FROM BARRIERS TO BRIDGES

Increasing access to HIV and other health services for trans people in Asia

BANGKOK, THAILAND
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Abbreviations

AJWS	American Jewish World Service
APTN	Asia Pacific Transgender Network
CBO	Community based organisation
CCM	Country Coordinating Mechanism
HIV	Human immunodeficiency virus
FHI 360	Family Health International 360
LGBTI	Lesbian, gay, bisexual, transgender and intersex
MSM	Men who have sex with men
NAP	National AIDS programme
NCPI+	National Coalition of People living with HIV in India
PEPFAR	United States President's Emergency Plan for AIDS Relief
PFTM	Pioneer Filipino Transmen Movement
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
SOGI	Sexual Orientation and Gender Identity
STI	Sexually transmitted infections
TRCARC	Thai Red Cross AIDS Research Centre
UNAIDS	Joint United Nations Programme on HIV
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
WPATH	World Professional Association for Transgender Health

The term "transgender" encompasses many culturally specific identities and refers to a diverse population of people whose gender identities and/or expression differs from the sex assigned to them at birth, typically based on biology. It includes people who self-identify as transgender as well as those that identify as gender non-conforming or non-binary or third gender. The trans health and rights conference *From Barriers to Bridges* includes transgender people in all their diversity.

Acknowledgements

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1. Introduction

Transgender women are one of the most vulnerable populations to HIV, with a global HIV prevalence of 19% and a risk of HIV infection 49 times that compared to the general population.[1] Despite this high risk, transgender women are subsumed under HIV programming for men who have sex with men (MSM), resting on the assumption that shared anatomy and sexual practices drive vulnerability. Transgender men are completely absent from the discourse.

Transgender persons share risk factors that are common with other populations, such as intimate partner violence, sexually transmitted illnesses (STIs), unprotected sex, injecting drug use, and multiple substance use, but they also experience unique biological, cultural, social, legal and economic barriers that drives their susceptibility to adverse health outcomes including mental and physical health. The vulnerability to HIV among transgender community is driven by multiple factors including social and economic determinants, legal/regulatory barriers, widespread stigma and discrimination, and, in many settings, a lack of trans-sensitive healthcare providers trained to offer medically appropriate services.

The growing focus on improving HIV services uptake and retention among transgender communities, and recognizing them, as a distinct population, different from men who have sex with men (MSM), has led to the development of several technical and programme guidance documents and tools. These include the WHO 2014 guidelines on key populations,[2] the Transgender Implementation Tool (TRANSIT),[3] and the Asia-Pacific Regional Trans Health Blueprint.[4] All of these resources offer practical advise on approaches to improve transgender health, reduce risk of HIV, and deliver trans-competent services. They recommend that HIV services need to be integrated and offered as part of a holistic, responsive trans health package, and that social and legal policies, especially those that criminalise and demean gender expression, need to change.

For countries in the region to bring the AIDS epidemic under control, and meet the UNAIDS 90-90-90 target—90% of all people living with HIV (PLHIV) know their HIV status, 90% of all PLHIV receive antiretroviral therapy, and 90% of all people receiving treatment achieve viral suppression—by 2020, requires a smarter, more comprehensive and targeted response that strengthens linkages to and across the HIV cascade of prevention, testing and treatment services.

The regional conference, ***From Barriers to Bridges: Increasing access to HIV and other health services for trans people in Asia***, held in Bangkok, Thailand, from 20 to 22 September, 2017, addressed the need expressed by transgender communities to develop trans-sensitive community health and HIV services and discussed how to replicate best practices on effective and innovative community-led and healthcare provider-driven models and strategies. The aim was to identify gaps in capacity to operationalise guidance on trans health and human rights, to propose potential partnerships and identify resources to fill the gaps, and to work towards achieving the UNAIDS 90-90-90 targets on testing, treatment and viral load suppression through the development of country roadmaps or actions plans.

Over 150 participants from 17 countries[5] in the region attended the conference and engaged in evidence-informed discussions on HIV, health, law and human rights issues in regional and national contexts, and also shared their personal stories on accessing health services. The country delegations included five people from different sectors of society, including transgender-led community based organisations (CBOs) or non-governmental organisations (NGO), government representatives, healthcare providers, national human rights representatives or an academic, and transgender people. Donors and technical partners were also present, and shared their experiences and knowledge. **Annex A** includes the full list of participants and the agenda.

1 Baral, S., Poteat, T., Strömdahl, S., et al (2012). Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *Lancet* 13(3):214-222.

2 World Health Organization (2014). *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. WHO. Geneva. In addition to recommendations on health sector interventions, the guidelines, as part of a comprehensive HIV response, also include recommendations on critical enablers that include social and legal barriers.

3 United Nations Development Programme (UNDP), IRGT: A Global Network of Trans Women and HIV, United Nations Population Fund et al. (2016). *Transgender People: Practical Guidance for Collaborative Interventions (the "TRANSIT")*. UNDP. New York. The implementation tool is based on recommendations of the 2014 WHO guidelines and is designed for use by public health officials, managers of HIV and sexually transmitted illnesses (STI) programmes, NGOs and CBOS, and health workers. It offers strategies for managing programmes and building capacity of trans-led organisations.

4 Health Policy Project, APTN, UNDP. (2015). *Blueprint for the provision of comprehensive care for trans people and trans communities in Asia and the Pacific*. Futures Group. Health Policy Project. Washington, DC. The Blueprint strengthens and enhances the policy-related, clinical, and public health responses and identifies high-level priority considerations including participation of trans people in research, advocacy, and policy, improving health service and public health, ending violence against transgender people, moving from discriminatory laws to protective laws, and promoting legal gender recognition.

5 The countries included: India, Nepal, Pakistan* from South Asia; Cambodia, Indonesia, Laos PDR, Malaysia, Myanmar, Philippines, Singapore*, Thailand, Timor Leste* and Vietnam from Southeast Asia; and Australia*, Mongolia*, New Zealand*, and Papua New Guinea. China was included in the mapping exercise of transgender health services but was unable to attend. * partial delegations.

2. Objectives, structure and expected outcomes

The conference provided a shared space for a range of stakeholders from different sectors, including transgender people, civil society and service providers, government officials and technical partners, to come together and design trans-specific services including HIV services that could assist countries in reaching the 90-90-90 targets. The specific objectives[6] included:

1. Discussions on HIV epidemiology and broader health and human rights issues facing trans communities, including the paucity of disaggregated data, limited policies and programming, and strategies to address these gaps;
2. Sharing successful models, practices, and lessons learned from the region to better reach trans communities with HIV prevention, testing and treatment services; and
3. Identifying technical assistance and capacity building needs of transgender communities, governments, and healthcare providers to support the implementation and roll-out of regional and global guidelines and tools for improving HIV Cascade performance including identifying, reaching, testing and diagnosing transgender people and linking those that test HIV positive into treatment, support, and care.

The three-day conference was organised as a series of panel discussions followed by a set of workshops, for in-depth learning and sharing of specific projects and interventions. On the third day participants developed country specific plans that identified capacity building and technical support needs. The intended outcome of the meeting was to develop national action plans that operationalised existing tools, guidance, and best practices in the form of a roadmap for trans health services, including an implementation strategy for reaching the first two 90-90-90 targets, identifying HIV-positive transgender persons and ensuring that they are on treatment and linking others to prevention services.

This meeting report summarises the presentations, discussions, and group work in different workshops.

6 From the Concept Note of the Trans Health and Rights Conference.

BRIDGES

3. Summary of proceedings – Day 1

Opening remarks

Joe Wong, Asia Pacific Transgender Network, welcomed all participants and noted that the gathering, the first of its kind, with a diverse set of regional and national partners, provided an opportunity to share and develop plans for trans health services. He expressed that over the next three days, participants had the opportunity to learn from each other and to form constructive partnerships shaping future trans health and HIV services for their countries. These community-led, innovative, and gender affirming services respectful of the rights of transgender people in all their diversity, he noted, could serve as an example for others in the region as well as those beyond Asia and the Pacific. He affirmed APTN's commitment, as well as other stakeholders involved in organising the conference, to building partnerships and supporting countries in delivering gender-affirming healthcare and meeting the UNAIDS 2020 HIV targets.

Professor Emeritus Dr. Praphan Phanuphak, Thai Red Cross AIDS Research Centre (TRCARC), reflected that despite the long history of the HIV epidemic in Thailand transgender persons were invisible, conflated with the MSM community. In 2014, with support from USAID and LINKAGES FHI 360, TRCARC separated out services for transgender people from MSM and set up the first ever clinic in Thailand (and the region) managed by transgender staff and gender-sensitive medical professionals serving the health needs of transgender men and women, and other non-binary persons in the form of the *Tangerine Community Health Centre* (Tangerine Clinic). At the Tangerine Clinic the HIV services were free, but transgender persons paid for other trans-related health services such as hormones, testing of hormonal levels, and other gender-affirming healthcare.

The success of the Tangerine Clinic in delivering stigma-free and high-quality health services has resulted in the expansion of transgender health services through community based organisations (CBOs) in Chiang Mai, Hat Yai, and Pattaya (urban centres in Thailand), and three teaching hospitals in Bangkok. These examples, linking transgender persons who come into receive trans-specific health services with HIV programming, provide much needed evidence for improving transgender health outcomes, he noted.

Clinical Professor Dr. Piyasakol Sakolsatyadorn, head of the Thai Ministry of Public Health, observed that Thailand was committed to achieving the UNAIDS targets including access to HIV and other health services--part of the United Nation's Sustainable Development Goal 3 on 'ensuring healthy lives and promoting well-being for all at all ages'. He noted that the transgender community was an important sector of Thai society, and faced pervasive social and legal barriers in healthcare settings and broader society. As part of Thailand's commitment to achieving the UNAIDS targets, it was important to ensure that no transgender persons are left behind in the HIV response.

U.S. Ambassador to Thailand, the Honourable Glyn T. Davies acknowledged that UNAIDS 90-90-90 targets were ambitious, but noted that achieving them was inevitable to end AIDS. He applauded Thailand's commitment in addressing the HIV epidemic, including expansion of health services for transgender people. He expressed that the big challenges for transgender communities were the social and legal environments. There were immense variations in the legal gender recognition laws and pervasive, and in some cases, growing, discrimination and social exclusion that affected access to social benefits and healthcare. The conference, he noted, provided an opportunity for transgender people to define and put into practice their vision of 'stigma-free' HIV and health services.

Rena Janamnuaysook from TRCARC ended the session with personal reflections on transitioning as a transgender woman, and difficulties faced by transgender persons in accepting their own identity and accessing appropriate and gender-affirming health services. But, she noted that, it was equally important to have access to mental health services since depression and post-traumatic stress disorder (PTSD) associated with violence and victimisation were common occurrences but rarely addressed by health services. There was, she recalled, very little information available on mental health, sexual risk-taking behaviours, and HIV. She urged participants in the room, especially government members, healthcare providers, and donors to support transgender people and ensure their greater participation in delivery of services and in research. Her experiences at the Tangerine Clinic show that it is an exemplary model of integrated services for transgender peoples from which participants could learn and adapt for their settings.

Panel 1: Reaching 90-90-90 through proactive HIV and health agendas

Panel members

- Eamonn Murphy, UNAIDS RST-AP, Thailand, provided a regional overview of HIV epidemiology and information on HIV
- Thomas E. Guadamuz, Mahidol University, Thailand, discussed HIV risks in the context of syndemics approach, which is defined as the concentration and deleterious interactions of 2 or more diseases or other health interactions, and in the current context syndemic psychosocial problems
- Asa Radix, Callen-Lorde Community Health Center, U.S.A. (via Skype), reviewed the global models of comprehensive care in the context of the right to health as a human right
- Nittaya Phanuphak, Thai Red Cross AIDS Research Centre, shared information on the Tangerine Clinic model of health service delivery and linkage to HIV services

Moderator

- Stephen Mills, FHI 360

Eamonn Murphy presented the latest epidemiological data on HIV in the Asia-Pacific region, and challenges in reaching the UNAIDS Fast-Track targets. There are 5.1 million persons living with HIV and 270,000 new HIV infections per year. The Fast-Track targets call for a reduction of fewer than 90,000 new infections. At the current trajectory of decline, with a 'business as usual' response, countries would fall short of the target by 151,000 new infections. The data shows that eight countries account for the majority of new infections, and there was significant variation among them (Figure 1). New infections were increasing in Pakistan and the Philippines. There was a general absence of data on transgender people, and the few available studies from select geographical locations showed a higher HIV prevalence in transgender people compared with the general population (Figure 2). With no information for transgender people on 90-90-90 targets and the low levels of prevention and testing coverage among them, Eamonn concluded that it would be difficult for countries to achieve 2020 Fast-Track targets and end AIDS without addressing the public health needs and social justice and human rights of transgender communities.

Thomas E. Guadamuz provided an important perspective into the syndemics[7] approach and HIV risk for transgender people. He noted that syndemic psychosocial problems, such as depression, anxiety, substance use or abuse, suicidal ideation, bullying, and violence (physical, verbal, social, sexual, and cyber-based), coupled with parental rejection, internalized transphobia, and discrimination by healthcare providers, contributed to the increased risk of HIV infection. Therefore,

7 Syndemics are defined as situations in which diseases co-occur in particular temporal or geographical context due to harmful social conditions and interact at community level with mutually enhancing deleterious consequences for health. Several publications discuss this approach including: Operario, D. and Nemoto, T. (2010). HIV in transgender communities: syndemic dynamicsand a need for multicomponent interventions. *Journal of acquired immune deficiency syndrome (1999)*. 55(Suppl 2), S91. Poteat, T., Scheim, A., Xavieer, J. et al. (2016). Global epidemiology of HIV infection and related syndemics affecting transgender people. *Journal of acquired immune deficiency syndrome*. &2(Suppl 3), S210. Wansom, T., Guadamuz, T.E., and Vasan, S. (2016). Transgender populations and HIV: unique risks, challenges, and opportunities. Journal of virus eradication. 2(2), 87.

Figure 1.

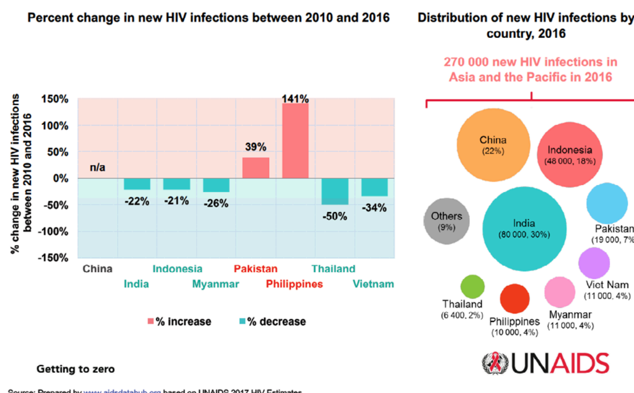
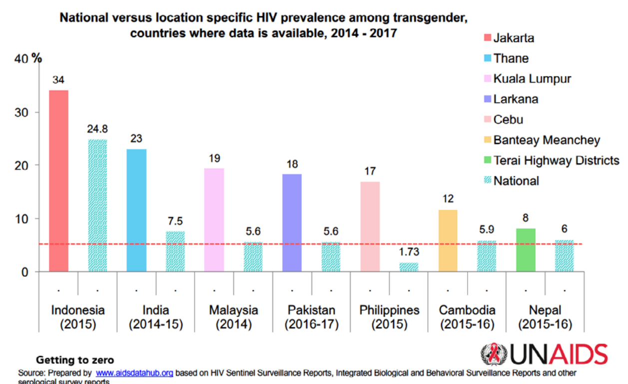


Figure 2.



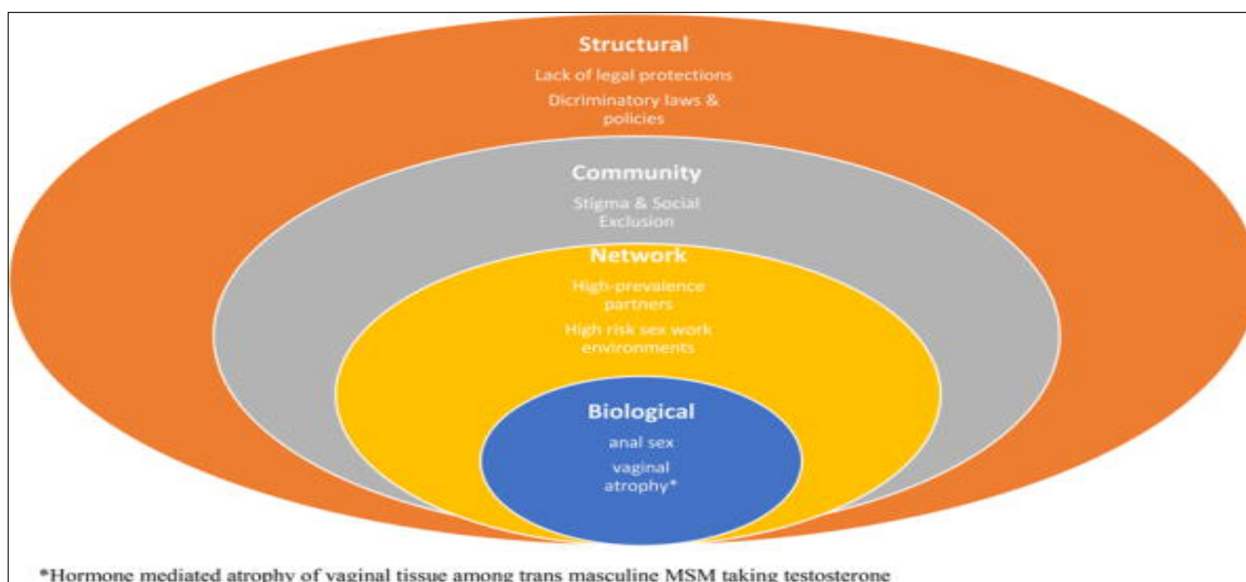
it was difficult to prevent and treat HIV in isolation from other social, behavioral and medical conditions. The risk of HIV among transgender people was driven by multilevel factors (Figure 3). Thomas observed that to successfully address HIV prevention the HIV Cascade, a multi-component response was required that including ‘bundling’ of HIV services with other health and social services for transgender people.

Asa Radix discussed that the right to health was recognized as a human right in international law, and yet transgender people were often denied the right to medical care and experienced transphobia in healthcare settings. He described that many healthcare providers were uninformed about transgender care, even though a fair amount of guidance was available on the standards of care for transgender people. The World Professional Association for Transgender People (WPATH), a global association devoted solely to the healthcare of transgender and gender nonconforming people, he noted, has published several editions of its Standard of Care guidance, and intends to release its version 8 in November 2018. Plus, there were also several recent guidance and tools available on transgender rights and comprehensive healthcare such as the TRANSIT and the Blueprint (specifically for Asia-Pacific region included a chapter on priority human rights issues for trans people). This information, he felt, was not reaching healthcare service providers or policymakers, but it was critical to create competent and informed healthcare providers who would treat transgender persons with respect and avoid judgmental attitudes and questions.

Nittaya Phanuphak shared her knowledge and experiences regarding the Tangerine Clinic at the Thai Red Cross, which was a pioneer in terms of HIV services for MSM. But first she focused on estimating the population size of transgender women and those at risk, and next discussed the importance of introducing a trans-led, integrated gender-affirming health services linked with HIV testing and prevention.

She noted that transgender women were part of the MSM community, and that MSM accounted for 53% of new HIV infections, roughly 29,626 new cases between 2015-2019. Achieving the first 90—people who are HIV positive, know their status—was a challenge and required targeted approaches, including for transgender women. Estimating the size of transgender women was difficult, and finally based on men (ages 15-59 years old) excluded from military conscription on the basis obvious female gender expression, around 1.24% and, another 0.25% (or 20% of 1.24% who do not express themselves as females). By this calculation, an estimated 1.5% of Thai males identified themselves as transgender women (62,500 persons), and of these at least 20% engage in high-

Figure 3.



Global Epidemiology of HIV Infection and Related Syndemics Affecting Transgender People.
Poteat, Tonia; PhD, MPH; Scheim, Ayden; Xavier, Jessica; Reisner, Sari; ScD, MA; Baral, Stefan; MD, MPH
Copyright © 2016 Wolters Kluwer Health, Inc. All rights reserved. Published by Lippincott Williams & Wilkins, Inc.
JAIDS Journal of Acquired Immune Deficiency Syndromes. 72 Supplement 3:S210-S219, August 15, 2016.
DOI: 10.1097/QAI.0000000000001087

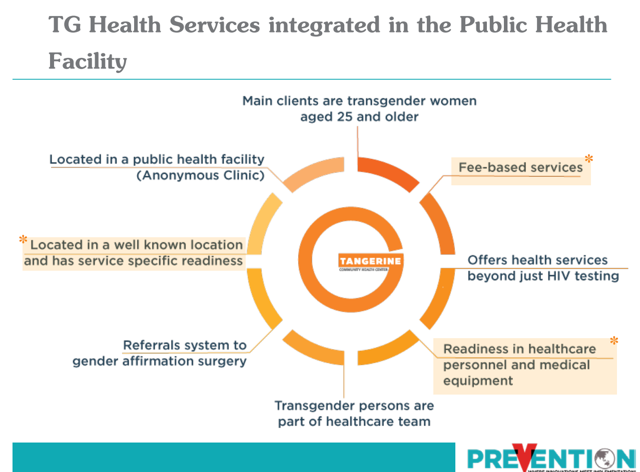
risk sex, resulting in 25,423 transgender women who were at risk of HIV and needed to be linked to the HIV Cascade. The HIV prevalence was 11.4% in transgender women based on community data.

While Thailand was a welcoming country for transgender people, and one of the top destinations for sex-reassignment surgery and purchasing of hormones, it was, she expressed, also a place where transgender people had negative experiences with Thai healthcare providers related to their gender identity. The recognition that health needs and vulnerabilities to HIV of transgender women were distinct and separate from the MSM community was the impetus for creating a model for a high-quality health clinic offering gender-affirming integrated healthcare for transgender people.

The Tangerine Clinic services included general health check-ups, hormonal administration and monitoring, psychosocial support and counselling, vaccinations for hepatitis B and C, testing for HIV and other sexually transmitted infections (STIs), and pre-exposure prophylaxis (PrEP). Managed by trained transgender staff and gender-sensitive medical professionals, the success of the Tangerine Clinic could be attributed to the sensitive and respectful manner in which services are provided. The Tangerine Clinic model was pioneering the way forward on how transgender health services could be provided through public health facilities (Figure 4), but that health professionals needed a clear set of trainings and hormonal and sexual health services packages. She closed by sharing that the Tangerine model had been extended to other parts of Thailand through standalone transgender community health centres managed by MPLUS in Chiang Mai, SISTERS in Pattaya, and RSAT in Hat Yai.

The discussion focused on the urgent need to recognise that transgender women as distinct from MSM, with unique HIV vulnerabilities. HIV data has, for far too long, conflated gender and anatomy, making it difficult to identify HIV risks among transgender people and it should be separated. The information on transgender people was essential for meeting the 90-90-90 UNAIDS Fast-Track targets, especially since the first 90 depended on HIV testing. The Tangerine Clinic model demonstrated that gender-affirming services delivered by transgender persons in partnership with informed and sympathetic medical professionals was an effective strategy in linking the transgender community with HIV and STI testing and the HIV Cascade. Participants also noted that while the right to the highest attainable standard of health set out in international human rights law served as a framework for non-discriminatory, available, accessible, and quality services, in the Asian context rising levels of fundamentalism and pervasive stigma made it difficult to visualize how transgender people could be claim their human rights. The session closed with the key message that transgender experiences, technical guidance and tools, and model health projects in Thailand, all point to strengthening and ensuring a transgender-led community response in tackling multi-dimensional health issues and HIV services.

Figure 4.



Panel 2: Enabling legal and policy environments

Panel Members

- Jack Byrne, Asia Pacific Forum/UNDP, New Zealand, presented preliminary results on legal gender recognition laws in nine countries (Bangladesh, India, Nepal and Pakistan in South Asia, China, and Indonesia, Malaysia, Philippines and Thailand in Southeast Asia)
- Zainab Noronha, UNDP, India, shared the history of transgender rights in India noting that self-determination was a basic human right and not an afterthought
- Bharat Sharma, Ministry of Women and Child Welfare, Nepal, discussed the legal provisions concerning gender minorities including transgender persons and other “O” gender recognition in Nepal
- Angkhana Neelapaijit, National Human Rights Commission, Thailand, provided information on the current legal and human right protections for transgender persons in Thailand

Moderator

- Nadia Rasheed, UNDP

Jack Byrne shared the results from a joint APTN-UNDP study on legal gender recognition. The study focused on nine countries (listed above) and reviewed in-depth the laws, regulations, policies and practices, measuring them against human rights standards (such as self-determination, dignity and freedom in the Yogyakarta Principles[8]) and impacts on trans people's lives. Jack noted that the vast majority of transgender people struggle to obtain official identification documents that reflect their gender identity, including legal change of names. In some countries, the research documented, transgender people having to undergo legally prescribed, state-enforced sterilization, or obtain a diagnosis of mental disorder to receive documents that reflected their chosen gender.

Jack expressed that the issue of legal gender recognition was a public health priority. WHO defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," and in the case of transgender people the denial of legal gender recognition affected access to gender affirming services and denied protections of transgender people. For example, having legal gender recognition would protect transgender women from being placed in male wards or prisons, and allow access to crisis shelter. The study, to be released at the end of 2017, found that most people could not obtain documents under the appropriate name and/or sex to match their gender identity. Jack noted that this was a violation of trans people's inherent human dignity and right to self-determination.

Zainab Noronha noted that self-determination was a cornerstone of *hijra* culture in India, forming distinct mythologies and power of eunuchs. With the British occupation the colonial government passed a sweeping law in 1871 that criminalized hijras and they could be arrested on the spot. After independence in 1947, it took another 55-years for 'third gender' recognition. The Indian Supreme Court noted that, "it is the right of every human being to choose their gender". But despite the legal victory, Zainab, a transgender woman, observed that the reality on the ground in terms of stigma and discrimination has not changed. The legacy of the British law and the discrimination it spawned locked the transgender community from most professions, and as result many of turned to sex work. Zainab noted that as a community they needed to continue fighting for their human rights, and demand recognition as equal citizens in Indian society.

Nepal, remarked Bharat Sharma, was one of the only countries to offer constitutional protection in the form of ending all forms of discrimination against gender and sexual minorities, and in 2007 the Supreme Court ordered the government to recognise a third gender category. He noted that this ruling gave activists an opportunity to fight and succeed in including third gender category on voter rolls, the federal census (2011), citizenship documents and passports. Nonetheless, he noted that transgender communities face challenges such as limited awareness in society about sexual and gender minorities, lack of data and statistics, ongoing social stigma, discrimination, and violence, few employment opportunities, and exclusion from governance processes such as parliament, national planning commission, and other government positions. Bharat recognized the positive role played by the Blue Diamond Society in raising awareness on sexual and gender minorities and providing them with life skills and income generation opportunities, and working on reducing prevalence of HIV.

Angkhana Neelapaijit commented that Thailand was regarded as tolerant country towards sexual and gender minorities, but it does not confer legal gender recognition on transgender people. For example, a Thai transgender, even after undergoing complete sexual reassignment surgery, could not legally change the sex on their identity card or other official documents. Same-sex marriage was also not recognised. She noted that the Gender Equality Act (2015) was aimed at ushering an inclusive future, but sections in it were inconclusive and the provisions did not go far enough to protect the rights of transgender persons. Of great concern, to her she noted, were transgender persons in prisons who had no access to hormones, and could be housed with people of the opposite sex (especially dangerous for transgender women who experience violence from male inmates and prison guards).

The participants noted that the strictly binary gender divisions limited access to services and resulted in greater vulnerabilities for transgender people, especially in the absence of legal gender recognition. It was not only important that the law protect transgender people allowing them to carry documents that reflect who they are by their own expression of choice, but also recognise that formal rulings were only the first step in changing entrenched societal attitudes of stigma against transgender communities. Transgender activists had to continue fighting battles for their human rights.

8 Yogyakarta Principles: Principles on the application of international human rights law in relation to sexual orientation and gender identity (2006). Recently, there was meeting to discuss changes in the region resulting from the application of thee principles. Asia Pacific Forum of National Human Rights Institutions and UNDP. (2017). Celebrating 10 years of the Yogyakarta Principles: What have we learnt and where to now? UNDP. APF. Bangkok, Thailand.

Panel 3: The lived experience of diverse transgender communities

Panel Members

- Amruta Soni, National Coalition of People living with HIV in India (NCPI+), India
- Nisha Ayub, SEED Foundation, Malaysia
- AR Arcon, Lakanbini Advocates Pilipinas, Pioneer Filipino Transmen Movement (PFTM), Philippines
- Abhipraya A. Muchtar, Youth Voices Count, Indonesia
- Rukhsana Kapali, Youth LEAD, Nepal

Moderator

- Stuart Watson, UNAIDS RST-AP

The panel opened with a poem by poet and transgender activist Lee Mokebe describing challenges faced by transgender persons.

The panel was set up in a format of a talk show discussion with transgender activists sharing their personal journeys and lived experiences with their families and in society. Given the personal nature of these narratives, the report describes experiences without attributing them to any particular individuals.

The panelists expressed difficulties and confusion that they faced in obtaining information regarding transitioning. Some were humiliated by healthcare providers, such as doctors, at hospitals and explicitly told that the changes they felt were wrong. Others wanted gender-affirming surgery but it was expensive and not available in local settings. In some cases, surgery was not available at all and persons had to travel to another country. Depression and thoughts of suicide were common experiences, exacerbated for some with diagnosis of HIV. Healthcare providers advised them that their lives were not worth living, and even denied life-saving HIV treatment. A supportive friend or peer network, especially social networks for young transgender persons, was most helpful in overcoming these challenges. The most empowering aspect of their journey was becoming an activist, organiser, peer-outreach worker and spokesperson for their community, a process that helped them to recognise that as transgender persons' they have the same rights as other citizens, including the right to be free from stigma, discrimination and violence. The fact that their experiences could help others was a motivating factor to continue.

The rise of religious fundamentalism and conservatism were emerging threats, but could be overcome by promoting concepts of SOGI and the Yogyakarta Principles and numerous human rights treaties signed by their countries. History and justice were on their sides, and their hopes were pinned on the growing global and regional movement of transgender activists.

Workshop 1:1. Community use of data and research for advocacy for trans community health and rights

The workshop facilitated by Sam Winter and Ha Chu Thanh included 44 attendees of which 33 were transgender persons. The focus of the research for advocacy workshop was APTN's study on employment discrimination against transgender people in four countries—Malaysia, Singapore, Thailand and Vietnam. The study design was simple, and included two job applicants of similar educational background and work experience history except that one applicant was cis-gender and the other transgender (equal numbers between transgender men and transgender women). The applications were sent to the same potential employer from either the private and/or public sector.

The responses from employers were noted as positive if the person was asked to call or invited for an interview, and negative if there was no response or told that no job was available. Preliminary results showed that transgender applicants received higher numbers of negative responses, and chances of transgender applicant being called back for an interview were 50% less than that compared with cis-gender applicants. Transgender persons carried out the research with support from Curtain University (Perth, Australia), and APTN intends to release the results of the study later this year.

The participants discussed how they could get involved in this kind of research for other countries. The documentation provided evidence of discriminatory practices employment practices that could be used to support advocacy. They questioned how this information could be shared with labour departments and private sector employers in order to bring about meaningful change in labour practices. It was suggested that coupling the quantitative data with personal stories could help to create a more powerful advocacy message, and the researchers noted that the plan was to include some of this information. Everyone agreed that the engagement of

transgender persons in the process of data collection and analysis was empowering and built capacity of transgender persons to conduct research. The study was an important contribution.

Workshop 1:2. Creating an appropriate clinical service environment for trans people

The workshop was facilitated by Dr. Nittaya Phanuphak, Rena Janammnuaysook and included healthcare providers and policy makers, a total of 31 persons. The discussion focused on models of transgender health service delivery, specifically the Thailand experience of the Tangerine Centre, SISTERS, and MPlus. Most of the questions focused on hormones and how to determine which to prescribe given their limited availability in many different setting. The facilitators noted that at the Tangerine Clinic they followed the algorithm: (1) reviewing what was globally recommended, (2) determining what was locally available, and (3) assessing what was popular in the transgender community. Based on this information, they determined the list of hormones that the Tangerine Clinic could prescribe in the local context.

The facilitators emphasised that dosage of hormones and trans health services be adapted for the local population, as most global recommendations were based on research in Western persons who had different body characteristics and sizes. It was also essential to develop communication materials that informed and educated the transgender community on harms of hormone misuse, and for health services to offer hormone monitoring.

Providing gender-affirming care, even fee-based services, was an opportunity for transgender persons to establish linkages with HIV and STI testing, treatment, and mental health services. The success of Tangerine Clinic has prompted the Ministry of Public Health in Thailand to consider introducing health services as part of the national healthcare scheme.

The involvement and active participation of transgender persons at all stages of building transgender services was an essential component of building the community trust in services provided by the Tangerine Clinic, SISTERS, and MPlus

Those in this workshop suggested that healthcare providers and community service providers establish a regional communication platform for sharing knowledge, experiences, and information, and noted that such an endeavour could be modelled after PrEP provider network.

Workshop 1:3. Legal gender recognition and its intersections with health

Facilitated by Jack Byrne, the workshop contained a mix of representatives from government, national human rights institutions and transgender organisations. Participants opened by sharing the local terms used to describe transgender persons in their respective countries. The countries in the region were at different stages of legal gender recognition for transgender persons, some allowed for name and sex change on official documents, and others (especially countries in South Asia) provided a third gender option. Whatever the format of legal gender recognition, participants expressed that it was a powerful statement when people were allowed to self-identify their gender backed by laws and legislation.

Participants noted frustration in terms of travel (and freedom of movement), facing discrimination even when in possession of proper legal documents. The third gender marker of 'O' or 'T' was not widely recognized by immigration officials and transgender persons often faced harassment. There was not sufficient time to discuss the gender-affirming healthcare and legal gender recognition, but participants remarked that governments should provide accessible, available, non-discriminatory, and quality healthcare that observed confidentiality and was respectful (and nonjudgmental) of transgender persons.

4. Summary of proceedings – Day 2

Steve Mills, FHI 360, summarized the proceedings from day 1 observing that, even though HIV funding has brought participants together for the conference, yesterday's discussions suggest that trans individuals have integrated health needs requiring integrated services. He noted that gender-affirming healthcare was necessary for meeting the UNAIDS 90-90-90 and linking transgender people to the HIV Cascade.

The focus of day 2 was on how to reach 90-90-90 through comprehensive trans healthcare, and opened with a presentation on the HIV Cascade. The next session discussed the strategic information gaps and how these could be filled. In the last panel discussion, patients and service providers shared their experiences and perspective on healthcare needs. The day ended with Workshop 2, World Café, structured and designed such that participants had the opportunity to shape interventions and create models of service delivery in relation to the HIV Cascade.

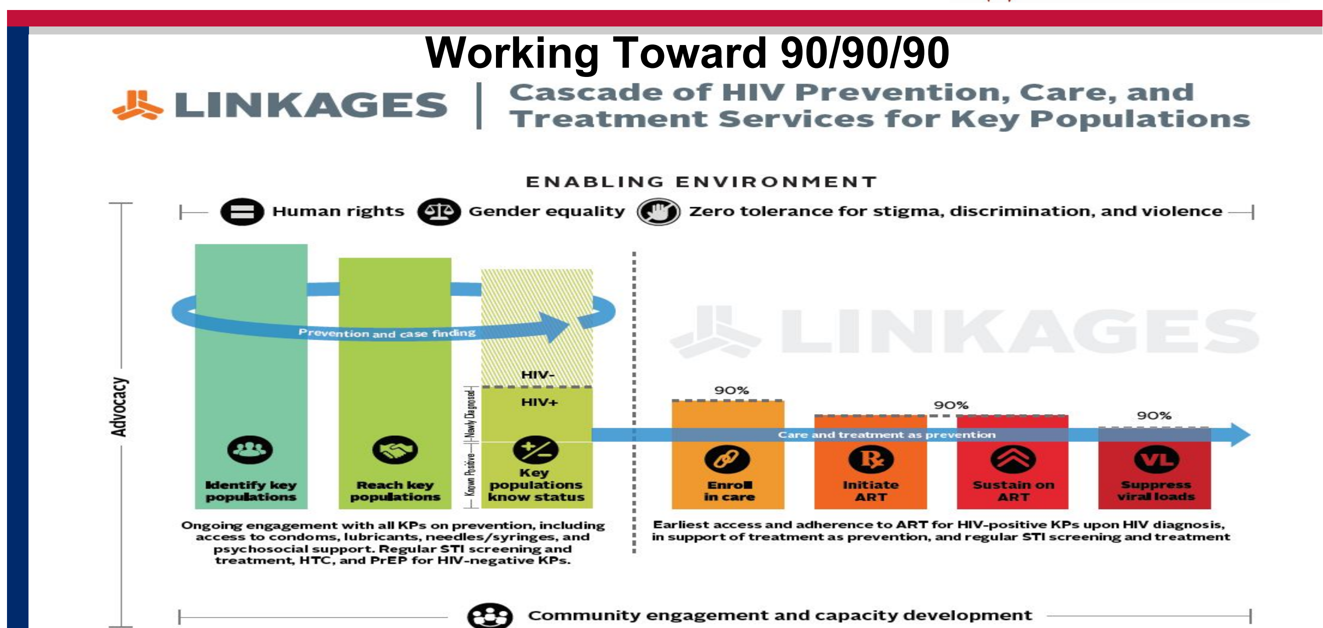
The HIV Cascade

Presenter

- Cameron Wolf, USAID

Cameron Wolf shared the LINKAGES Cascade of HIV Prevention, Care, and Treatment Services for Key Populations (Figure 5). He noted that the USAID LINKAGES Project was one of the biggest projects under the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the biggest project for key populations. The first three bars of HIV Cascade, he discussed, focused on identifying, reaching and offering testing, and promoted combination prevention approaches include PrEP, condoms, lubricants, and needles/syringes. It was important that those persons who tested negative to continue to engage and return for testing. The remaining bars measured diagnosis and enrollment in care (the first 90), treatment initiation and

Figure 5. HIV Cascade



continuation (second 90), and viral load suppression (third 90). All the steps in the HIV Cascade took place within an enabling environment that respected human rights and gender equality, observed zero tolerance for stigma, discrimination, and violence, and mobilised and engaged communities. Supportive environments and empowered communities were essential elements facilitating the flow of persons in the HIV Cascade.

Cameron emphasized that as participants flow through the three facilitated discussion groups in the Workshop 2, they should keep in mind opportunities and challenges at every stage: (1) entry points for reaching and recruiting transgender people; (2) offering diverse models for testing; and (3) strategic use of antiretroviral therapy for treatment and prevention. They should discuss strategies for minimising the loss to follow-up, an immense challenge for key populations.

Panel 4: Knowing what we don’t know

Panel Members

- Taoufik Bakkali, UNAIDS RST-AP, identified transgender data gaps for in HIV planning and implementation
- Bounpheng Philavong, Laos Ministry of Health Center for HIV/AIDS and STI, discussed the national approach by Laos for including transgender persons in the HIV response
- Frits van Griensven, Thai Red Cross AIDS Research Centre, hypothesized on potential biological risk factors of HIV transmission
- Phylesha Brown-Acton, Asia Pacific Transgender Network, provided a transgender perspective and meaningful involvement of the community in research

Panel Moderator

- Cameron Wolf, USAID

Taoufik Bakkali soberly described that even with 30-plus years of the AIDS epidemic, information on transgender women was limited, and largely absent for transgender men. Most HIV indicators collected information on MSM of which transgender women were a small component. In 2014, transgender specific indicators were introduced as part of the UNAIDS global reporting mechanisms but only for transgender sex workers.

He noted that UNAIDS recommended in 2017 collection of specific indicators on prevention and treatment coverage, hepatitis B and C, and stigma and discrimination for transgender people, but the decision to collect this information was up to each country. A few countries have collected this information, but he thought that there were some data problems. In reviewing different plans and proposals, Taoufik commented that transgender persons were mentioned in the situational analysis but not included in any planned activities. He closed his presentation noting that there were immense data gaps on understanding transgender health needs.

Bounpheng Philavong discussed that the Laos HIV response was experiencing difficulty in introducing transgender specific programming. The transgender community, he felt, was largely invisible and under the umbrella of MSM, organized as part of the joint MSM/TG network. There was no transgender-specific information. One reason for the absence of information, he postulated, was associated with use of language and absence of definitions differentiating transgender women from the MSM/gay community. He described that with support from LINKAGES FHI360, Laos was beginning to address and separate out transgender programming from MSM.

Frits van Griensven hypothesized whether there were biological interactions at the immunological level that increased levels of vulnerability to HIV for transgender women. He noted that evidence already suggested that poor nutrition, psychosocial stresses, and other factors, together, created greater susceptibility to disease and HIV infection. And taking this scenario a step further, he postulated whether hormone use by transgender women created internal vulnerability in the rectum for HIV transmission.

Phylesha Brown-Acton, transgender woman activist, expressed that while she appreciated the views of her fellow panellists she was dismayed to hear that her community was still viewed as the ‘subject’ of research. She expressed that the transgender community must be involved at every step of design, implementation and evaluation of research and programmatic interventions. Transgender persons had demonstrated that they had leadership capacity through examples such as the Blueprint and TRANSIT, and even in situations where education and credentials of transgender persons was lacking, she commented, technical partners, experts, healthcare providers and donors should invest in building capacity. The meeting of 90-90-90 targets, successful linkages across the HIV Cascade and the minimum loss to follow-up, and ending AIDS, she noted, depended on an empowered community. Otherwise, the HIV response will not be sustainable. She concluded her talk with powerful words: “Nothing about us, without us”.

In the discussion that followed, several participants emphasised that it should be recognized that transgender women are women, and not men or MSM!

For several years now, there has been an agreed upon definition for transgender people—"*Persons who identify themselves in a different gender than that assigned to them at birth*"--UN agencies including UNAIDS should widely promote and use this definition. The definition of transgender people, a participant commented, should not be left up to individual countries.

Participants discussed that the HIV Cascade required specific approaches and modalities of outreach for linking transgender women at high risk to HIV services. The transgender community should address the low reasons for testing including the mobility of sex workers, stigma and discrimination and other factors. Specific 'boutique' projects, such as the one managed by SISTERS, provided the opportunity to look in greater details in terms of the HIV Cascade (Figure 6).

Lastly, participants noted that while there was guidance on transgender healthcare and HIV programming, funding for transgender organisations was lacking. The challenge of raising funds for advocacy or implementation of transgender friendly services was huge, and as more countries move to self-financing their HIV responses it was not clear if services for transgender would be integrated. Healthcare services had to be designed to be gender-affirming, comprehensive, quality-based, affordable and accessible.

Panel 5: Experiences of healthcare in Asia and the Pacific from a patients' and providers' perspective

Panel Members

- Shan Menon, Amkfsc Community Services Ltd, Singapore
- Thitiyanun Doi Nakpor, SISTERS Foundation, Thailand
- Tommy Hamilton, Re.frame, Australia
- Jiraporn Arunakul, Ramathibodi Hospital Mahidol University, Thailand
- Venkatesan Chakrapani, PGIMER and C-SHaRP, India

Moderators

- Manisha Dhakal, Blue Diamond Society
- Sam Winter, Curtain University

The first three panellists provided a patients view on accessing health services. They noted that for transgender persons it was often difficult to find gender-affirming information and health services, and that just walking into a clinic was viewed as similar to being "*outed*". They also expressed that as patients, they were often better informed than the healthcare service provider, and felt that they were being treated as an object of curiosity rather than a paying client. Information on health was largely exchanged through peer-based networks, and/or other transgender persons that had gone through similar experiences. It was noted that many transgender persons come to Thailand for gender-affirming surgery and purchasing of hormones.

Confusion among transgender youth regarding gender identity, noted one panellist, often resulted in ideations of suicide and depression. Support for youth was generally lacking in most countries, and these persons were at greatest risk of HIV.

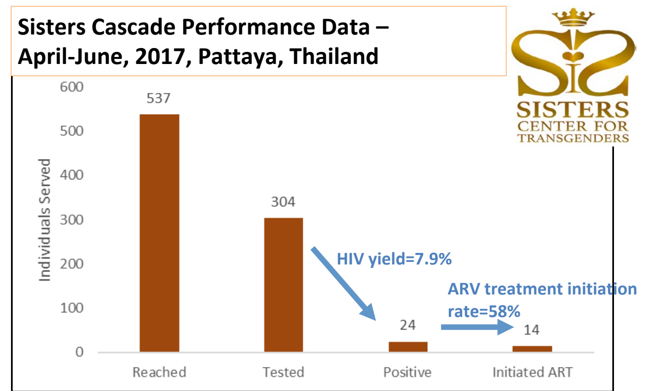
It was better for the community to provide HIV services because they understood the challenges needs of their own community. Nonetheless, linkages and good working terms with government and medical staff were essential for referrals and access to antiretroviral treatment. Transgender youth were another vulnerable subgroup with high risk of HIV; often confused regarding gender identity with ideations of suicide and depression they exhibited risky sexual behaviour, noted a panellist.

Jiraporn Arunakul agreed that adolescence was a sensitive period for transgender youth, and shared her experience as a service provider who set up the first Gender Variation Clinic (Gen-V) aimed at providing hormones and psychological support to Thai teens. The Gen-V team worked with teens and their parents on acceptance of gender diversity. As an adolescent medical specialist, her aim was to create a safe space for transgender teens where they could learn to accept themselves and parents could support their children. The clinic was now offering hormonal blockers, and planned to include a surgeon for gender-affirming surgery.

Venkatesan Chakrapani stated that he started out working in a referral centre for STI and HIV, and would come across many sexual and gender minorities. He observed that the adverse health for transgender persons was not only associated with their own behaviours but also the negative attitudes of health care providers. He expressed that in India, healthcare service providers needed specific trainings sensitising them to the health needs and care of sexual and gender minorities. He suggested that transgender persons should be engaged in the HIV response as trainers of healthcare providers and programme design including for PrEP.

The discussion concluded with two useful strategies for transgender patients to consider. The first suggestion was to develop an online platform that shares information on where to go for hormones and surgeries, especially rating medical practitioners that provide such services. The second idea was to support HIV+ transgender persons and those at higher risk by developing peer-to-peer networks across countries. This way information on interactions on hormones with HIV treatment, use of PrEP and side effects, and other risk related could be shared across the transgender community.

Figure 6. HIV Cascade



Workshop 2: World Café

Workshop 2 was designed to address challenges and resources, strategies and technical assistance in the HIV Cascade. The discussions of the workshop are summarized in table format below (Table 1).

Steps in the HIV Cascade	Challenges	Resources, strategies and technical assistance needs
Reach and recruit	• Self Identity • Hormone knowledge, services related to health • Locations of services, long distances to access • Movement of trans persons to find work • Stigma and discrimination • Mapping of communities	• Use peer-driven models of recruitment • Mapping of communities for outreach • Using trans-specific clinics supported by transgender persons • Engaging NGOs and governments as technical partners
Test and diagnose	• Confidentiality of test results • Stigma and discrimination by service providers • Self stigma • Costs of services • Absence of pre- and post-counselling services • Incentives to get tested • Ignorance of service providers in discussing gender issues • Persons who can't reach testing facilities (hidden populations)	• Community-based health centres • Peer-based models for rapid screening • Integrated services that are free • Trained service providers sensitive to transgender health issues • Mobile hot spots (include HIV and syphilis test) • Self-testing with online counselling • Building capacity of outreach workers and healthcare providers through existing guidance
PrEP (part of combination prevention)	• Understanding of PrEP among healthcare providers and transgender persons • Concerns on costs • Concerns on drug interactions, side effects and drug resistance • Gap between policy makers, healthcare providers and trans community and partners	• Understanding of PrEP among healthcare providers and transgender persons • Concerns on costs • Concerns on drug interactions, side effects and drug resistance • Gap between policy makers, healthcare providers and trans community and partners
HIV treatment, adherence and retention	• Stigma and discrimination in facilities • Lack of knowledge on HIV treatment side effects, interaction with hormones, and other illnesses • Inconvenient timings at facilities • Costs of other tests • Confidentiality	• Promoting community for distribution of HIV treatment • Case management through community counsellors or peer navigators • Same day as diagnosis of HIV treatment initiation • Emphasize beauty in treatment literacy and dissemination through social media
Viral load suppression	Not discussed	

5. Proceedings – Day 3

Panel 6: Funding landscape

Panel Members

- David Scamell, American Jewish World Service (AJWS)
- Jack Byrne, International Trans Fund
- Cameron Wolf, USAID PEPFAR
- Eric Fleutelot, Embassy of France
- Nicole Delaney, The Global Fund to Fight AIDS, Tuberculosis and Malaria

Panel Moderator

- Edmund Settle, UNDP

David Scamell noted that trans groups in Asia-Pacific, as well as globally, were engaged in critical work with little to no resources, financial and human. From the private philanthropy monies that were awarded to LGBTI groups, only USD 1 out of USD 10 went to trans groups. *The State of Trans* and Intersex Organizing*, prepared by AJWS and the Global Action for Trans Equality (GATE) in, showed that more than 50% of trans groups in Asia-Pacific (52 groups in Asia and 15 in Pacific receiving funds) operated on a budget of less than USD 10,000. In the next report, to be released at the end of this year, he noted that the groups receiving funds had doubled but continued to be under-resourced. He listed the top priorities for Asia-Pacific groups if more funding was available (Table 2).

Table 2.

Steps in the HIV Cascade
Train health care providers about trans issues **(36.4%)**
Provide legal services **(36.4%)**
Provide job training **(33.0%)**
Advocate to improve national laws or policies **(33.0%)**
Provide trans-specific health care **(31.8%)**

Jack Byrne noted that there had been positive developments in the state of trans funding with the launch in 2016 of the International Trans Fund (ITF), a small grants funding mechanism for transgender-led CBOs. The mission of ITF was to create sustainable resource for strong, trans-led movements and collective action, and to address (and ideally eliminate) funding gaps for trans groups across the globe. The ITF in its first call for proposals received applications from 280 groups, but was only able to fund 23 groups. The total funds disbursed were USD 500,000.

Cameron Wolf discussed that USAID/PEPFAR were making decisions based on data and metrics. The Country Operational Plans, the mechanism by which USAID operates at national levels, was based on the size of the population at risk and the burden of HIV. Transgender groups, he remarked, need to advocate for countries to collect transgender data (especially as part of routine monitoring systems). Cameron emphasized that donors make funding decisions based on evidence, and meetings like the current conference were critical for understanding transgender issues. He closed by noting that USAID had launched the Key Population Investment Fund, which should be operational in the coming year.

In Asia-Pacific, Eric Fleutelot noted that bilateral donors were more likely to support transgender organizations but their tendency was to support well-established and larger groups. He described the role of the French government in supporting HIV, noting that it was the second largest contributor to the Global Fund. The French government has set up a project referred to as the 5% Initiative that supports activities which cannot be directly funded by the Global Fund such as governance and capacity building. He noted that in Asia only a few countries were eligible—Cambodia, Laos, Myanmar, Thailand, Vietnam, and Vanuatu in Pacific. The next call for the 5% Initiative will be in February 2018, and he encouraged organisations to request support for up to 3-years. He advised participants to reach out to foreign embassies in their countries, noting that there was usually one person responsible for human rights and sexual and gender minorities and hold some discretionary funding,

Nicole Delaney expressed that the Global Fund was funding a mechanism that aimed at achieving impact through its investment in HIV, tuberculosis and malaria. At the beginning of each funding cycle, it allocated donor money to eligible countries and at the country level the Country Coordinating Mechanism (CCM) played a critical role in deciding on priorities

for national investment. She advised participants that they get to know CCM members, and that transgender organisations participate in the country dialogue processes to ensure transgender priorities were reflected in national concept notes. She commented that the Global Fund under the Community Rights and Gender Special Initiative has set up processes to support and build capacity of CBOs, and that participants should explore how to engage with them. She noted that the next call for regional proposals will be in April 2018.

Edmund Settle highlighted the role of Sweden in promoting trans rights in the region. Through the *Being LGBTI in Asia* program, Sweden has supported the implementation of the multi-country legal gender recognition study, the multi-country trans employment studied being carried out by APTN and Curtin University (in Perth, Australia), and the regional project on building the capacity of national human rights institutions and civil society groups with APF. Additionally through *Being LGBTI in Asia*, UNDP with Swedish support has built the capacity of two regional civil society organizations including APTN.

The discussion focused on the lack of capacity that many transgender persons and groups experience in terms of approaching donors, completing complicated application processes, and looking for evidence to support their claims. Fundraising, they expressed, was a daunting process. The participants also noted that at the national level transgender groups were not taken seriously, and largely invited for tokenistic representation in meetings. They had no voice in country level decision-making processes such as preparation of Global Fund proposals. Most participants expressed frustration in terms of fundraising, noting that donors had high expectations from the transgender community, which were not reflective of current capacity amongst trans groups, but that it was difficult to raise funds for building capacity.

Edmund noted, in some countries, local governments have started to explore social contracting models to support local trans groups provide HIV prevention services. Government participants from India and the Philippines provided examples where local governments were providing funds to trans group to implement HIV prevention services. He went on to remark on the role of UNDP as a technical partner that was not a donor but channelled funds through partnership programmes with the goal of building capacity.

Transgender groups faced many barriers in accessing funds given their lack of experience and capacity. For example, many don't know how to make contact with donors; the application processes tend to be complicated often surpassing the capacity within a group; and many groups don't know how to access evidence to support their claims and there was a lack of data and evidence. Transgender groups felt that they had almost no voice in country-level decision-making such as around the Global Fund proposals or the HIV National Strategic Plans. Given that most members in their communities had barely finished schools and the societal stigma against them, even in the health sector, these processes were daunting and complex. It was clear from the discussion that donors and technical partners needed to support and build capacity, and correct the historical disenfranchisement and disadvantages experienced by transgender communities.

Workshops 3 and 4: Mapping transgender health and HIV services

The last two sessions, Workshops 3 and 4, of the From Barriers to Bridges conference focused on mapping out current health services for transgender communities, planning for trans competent health services, and identifying potential obstacles.

Prior to the conference, APTN had sent out preparatory questionnaires on the state of current health services for transgender people, mapping exercise. Participants from 16 countries had completed a mapping survey, and Jack Byrne, lead consultant on the mapping project, shared the preliminary findings. He reported on data from the 16 countries, summarizing that:

- Gender-affirming healthcare was legal only in seven countries and regulated only in four.
- Gender-affirming surgery was available in four countries.
- Hormones were available in 11 countries.
- Transgender persons were included in nine national AIDS strategies but under MSM activities.

The information, he noted, was far from completed and one of the purposes of the workshops was to correct any inaccuracies and add new information. APTN intended to release the mapping report on the state of trans health services, part of its South-to-South Learning Initiative, later in the year.

In Workshop 3, each country delegation supported by a facilitator prepared an action plan for rolling out comprehensive trans healthcare. In Workshop 4, delegates had an opportunity to review and comment on plans of other countries. The key actions outlined by each are presented in table 3.

Table 3. Key Action Priorities by Country.

Country	Key Action
Cambodia	• Identify service providers who are currently providing, or willing to provide, gender-affirming care. • Coordinate with the MoH on developing a technical working group who would develop guidelines and standard operating procedures on gender-affirming care. • Build the capacity of transgender people as advocates on national HIV policy and programming.
India	• Develop the competencies of healthcare providers in transgender health. • Introduce hormone monitoring for transgender people. • Advocate for creating a regulatory system on gender-affirming surgeries, and expanding services.
Indonesia & Timor Leste	• Expand anti-stigma trainings with healthcare providers to include key populations. • Introduce anti-stigma trainings with other stakeholders at national and local levels. • Improve access to key information on using hormones in a safe and responsible manner, including for trans men. • Introduce HIV, STI and sexual and reproductive health services for trans men and educate healthcare providers on their issues. • Promote social inclusion of trans men in national HIV policies, including the collection of data on HIV vulnerability.
Laos, PDR	• Introduce measures to collect disaggregated data for transgender people, separate from MSM. • Engage in South-to-South government exchanges with countries in the region that have experience with implementation of transgender health services.
Malaysia	• Develop a code of conduct for healthcare providers who interact and provide services for transgender people. • Engage in a dialogue on the legal and regulatory framework for hormones. • Set up a model trans-specific health clinic based on the Tangerine Clinic. • Prepare information modules on HIV combination prevention and treatment for transgender people.
Myanmar	• Make existing health services transgender friendly, and develop services specific for needs of transgender people. • Understand and develop a shared vocabulary on sexual and gender minorities, and use this information as the basis for identification, collection, reporting and analysis. • Educate and sensitize healthcare providers, development partners, and other stakeholders that trans rights are human rights. • Adopt and translate global and regional guideline and adapt them for the Burmese context. • Use both top-down (policy changes and guidelines) and bottom-up (programming) approaches for informing National AIDS program.
Nepal	• Expand trans competent care to include general health services. • Adapt and implement standards of care for trans health and build alliances between WPATH and Nepal Medical Association. • Work with teaching hospitals on developing a trans health curricula and train medical students on it.
Pakistan	• Advocate for removal legal and diagnostic barriers to gender-affirming care. • Develop official guidelines and standard operating procedures for gender-affirming health care. • Ensure meaningful engagement between community and government in development of laws and policies.
Papua New Guinea	• Engage trans community to provide sensitivity training for health care providers. • Advocate for trans representation in the Department of Health's HIV Technical Working Group. • Train the trans community on the Blueprint. • Support the dissemination of trans health information.
Philippines	• Develop transgender sensitisation programmes for healthcare providers. • Advocate with the Department of Health on developing trans health policy and disseminating it through a module for all health service providers. • Raise awareness on the Government's Gender and Development Plan, and build capacity of the community to use it.
Singapore	• Create training curricula for healthcare providers, school counsellors, and social workers. • Adapt international guidance for the local context. • Collect and adapt transgender resources for trans communities and healthcare providers. • Generate trans specific national data for advocacy on gender-affirming healthcare services. • Mobilise funds for trans advocacy, research, and trainings.
Sri Lanka	• Institute laws, policies and procedures for importation of hormones, and provide them for free to transgender people. • Sensitize staff, including lower level personnel, at government hospitals on transgender needs and health. • Create better linkages and opportunities to sensitize all stakeholders.
Thailand	• Encourage meaningful government engagement in research and funding. • Develop clear guidelines on gender-affirming healthcare. • Disaggregate data, services and sexual and reproductive health programmes from MSM.
Vietnam	• Build advocacy capacity of trans communities. • Support transgender women to move out of MSM group. • Develop resources for transgender health and rights.

6. Closing

In summarizing the three days of meetings, common priorities were identified and included:

Transgender resources and information sharing

- Ensuring that UN agencies including UNAIDS use and promote with national ‘country’ partners the accepted definition for transgender people.
- Simplifying, translating, and widely disbursing the guidance and tools on transgender health and using them to develop a standard operating procedure for trans healthcare providers.
- Setting up regional networks for healthcare providers on transgender health.
- Setting up regional communication platform for transgender persons on sharing information on how to access hormones, gender-affirming healthcare and surgery, and psychosocial support.

Capacity Building

- Increasing knowledge of transgender people on combination prevention, including PrEP, and improving access to prevention services.
- Developing curricula and trainings for healthcare providers on trans competent health services.
- Developing skills of transgender organisations and leaders on raising funds.

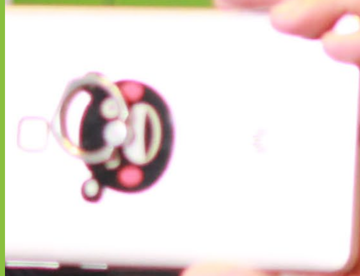
Research and Advocacy

- Advocating for trans-specific services, training, and HIV services.
- Advocating for the disaggregation of data for transgender people, specifically separating out indicators on transgender women from MSM.
- Developing research skills of transgender people, and including their participation in research projects.
- Expanding APTN employment discrimination project to other countries.

Health and HIV Services

- Integrating health services and using gender-affirming care to link transgender people to HIV services modelled after the Tangerine Clinic.
- Developing protocols, standard operating procedures, and guidance on gender-affirming services and specifically hormone use.
- Developing a regulatory framework for hormone use and gender-affirming surgery.
- Ensuring that HIV services are transgender friendly and trans competent, and treat trans clients with respect.

The *From Barriers to Bridges* conference ended with a round of thanks, and appreciation by participants. The organisers of the conference committed to developing a detailed roadmap of next steps and plans to follow-up with country partners.



Annex A. List of Participants and Agenda

Delegation Country	Use name
Australia	Sam Winter
Cambodia	Bunna Sok
Cambodia	Dr. Voeung Yanath
Cambodia	Sok Chamreun
Cambodia	Lan Vanseng
Cambodia	Thim Sotheara
Cambodia	Katta Orn
Cambodia	Uy Da
Cambodia	Seaklay (Pipi) Say
India	Ravi Kumar Bandi
India	Alka Narang
India	Shrikala Acharya
India	Venkatesan Chakrapani
India	Sanjay Dubey
India	Aryan Pasha
India	Alok Saxena
India	Rajeenald T. Dhas
India	Nandini Kapoor Dhingra
India	Marietou Satin
Indonesia	Irawan Afriyanto
Indonesia	Indri Oktaria Sukmaputri
Indonesia	Yogi Prasetia
Indonesia	Eka Christiningsih Tanlain
Indonesia	Abhipraya A. Muchtar
Indonesia	Alexa Dominih
Laos	Oudone Souphavanh
Laos	Bounpheng Philavong
Laos	Ya Phoummalinno
Laos	Metta Khanthavone
Malaysia	Azrul Mohd Khalib
Malaysia	Mitch Yusmar Yusof
Malaysia	Nisha Ayub
Myanmar	Robert Kelly
Myanmar	Myo Kyaw Lwin
Myanmar	Kiira Gustafson
Myanmar	Htun Nyunt Oo
Myanmar	Thinzar Linn
Myanmar	May Pyae Phyo
Myanmar	Thet Mon Phyo
Myanmar	Than Naing Oo
Nepal	Ivana Lohar
Nepal	Bharat Shrestha
Nepal	Bharat Sharma
Nepal	Malaika Lama
Nepal	Rewa Kumari Regmi
Nepal	Milan Shah
Nepal	Manisha Dhakal
New Zealand	Jack Byrne
New Zealand	Tommy Hamilton
New Zealand	Phylesha Brown-Acton
Pakistan	Zahra Lau
Pakistan	Fahmida Iqbal Khan
Pakistan	Bubbli Malik
Papua New Guinea	George Raubi
Papua New Guinea	Kila William
Papua New Guinea	Mathew Densil
Papua New Guinea	Angela Kelly-Hanku
Papua New Guinea	Jonathan Wala
Philippines	Fe Cabral
Philippines	Rolly Cruz
Philippines	John Darwin B. Ruanto
Philippines	Christa Joan Gapoy Balonkita
Philippines	AR Arcon
Philippines	Eda Catabas
Singapore	Zheng Zhimin
Singapore	Shan Menon
Singapore	Sherry Sherqueshaa
Sri Lanka	Bhoomi Harendran
Sri Lanka	Subash Chandra Ghosh
Sri Lanka	Sisira Liyanage
Sri Lanka	Chanaka yatiwawala
Thailand	Stephen Mills
Thailand	Patchara Benjarattanaporn
Thailand	Taweesap Siraprapasiri
Thailand	Nittaya Phanuphak
Thailand	Angkhana Neelapaijit
Thailand	Mon Unsathit
Thailand	Thitiyanun (Doi) Nakpor
Thailand	Pairpailin Buppha
Thailand	Farida Langkafah
Thailand	Philippe Girault
Thailand	Siroat Jittjang
Thailand	Dr. Nipat Teeratakulpisarn
Thailand	Dr. Michelle DuMond
Thailand	Panus Na Nakorn
Thailand	Nuttawut Teachatanawat
Thailand	Phumjai Krisintu
Thailand	Philip Limbumrung
Thailand	Thanawan Tangthanasup
Thailand	Fahmida Iqbal Khan
Thailand	Jetsada Taesombat
Timor-Leste	Nedia Da Costa
Timor-Leste	Zizinha Belo
Vietnam	Huynh Lan Phuong
Vietnam	Nguyen N. N. Trang
Vietnam	Nguyen Duc Long
Vietnam	Dung Mai Ba Tien
Vietnam	Chu Thanh Ha
Vietnam	Mia Nguyen
Vietnam	Boi Nhi

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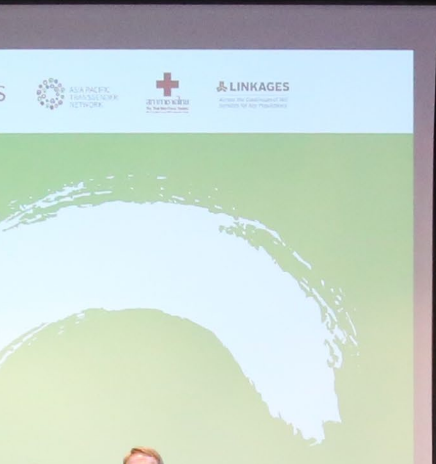
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