol, tobacco and marijuana, among others), dose, frequency of use, administration and the conditions related to substance use (feeling nervous at work or after an episode of violence, among others).

We recommend working with a standardized (confidential) questionnaire to record:

- Substance abuse
- Frequency of substance abuse (current and past)
- Drug dosage
- Drug administration
- Conditions leading to use
- Body and mental reactions perceived after use

Many times substance use is a way of evading the depression or unease caused by the constant and systematic discrimination and social exclusion faced by trans women. Therefore, there are psychological treatments to discuss this situation and reduce, as a direct consequence, drug and psychoactive drug use.

Stress, anxiety and panic attacks may be triggered by withdrawal symptoms or intoxication, so if the questions are designed appropriately it may change the way of addressing the issue.

We recommend designing counselling programs for trans women to prevent, reduce or discontinue substance use. These spaces should be friendly, preferably coordinated by trans women who have lived similar situations, and organized in spaces and opening hours compatible with trans women's activities.

In cases of moderate or high use, health agents should inform us on drug-related dangers, risks and problems.

Finally, when dealing with substance use, there are two possibilities available: (a) abstaining (completely avoiding substance use and abuse) and (b) moderation (changing the patterns and substance used by another one less harmful). The outcomes and sustainability of these treatments are

very different and should be considered based on the conditions, dose, administration, dependency level, use conditions and social context of each trans woman.

4.5. Psychological care (nonpathologizing mental health)

A medical team that seeks to adopt a holistic approach should be multidisciplinary and contemplate the different dimensions of health from the first visit.

As already mentioned, health care should be provided from a depathologizing standpoint. Health, defined as physical, mental and social wellbeing, includes several individual and collective factors.

Trans women cope with rejection by health and education institutions, discrimination, economic inequality, stigmatization, difficulties to access the formal employment market, the impossibility to access decent housing and family rejection, among others. Although these issues do not necessarily characterize trans women's lives, many of us deal with some or several of these experiences.

They may lead to depression, anxiety and even suicidal thoughts or ideas. Most trans women do not display symptoms, but require psychological treatment to overcome these situations.

People working in health care institutions should be aware that referral of trans women to mental health is an option provided that they know that the problem is not our gender identity; instead, what affects our wellbeing is the way society treats us on the basis of our identity.

Our full development depends on others and we handle hostile and confrontational people on a daily basis. This happens to many people, not just trans women (for example, the LGBI community, women who decide not to be mothers, people who contravene social customs, among others). Some studies showed that belonging to a trans women's association, peer support, support networks and family acceptance are successful strategies in reducing the consequences of stigma-driven discrimination.

A proper psychological or psychiatric treatment for depression, anxiety, panic and suicidal tendencies can improve the quality of our lives and, consequently, promote treatment completion and help us reduce substance abuse.

The person in charge of making the first contact, for example, in an emergency room, and, if appropriate, the mental health specialists in case of referral, should be cautious upon analyzing a

trans woman's life (whether she is socially isolated or homeless, if she has any STI, if she has poor health, if she is self-medicating or if she discontinues her hormone treatment, among others).

A peer-based psychological treatment is recommended since counselling of other trans women who have already lived and addressed or resolved that issue is both a support and goal for trans women who are beginning psychological or psychiatric treatment.

In several occasions, physicians refer trans women to mental health specialists because they find them unstable, irascible or apathetic. However, this is caused by a hormonal imbalance (due to hormone self-medicating) rather than a psychological reason.

We recommend hiring trans personnel to help us in crisis or to accompany us during therapy. We also suggest making waiting rooms and administrative processes friendlier and more inclusive.

4.6. Support in cases of violence, discrimination and stigmatization

Trans women face higher levels of violence than other sectors. In addition to the macho violence suffered by all women, there is the institutional violence lived while working in the streets and gender violence may even end in a transfemicide. Gender violence is individual and group attitudes and behaviors of rejection, disdain and violence to trans people. In line with the ideas mentioned in the second section, gender violence against us is highly related to ignorance, prejudice and discrimination. Violence against trans women is very common across Latin America and the Caribbean, so trans women are always on the defensive. Trans women's vulnerability increases as these cases go unpunished and victims are not provided with legal accompaniment.

Many trans women go to clinics and hospitals for emergencies. Health care personnel should pay attention to the victim's stress and avoid creating additional burdens to her already difficult situation. They should cultivate an open, depathologizing, respectful and nonprejudiced attitude based on the awareness of the violence suffered by trans women.

They should check for potential sexual aggression, which may be related to physical aggressions or not. The severe emotional distress suffered by a trans woman who was exposed to physical

and sexual violence should be addressed, as well as the physical injuries. She should also be offered the proper HIV or other STI post-exposure prophylaxis.

The medical teams should request, if appropriate, training on gender identity and sexual identity, and become acquainted with the situation lived by vulnerable groups, such as trans women. Primary health care teams are essential to improve our health; therefore, they should be competent and skilled to provide comprehensive health care services.

Peer counselling is an efficient method to buffer the negative effects of the violence suffered. Besides, easing access to a legal counsel to file a claim may be welcomed, especially if it is understood as an articulation between the medical and legal systems.

5. How do we move forward? Creating networks and fostering dialogue

Changing the representations or social ideas on gender and sexuality is a difficult and lengthy process. Much progress was accomplished in Latin America and the Caribbean in recognizing people's right to decide their gender identity, appearance and sexual orientation. However, hate crime, discrimination and transphobia warn us on the need to continue working to create a more equal and inclusive society. Obtaining more information on gender identity, sexual identity and sexuality has allowed us to deepen the discussion on the construction and reinforcement of stereotypes and categories that affect our life and prevent full health development.

REDLACTRANS led the way to disclose information on our situation as trans women. We published health materials (see section 2 herein) on HIV/AIDS among trans women and the violation of our basic rights that jeopardize our health.

The next steps are aimed at creating an exchange network made up of players and organizations involved in the subject matter to consolidate a comprehensive approach to trans women's health. We propose working with peers to consolidate debate channels and drafting proposals involving civil society members, health care professionals, members of the scientific and academic fields, decision makers and the general population. To this end, REDLACTRANS will work on training trans women so that they may replicate these recommendations to health care professionals and other trans women.

We strongly believe in the creation of dialogue and exchange channels between peers. We refer to people interested in working towards the consolidation of comprehensive health care facilities or services from an inclusive approach. Thus, we suggest reinforcing exchange between trans women and health care organizations, as well as between health care professionals in different countries, cities and establishments. Generating exchange channels between health care professionals that can reveal successful experiences may be a future task of paramount importance.

Our experience has showed us that building exchange networks that involve those willing to work actively in this field makes our claims and strategies visible and powerful. Building networks does not necessarily entail formalizing these spaces, but rather joint work, information exchange, debate on future strategies and sympathy when making a claim.

To ensure health establishments where trans women may access and feel welcomed and understood, implementing strategies with trans women's involvement is fundamental. Trans women may participate in these spaces to transmit specific knowledge to health care professionals, as well as provide other trans women with vital information on treatment and care. This can be possible if the organizations have allies that facilitate the meaningful involvement of trans women in debates and decision-making processes (UNDP and IRGT, 2016). As already mentioned, there are success stories which show that health treatments were effective when accompanied by others trans woman to the consultation.

Finally, we believe that strategies like these guidelines exceed the individual actions displayed by referents and outstanding professionals in the medical field and broaden the field of action to all trans women who seek health care and all the professionals rendering these services. The best way to achieve the targeted long-term changes is to devise a collective approach to trans women's health.

6. Final recommendations

Throughout these guidelines, we gathered information on trans women's health in Latin America and the Caribbean. We described the specific health needs of the trans community and included a plethora of recommendations on different aspects regarding our health.

We designed these guidelines as a quick and practical source to be reviewed and followed. Users have a different age, profession, education and time availability.

These guidelines express trans women's voice because we are acquainted with comprehensive health care strategies to ensure trans women access to health and do not avoid medical treatment altogether.

Below we include some recommendations mentioned herein, which implementation will ensure comprehensive access to health care for all trans women.

- ✓ While drafting these guidelines, we noticed there is not much information on health care services from a comprehensive and human right-based approach characterized by the best practices at regional level. The information contained herein describes countries or subregional blocs. We should generate such information, especially concerning the different countries across the region.

- ✓ Trans women's associations should be included in assembling, designing, changing and sustaining the comprehensive health care services destined to trans women. We have a deep knowledge on the most efficient techniques and the specific ways of approaching the trans women community.

- ✓ Employing trans women for initial care and reception in the areas earmarked for and planned for trans people usually boosts the quality of our experience in health care services.

- ✓ Health care workers should use the gender identity reported by trans women. In this sense, it is essential to refer to trans women by their preferred name and pronoun.

- ✓ Comprehensive health care should consider trans women's diversity. This refers not only to gender diversity, but also social, ethnic, capacity, age and economic, among others.

- ✓ Our body, mental and social wellbeing depends highly on context. No diagnosis or treatment, consultation or recommendation will be accurate if it fails to consider the stigmatization, discrimination, violence or harassment lived by trans women almost every day.

- ✓ Enacting a gender identity law changes these conditions drastically. However, many countries in Latin America and the Caribbean still have not passed this law.

✓ If the right to health is a human right, the provision of trans-friendly health care services is a necessary and unavoidable tool to access this universal right.

✓ It is essential that a depathologizing approach is adopted, which acknowledges gender identity as one of the multiple expressions of human diversity rather than a disease or pathology.

✓ Health care services should prepare an institutional and structural response. The quality and continuity of trans women in comprehensive health care services cannot depend on the kindness or sympathy of isolated people, regardless of their good intentions.

✓ First, health care services should reorganize existing resources and train its personnel.

✓ Intervening common and public spaces will make it easier for trans women to access and stay on health care, as well as finish treatment.

✓ Signals, boards, brochures and administrative forms should acknowledge and account for gender diversity (and other diversities as well).

✓ Health agents should stay abreast of gender issues and body transition.

✓ Front-line and second-line support personnel (receptionists and initial care) should undergo sensitivity trainings on diversity and gender.

✓ Any question left unasked may support an incorrect assumption and lead to a wrong treatment. To optimize time, resources and service quality, the people involved should ask everything deemed necessary and should not make any assumption on our practices and bodies.

✓ Physicians and nurses should provide us with clear information related to the reason for the medical consultation, the diagnosis, the potential responses and the advantages and disadvantages of different treatments. This should be conducted in an environment characterized by horizontal relationships, preferably nonhierarchical, conducive to discussing our questions and inquiries.

✓ Health care services and providers should ensure confidentiality and privacy.

✓ We promote and encourage the creation and consolidation of communication networks and strategies between trans women and people working in the medical field; between organized trans women and trans women who still have not joined any organization, and between the different health care centers to share the best practices and recommendations.

“With no human rights for trans people, there is no universal health prevention, care and treatment”.

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