

**REPORT FOR THE MEDICAL SENSITIZATION WORKSHOP FOR
HEALTH PROVIDERS BY JINSIANGU KENYA ON TRANSGENDER
POPULATION IN KENYA HELD ON APRIL 9, 2016 AT SILVER
SPRINGS HOTEL, NAIROBI**



DEFINITIONS

- **Trans*:** This is a term used in the discipline of gender studies to refer to all persons whose own sense of gender does not match with the gender assigned to them at birth. Spelt with an asteroid, trans* is an umbrella term used to refer to all non-cisgender identities and expressions. This includes transgender, transsexual, male to female (MtF), female to male (FtM), gender queer, third gender, other and so on.
- **Lesbian:** refers to women who date other women and or have sex with other women; sexually attracted to someone who is the same sex
- **Gay:** men who date other men and or have sex with other men; sexually attracted to someone who is the same sex
- **Trans-man:** A person who is assigned gender female at birth (PAGFB) but identifies with the gender male. The person may or may not have undergone sex reassignment surgery/procedures.
- **Trans-woman:** A person who is assigned gender male at birth (PAGMB) but identifies with the gender female. The person may or may not have undergone sex reassignment surgery/procedures.
- **Male to Female Trans person (M to F / MtF):** A person who is PAGMB, but identifies with the female gender.
- **Female to Male Trans person (F to M / FtM):** A person who is PAGFB, but identifies with the male gender
- **Transsexual:** Transsexual refers to a person who firmly identifies oneself as belonging to a gender that is opposite to that of the birth-assigned gender.
- **Gender queer:** implies persons who identify as non cis gender and is used as an umbrella term to refer to a range of non-normative gender expressions. Some persons may be more comfortable choosing terms that do not adhere to the notion of gender binaries of male and female. They may see gender as less rigid and may prefer to use the term Genderqueer to refer to their gender identity.
- **Persons with Intersex Variations:** Persons who at birth show variations in their primary sexual characteristics, external genitalia, chromosomes, hormones from the normative standard of female or male body.

- **Sex reassignment surgery/procedure:** refers to a range of medical procedures, including surgical procedures that people undergo to transform their bodies and or genitalia to that of the supposed opposite sex. This includes a range of procedures such as injection of hormones, laser treatment for removal of body hair, genital re-constructive surgery and so on.
- **Transgender persons:** All persons whose own sense of gender does not match with the gender assigned to them at birth. They will include trans-men & trans-women (whether or not they have undergone sex reassignment surgery or hormonal treatment or laser therapy, etc.), gender queers
- **Gender:** Means the internal experience
- **Sex:** Attributes of the body (appearance)
- **Genitalia:** the organs of reproduction, especially the external organs
- **Cisgender:** is a term for people whose experiences of their own gender agree with the sex they were assigned at birth. **Cisgender** may also be defined as those who have "a gender identity or perform a gender role society considers appropriate for one's sex."
- **Chromosomes:** is a strand of DNA that is encoded with genes. In most cells, humans have 22 pairs of these *chromosomes* plus the two sex *chromosomes* (XX in females and XY in males) for a total of 46.
- **Hormones:** are chemical messengers that are secreted directly into the blood, which carries them to organs and tissues of the body to exert their functions. There are many types of **hormones** that act on different aspects of bodily functions and processes. Some of these include: Development and growth.
- **Dysphoria:** a state of unease or generalized dissatisfaction with life
- **Karyotype:** is the number and appearance of chromosomes in the nucleus of a eukaryotic cell. The term is also used for the complete set of chromosomes in a species, or an individual organism.
- **Gender Identity:** A person's internal, deeply felt sense of being a man or woman, or something other, or in between, which may or may not correspond with the sex assigned at birth.
- **Gender Affirmation:** The process by which individuals are affirmed in their gender identity. Gender affirmation typically involves three dimensions: social (being called by a name and pronouns that are aligned with a person's gender identity); medical (hormone therapy, surgical procedures); and legal (changing a person's legal name or sex designation).
- **Gender-Based Violence:** Any form of violence that is directed at an individual based on biological sex, gender identity (e.g., transgender), or behaviors that are not in line with social expectations of what it means to be a man or woman, boy or girl (e.g., MSM and female sex workers). It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life.
- **Transgender:** An adjective to describe a diverse group of individuals whose gender identity differs to varying degrees from the sex they were assigned at birth. In this document we will use TRANSGENDER and the shortened form "TRANS" as umbrella terms to refer to people whose gender identity and/or gender expression does not correspond with the social norms and

expectations traditionally associated with their sex assigned at birth. It includes identities that fit within a female/male classification and those who are NONBINARY (meaning their gender identity and/or gender expression does not conform to a binary, mutually exclusive understanding of gender in terms of male or female). TRANS WOMEN are people who were assigned male at birth and identify as female. TRANS MEN were assigned female at birth and identify as male. Medical professionals may be most familiar with the term TRANSSEXUAL which is often used by health care providers and/or members of the trans community to refer to individuals who intend to, have changed, or are changing their primary and/or secondary sex characteristics.

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1.0 INTRODUCTION

Trans people are not sick; we are not confused. We are poorly understood, negatively portrayed, and even invisible in some settings. We experience discrimination and violence, and suffer from a lack of access to justice, housing, education, employment and health care. HIV-related deaths among trans people, as a result of failure to seek medical services due to provider, ignorance, discrimination and stigma, require urgent intervention. We need gender-affirming HIV and other medical services that respect us, that acknowledge trans people as a unique population, and that treat us as partners.¹

Medical practitioners are often overwhelmed when dealing with transgender patients for they often prefer to direct such patients toward psychological counseling and or other avenues. The lack of informed, knowledgeable health service providers is a barrier for transgender [individuals] getting medical care is the lack of access to physicians who are knowledgeable and comfortable providing that care. What's concerning these providers is a sense that treating transgender is too complicated, and that they think this is a mental health concern. In the current nature of the field of transgender there is not enough research being done currently on the health of gender identity minorities, including those who identify as transgender. This has made it difficult for these minority population to access health services well-tailored for them.

Every day, transgender (trans) people face human rights violations that harm their health and well-being, limit their opportunities, and increase their vulnerability to HIV and other diseases. In order to meet the WHO requirements in relation to health as well as fulfil Article 43 of the Kenyan constitution², greater understanding of and attention towards the trans population is really required. For this to be achieved, research and surveys need to be conducted and done. Policies and guidelines also rely on the data and information collected during the surveys and researches since they are formulated from evidence based interventions.

Jinsiangu is a Transgender, intersex and Gender Non- Conforming (ITGNC) group that exclusively deal with gender minorities. It facilitates a safe space in Nairobi for the trans population who are in need and offer training in basic skills to allow them more independence. Jinsiangu is a combination of the Swahili words 'jinsia yangu', meaning "my gender." they are committed to ITGNC-led, anti-

¹ Lexy Ogeta, trans activist from Kenya

² Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care;

oppressive organizing. The group strives to develop and create spaces and platforms within Kenya in which all citizens are free to determine and express their own gender. The organization advocates for the rights of the trans population in Kenya by sensitizing the community which herein includes the health care providers.

This report will equip healthcare providers with the necessary skills and knowledge to provide timely and efficacious medical services that support and adequately cater for the ITGNC population and their unique health care needs within the Kenyan Healthcare System. The report intends to strengthen the ability of programmers and policymakers to understand and respond to HIV and health risks faced by transgender people around the country in order to reduce the burden of HIV and other risks and protect the rights of trans communities.

2.0 BACKGROUND

2.1 Basic Concepts of Understanding Gender

Transgender people often experience discomfort or distress (dysphoria) due to their gender not being recognized by others, and therefore wish to transition to being viewed as their true gender identity. Some feel that way from a very young age, while others go through a period of questioning before realizing they are transgender. In order to define or describe who is a transgender person, it is necessary to establish a basic understanding of what gender is and how and who it is determined by. Since gender is one of the most pervading and given social category, one may not be aware of it on a daily basis and yet while going about the business of daily living, gender is present at every step. It determines every aspect of our life including our name, clothes, hair length, appearance, behaviors, occupation, and mobility and so on. It is present in every document of identity, including birth certificate, national identity card, voter ID, passport; mark sheets/grade cards and so on.

In the public arena, there are spaces that are strictly gender segregated such as toilets for men and women, queues and lines in several public utilities that are separate for men and women, for instance security checks. In essence what this implies is that, while living out one's life in a rural or an urban area, in a poor or a rich neighborhood, nationally or globally, gender is constantly present, both in our minds and our interactions.

Hence the question, how and by whom is this gender determined, we first need to understand that none of us are born with a gender, but gender is assigned to each one of us based on the kind of primary sexual characteristics or external genitalia that we are born with. Thus an infant born with genitalia looking like a "vagina" is assigned gender female at birth and an infant born with genitalia looking like a "penis" is assigned gender male at birth. This basic idea of 'gender as assigned' is expressed through the two terms - person assigned gender female at birth (PAGFB) and person assigned gender male at birth (PAGMB). Therefore, it can be stated clearly that gender assignment is not the choice of the person but of the assignee whom might be the doctor, parents and/or even the society at large.

Having established that gender is assigned, it should be understood that this assigned gender at birth may or may not match the person's idea of their own gender as they grow up. As a result there would be those, who grow up with a sense of comfort and alignment between their 'felt' or own sense of gender and the gender assigned to them. These would be persons who are 'cisgender', both cismen (commonly referred to as 'man') and cis women (commonly referred to as 'woman'). On the other hand, there would be those whose own/inner sense of gender does not match the gender assigned to them. These would be persons who are 'transgender'. However, when people choose a gender other than the gender assigned at birth, then they express their gender through several identity terms and names, all of which largely fall under the category of transgender.

2.1.1 Sexual Orientation and Gender Identity

It is important that while talking about transgender persons, one should be able to make clear distinction between 'sexual orientation' and 'gender identity'. Significantly, this distinction has been clearly explained in the Yogyakarta Principles on the application of International Human Rights Law in relation to sexual orientation and gender identity, as follows: "Sexual orientation" is understood to refer to each person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender. "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. It is also clear from the Yogyakarta Principles that while the perception of being a Lesbian, Gay or Bisexual is a function of sexual orientation, in case of transgender persons, it is a function of gender identity. This is evident from the following excerpt from preamble of the said principles: *Page / 10* "...historically people have experienced these human rights violations because they are or are perceived to be lesbian, gay or bisexual, because of their consensual sexual conduct with persons of the same gender or because they are or are perceived to be transsexual, transgender or intersex or belong to social groups identified in particular societies by sexual orientation or gender identity;" However, what is significant is that under these principles both Sexual orientation and gender identity are integral to every person's dignity and humanity and must not be the basis for discrimination or abuse. All human beings are born free and equal in dignity and rights. All human rights are universal, interdependent, indivisible and interrelated.

Transgender people can have any sexual orientation. Media portrayals which suggest that all trans people are attracted to those of the same assigned sex, and seek to transition in order to make such relationships heterosexual and therefore accepted, are very inaccurate. Transgender people can be heterosexual, homosexual, bisexual, asexual, or any other sexuality, just as cisgender people can.

In the past, "gay" was a term used for anyone who did not fit into heterosexual gender norms, and thus transgender people were often associated with the gay community and cultures. However, since more terminology has been created, many of these people now identify as transgender instead, and

gay is only used to refer to non-heterosexual people. However, there is still a sense of connection between the two groups from this shared history, as shown through terms like the "LGBT community", in which the T stands for transgender.

Transgender people's relationships are described with reference to gender identity, not sex characteristics. For instance, a trans woman who is only interested in relationships with women (cis or trans) may identify as a lesbian, even if she is non-op. This can be complicated to describe for non-binary people who are only attracted to one gender, as traditional terms of sexuality rely on the gender binary (such as "heterosexual" attraction to the "opposite" gender). Terms such as androsexual (attracted to men) and gynosexual (attracted to women) have been created in order to solve this problem.

2.2 The Transition Concept

Transition is any action a transgender person takes in order for the external world to better recognize and reflect their internal gender. This can range from asking people to use different names and pronouns, to a change in dress or appearance, to extensive surgery. The three main forms of transition are social, legal, and medical, although all of these are broad categories which can reflect dozens of different possible actions.

Some transgender people have extreme dysphoria (feelings of distress) arising from their sex characteristics not matching their self-image and/or being seen and treated as the wrong gender (misgendered). This dysphoria may be referred to by the medical term of Gender Identity Disorder, for which the correct treatment is considered to be transition, accompanied by any necessary support to achieve the desired state.

Every transgender person has different desires for what they want (or do not want) to include in their transition, including surgery and other medical procedures. Transgender people who do not plan to have surgery are sometimes referred to as non-op; transsexual is sometimes used to refer to only those who do. It is possible for a transgender person to be completely comfortable with their body and/or to experience no dysphoria. It is important not to make assumptions about what is, was or will be involved in any individual person's transition.

Some transgender people are aware of their condition as children and begin transitioning then, such as by taking puberty blockers to delay the development of sex characteristics until they are old enough to be allowed to medically transition. However, many attempt to reconcile themselves with living as their assigned gender, and only transition later in life when they realize they are not happy with the way things are. This may involve a period of questioning in which a person is uncertain of their gender identity, and wishes to explore before settling on a label for themselves. Even after transition, transgender people may not want to reflect societal stereotypes of their gender identity. For instance, a trans woman can be masculine, a tom boy, work as a mechanic, or hate wearing dresses - just as a cis woman can do any of those things.

2.2.1 The Transition process

Note: The information in this section applies only to transsexuals, not to transgender people in general. Remember that not all transgender people want to transition. There are a variety of paths that people follow, but many use a series of guidelines set out by the World Professional Association for Transgender Health. These guidelines are called the Standards of Care (SOC) and they outline a series of steps that people may take to explore and complete gender transition.

These may include:

- Counseling with a mental health professional
- A “real life” experience where an individual lives as the target gender for a trial period
- Learning about the available options and the effects of various medical treatments
- Communication between the person’s therapist and physician indicating readiness to begin medical treatment (usually in the form of a letter)
- Undergoing hormone therapy
- Having various surgeries to alter the face, chest and genitals to be more congruent with the individual’s sense of self.

Not all transsexual people follow these steps nor does the community agree about their importance. It’s a believe that people should make their own decisions about their health care, in consultation with medical or mental health professionals as appropriate to their individual situation. Trans people may undergo hormone therapy. Transwomen may take estrogen and related female hormones; transmen may take testosterone. It is important that people obtain hormones from a licensed medical professional if at all possible to be sure that the medications are safe and effective. Doctors should monitor the effects on the body, including checking for negative side effects. Some of the effects of hormone treatment are reversible when a person stops receiving hormone therapy; other effects are not.

Many people report feeling more at peace after they begin hormone treatments, but hormones may also cause other fluctuations in mood. For many transgender people, there is no discernable difference in moods after beginning hormone treatments. Some people and their doctors decide to pursue a full dose of hormones while others choose to go on a lower dose regimen or not take hormones at all for personal or medical reasons. Some transsexuals have surgery to change their appearance. There is no single “sex change surgery.” There are a variety of surgeries that people can have, including:

- Genital reconstructive surgery, to create a penis and testes or clitoris, labia and vagina
- Facial reconstruction surgery, to create a more masculine or feminine appearance
- Breast removal or augmentation
- For FTMs, surgery to remove the ovaries and uterus
- For MTFs, surgery to reduce the Adam’s apple or change the thorax.

Whether or not someone has had surgery should never make a difference in how they are treated. In addition to the medical procedures, transsexual people often follow a series of legal steps to change

their name and gender markers. This may not be the case in Kenya though the Transgender Organizations and community in the country are in the process of sensitizing the society and influencing policy formulation. Some of the things that may need to be changed are the identity documents and personal records.

3.0 THEORIES OF THE EXISTENCE OF THE TRANS POPULATION

There are a number of theories about why transgender people exist although there is not yet scientific consensus. When you look across cultures, you will find that people have had a wide range of beliefs about gender. Some cultures look at people and see six genders, while others see two. Some cultures have created specific ways for people to live in roles that are different from that assigned to them at birth. In addition, different cultures also vary in their definitions of masculine and feminine. Whether we view someone as transgender depends on the cultural lenses we are looking through as well as how people identify themselves.

Biologists tell us that sex is a complicated matter, much more complex than what we may have been taught in school. A person with XX chromosomes is generally considered female, while a person with XY chromosomes is generally considered male. However, there are also people who have XXY, XYY, and other variations of chromosomes; these genetic differences may or may not be visibly apparent or known to the person. Some people are born with XY chromosomes, but are unable to respond to testosterone and therefore develop bodies with a vagina and breasts, rather than a penis and testes. A variation in gender may just be part of the natural order and there are more varieties than we generally realize. People with biological differences in gender may be considered intersex; they may or may not identify as transgender.

There are medical theories about why people are transgender. Some speculate that fluctuations or imbalances in hormones or the use of certain medications during pregnancy may cause intersex or transgender conditions. Other research indicates that there are links between transgender identity and brain structure. Some people believe that psychological factors are the reason for the existence of transgender people. It is clear that there are people who are aware that they are transgender from their earliest memories. Many trans people feel that their gender identity is an innate part of them, an integral part of who they were born to be.

Then there are people who feel that everyone has a right to choose whatever gender presentation feels best to that individual. People should have the freedom to express themselves in whatever way is right for them. Sex and gender are complex issues. A huge variety of factors are at work in making each individual the person that they are and there is no one reason that causes people to be transgender. Trans people are part of the variety that makes up the human community.

3.1 Biological Understanding of Transgender

It's clear that a significant segment of human society has difficulty accepting that transsexuality is a real medical condition which is part of our inherited genetics. The common tactic of the blatant transphobe is to dismiss us as freaks, psychopaths, or even monsters deserving of involuntary institutionalism. Many theories and researches have tried to discover the biological concept of origin and transformation of transgender. Controversial outcomes and findings have been brought forth hence making the topic and discussion more complex and confusing. Some state that it's a mental disorder, others say it's a choice, others say its chromosomal disorder and others reflect the same on hormones just to mention but a few. Hence the question would be, is there a biological explanation of transgender

Researchers from the Boston University School of Medicine published a review concluding that there is a biological basis for transgender identity³. The researchers were contesting the notion that transgender people choose what gender they prefer. Evidence that gender has a biological basis may improve health care, including surgery and hormone treatment, for transgender patients, the release stated.

In the Dominican Republic one in 90 children there that are born girls are not destined to stay girls. Once these children start puberty, *they grow penises and testicles*. They are known locally as *guevedoces*, literally “penises at age twelve”. Scientists call them pseudo hermaphrodites. According to Dr. Julianne Imperato, one of the first to study the guevedoces, discovered that the startling transformation was due to an enzyme deficiency⁴.

3.2 Mental Theory

Trans people are NOT mentally sick and or incapacitated, but there remains a stereotype about transgender people. Gender Identity Disorder is listed in the Diagnostic and Statistical Manual-4th Edition (DSM-IV), a guide used by mental health professionals to diagnose psychological conditions. Transgender identity is not a mental illness that can be cured with treatment. Rather, transgender people experience a persistent and authentic difference between our assigned sex and our understanding of our own gender. For some people, this leads to emotional distress. This pain often can be relieved by freely expressing our genders, wearing clothing we are comfortable in, and, for some, making a physical transition from one gender to another.

For people who identify as trans, counseling alone, without medical treatment, is often not effective. Our society is, however, very harsh on gender-variant people. Some transgender people have lost their families, their jobs, their homes and their support. Transgender children may be subject to

³ <http://dailyfreepress.com/2015/02/18/bu-researchers-find-biological-basis-for-transgender-identity/>

⁴ <http://brainspongeblog.com/2015/10/29/boy-or-girl/>

abuse at home, at school or in their communities. A lifetime of this can be very challenging and can sometimes cause anxiety disorders, depression and other psychological illnesses. These are not the root of their transgender identity; rather, they are the side effects of society's intolerance of transgender people.

3.3 The Brain Development Concept

Gender identity was once thought of as being entirely a social construct, with most of our gender formation occurring between the ages of 1-4⁵. In the 21st century, the general thought is that gender identity is programmed at birth, although social factors can potentially overwhelm this programming. One tragic example is the “John-Joan-John” case, where a boy who lost his penis at 8 months was surgically turned into a girl, including the administration of estrogens and receiving psychological counseling. Although raised a girl all her life, she had the unshakeable feeling that she was in fact a boy. She transitioned back to male at age 14, and attempted to live as a male, but eventually, due to financial instability and a failing marriage, committed suicide⁶

Male and female brains are, on average, slightly different in structure, although there is tremendous individual variability. Several studies have looked for signs that transgender people have brains more similar to their experienced gender. Spanish researchers⁷ used MRI to examine the brains of 24 female-to-males and 18 male-to-females—both before and after treatment with cross-sex hormones. Their results, published in 2013, showed that even before treatment the brain structures of the trans people were more similar in some respects to the brains of their experienced gender than those of their natal gender. For example, the female-to-male subjects had relatively thin subcortical areas (these areas tend to be thinner in men than in women). Male-to-female subjects tended to have thinner cortical regions in the right hemisphere, which is characteristic of a female brain. (Such differences became more pronounced after treatment.)

Trans people have brains that are different from males and females, a unique kind of brain. It is simplistic to say that a female-to-male transgender person is a female trapped in a male body. It's not because they have a male brain but a transsexual brain. Of course, behavior and experience shape brain anatomy, so it is impossible to say if these subtle differences are inborn.

Other researchers have looked at sex differences through brain functioning. In a study published in 2014, psychologist⁸ used functional MRI to examine how 39 prepubertal and 41 adolescent boys and girls with gender dysphoria responded to androstadienone, an odorous steroid with pheromone like properties that is known to cause a different response in the hypothalamus of men versus women.

⁵ Bao, Gooren 2006

⁶ <http://transascity.org/the-transgender-brain/>

⁷ led by psychobiologist Antonio Guillamon of the National Distance Education University in Madrid and neuropsychologist Carme Junqué Plaja of the University of Barcelona

⁸ Sarah M. Burke of VU University Medical Center in Amsterdam and biologist Julie Bakker of the Netherlands Institute for Neuroscience

They found that the adolescent boys and girls with gender dysphoria responded much like peers of their experienced gender. The results were less clear with the prepubertal children.

This kind of study is important because sex differences in responding to odors cannot be influenced by training or environment. Another study measured the responses of boys and girls with gender dysphoria to echolike sounds produced by the inner ear in response to a clicking noise. Boys with gender dysphoria responded more like typical females, who have a stronger response to these sounds. But girls with gender dysphoria also responded like typical females.

Overall the weight of these studies and others points strongly toward a biological basis for gender dysphoria. But given the variety of transgender people and the variation in the brains of men and women generally, it will be a long time, if ever, before a doctor can do a brain scan on a child and say, “Yes, this child is trans”⁹

In summary, taking the entire breadth of the findings uncovered several researches, it appears that there is more than sufficient evidence that transgender persons either have a serious hormonal-based birth defect, have been exposed to exogenous chemicals which have impacted their gender development in the womb, have a genetic karyotype which differs from the general population, or via some other process have a brain structure which is different than would be indicated by their chromosomes. While no single study presents proof beyond any shadow of a doubt or with metaphysical certainty, taken together they do present a preponderance of evidence such that one can say with confidence that transgender individuals have a congenital gene-based difference from cissexual individuals.

4.0 THE TRANS- POPULATION IN KENYA

Transgender people, like any group of people, come from a range of backgrounds. They live in cities and rural areas; are young, elderly, and middle-aged; begin to live as their true gender when they are children, young adults, or much later in life; and live in families of all varieties.

Transgender people, and the communities they live in, are diverse in terms of factors such as race, income, and sexual orientation.

The Kenyan Constitution recognizes the trans population under Article 260 which defines them as ‘marginalized community’ in that its a community that, because of its relatively small population or for any other reason, has been unable to fully participate in the integrated social and economic life of Kenya as a whole. The trans population fall under this category simply because of the following underlying fact:

1. Transsexual people face discrimination
2. Are a non-dominant group having no influence in the running of the State
3. They are a statistical minority in that there is no much research and or information available in relation to the population

4. Have a sense of camaraderie, fighting for rights and freedom exercised by the cisgender community
5. Have common burdens
6. Have common traits that are disapproved by the cisgender community
7. Are at a high risk of poverty and social exclusion

The constitution still stipulates that all State organs and all public officers have the duty to address the needs of vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of minority or marginalized communities, and members of particular ethnic, religious or cultural communities¹⁰. Hence this means that, by the fact that the trans population is and are recognized through the aforementioned provision, they are and should be protected by the bill of rights.

Unfortunately, transgender people from all backgrounds commonly face discrimination in a wide array of settings. Transgender people across the country today encounter prejudice, violence, and institutionalized discrimination in areas of everyday life such as health care, housing, employment, education, and legal recognition in their true gender. These disparities multiply for transgender people who are also members of other disadvantaged groups, such as transgender people of color and transgender women.

The consequences of discrimination are deadly. The transgender people are disproportionately likely to experience violence in the home, on the street, and even in health care settings¹¹. They are four times as likely as the general population to live in extreme poverty, more likely to be uninsured, and less likely to get preventive care that can catch diseases such as cancer early in disease progression. Under this situations and more so non- acceptability in the society, most of this population end up committing and/ or contemplating suicide.

In Kenya, less or no information is available for the trans population. Researchers have shunned this topic stating complexity and controversy. Hence this leaves the society including the trans population with the lack of knowledge with regard to the same. This has really impacted negative towards the wellbeing of the trans population mostly on legal and health aspects.

4.1 Transgender and Healthcare in Kenya

The Kenyan constitution under Article 43(a), every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. This applies to every citizen in Kenya of which it includes the trans population. Apparently, Medical practitioners in Kenya are often overwhelmed when dealing with transgender patients for they often prefer to direct such patients toward psychological counseling. The largest barrier for trans population in Kenya to getting medical care is the lack of access to physicians who are

¹⁰ Article 21(3) of the Constitution of Kenya

¹¹ The 2011 National Healthcare Disparities Report

knowledgeable and comfortable providing that care. What's concerning these providers is a sense that treating trans population is too complicated, and that they think this is a mental health concern. In the current nature of the field of transgender there is not enough research being done currently on the health of gender identity minorities, including those who identify as transgender. This has made it difficult for these minority population to access health services well-tailored for them. The health and health care needs of trans persons are affected by a number of social, behavioral, and structural factors including deep-rooted stigma and discrimination and health policies.

The health care needs of trans persons may not be adequately addressed either because their health care providers may be unaware of their sexual orientation, and they may face specific health issues. Moreover, some patients may have a perception of discrimination in the health system. Analysis of Canadian Community Health Survey data (2003-2005) by Tekamah found that trans persons were more likely to visit mental health service providers than heterosexuals – an indicator of the prevalence of mental health issues in trans populations. Other studies indicate that trans persons report higher levels of unmet healthcare needs than heterosexuals. Hence, this has brought out the perception that trans persons perceive that they have less equitable access to health care and social services, and report higher unmet health needs compared to heterosexual persons. Given the health disparities and unique challenges that trans persons experience, it is important to understand the facilitators and barriers to accessing health care and to consider current approaches to meet their health care needs.

4.2 General Barriers to Accessing Healthcare by the Transgender in Kenya

Trans individuals often face challenges and barriers to accessing needed health services and, as a result, can experience worse health outcomes. These challenges can include stigma, discrimination, violence, and rejection by families and communities, as well as other barriers, such as inequality in the workplace and health insurance sectors, the provision of substandard care, and outright denial of care because of an individual's sexual orientation or gender identity. While sexual and gender minorities have many of the same health concerns as the general population, they experience certain health challenges at higher rates, and also face several unique health challenges. In particular, some trans population have more chronic conditions as well as higher prevalence and earlier onset of disabilities than heterosexuals. Other major health concerns include HIV/AIDS, mental illness, substance use, and sexual and physical violence. In addition to the higher rates of illness and health challenges, some trans individuals are more likely to experience challenges obtaining care.

Assessing the health needs and barriers to care of the trans population has been challenging due to the historical lack of data collection on sexual orientation and gender identity. While some health surveys have asked about sexual orientation, it has not been routine to collect and analyze data on sexual orientation and gender identity in many major health surveys, particularly nationally representative ones, meaning that much of the data available to date have been from smaller, non-representative studies and convenience samples. Where data have been collected, they have mostly

focused on same-sex couples using data systems that collect information on relationship status. In addition, where data are available for individuals, there is more information about lesbian, gay, and bisexual persons than transgender individuals. There has been growing recognition of the need for research focused on the transgender community

Barriers include gaps in coverage, cost-related hurdles, and poor treatment from health care providers. Herein below, we have tried to categorize the barriers:

a. Knowledge and Attitudes of Health Care Professionals

Knowledge and attitudes of health care professionals can be a barrier to health care for trans populations. Some trans persons have stated being refused treatment, or experiencing verbal abuse and disrespectful behavior from healthcare providers. Most of the health practitioners and health care providers are inattentive to the realities of trans patients. Rarely do the practitioners and service providers consider the sexual identity of their patients in that they use the assumption nature to classify the patients which really is discriminatory to the trans population. It is evident that health care providers have no enough training to care for trans persons and lacking knowledge of the health issues trans populations face. This lack of knowledge leads some health care professionals to feel uncomfortable providing services to trans patients. For example, most transgender men still have a cervix and should be screened for cervical cancer, which requires a sensitive approach.

On another blink, medical education does not routinely encompass trans population health issues. More than half of medical schools and public health school curricula lack instruction about the health concerns of trans people. Trans individuals also felt vulnerable around the fact that their hormones and overall care could be ended abruptly; this in turn affected what they felt comfortable telling their health providers.

b. Discrimination and Reluctance to Disclose Gender Identity

Trans persons' previous negative experiences with the health care system or perceptions of discrimination in the system may cause them to delay seeking health care. The perceived homophobia and heterosexism of health care providers towards the trans population affects the quality of service provided. Trans persons may also be reluctant to disclose their sexual orientation out of fear that information will bias their care. The degree to which an individual feels comfortable disclosing his or her gender identity appears to be related to health care access and utilization. Being open about one's sexual identity in general is related to increased disclosure to health care professionals, which leads to better care. Some trans individuals may be willing to open up and seek care from their health care provider; however, their decision may be influenced by the attitudes of the individuals themselves and of their health care providers.

Stereotyping by the society acts also as an influence to non-disclosure and or fear for disclosing their gender identity. Pathologization of status the population (consideration of sexuality/gender status as part of illness, history of homosexuality and gender identity disorder in the DSM has created a cloud of fear and stereotype amongst the population as well. In the health centres and other social

platforms, the trans population are not given the opportunity for disclosure in that, most providers are not asking the right questions as to their gender identity and hence perceiving them as “Dual alienation’

c. Insurance policies and Medical aid

The cost of surgery for the trans persons in relation to transition is very costly in Kenya. Many health plans include transgender-specific exclusions that deny transgender individuals coverage of services provided to non-transgender individuals, such as surgical treatment related to gender transition, mental health services, and hormone therapy. Therefore, this means most of the trans population may lack timely health services due to lack of fund and or cover. The transgender population is much more likely to live in poverty and less likely to have health insurance than the general population. Most went without care when they were sick because they could not afford it. In addition, the barriers that trans people face in accessing care may be compounded by other factors including racial status, education and income level, geographic isolation, immigration status, knowledge and cultural beliefs.

d. Sexual assault and physical violence

Sexual assault and physical violence can have lasting consequences for victims, families, and communities. trans individuals experience higher rates of sexual and physical violence compared to heterosexual and non-transgender individuals. Many trans population have experienced some form of discrimination because of their sexual orientation or gender identity, including subjection to slurs, rejection by a friend or family member, being physically threatened or attacked, receiving poor service at a place of business or treated unfairly by an employer, or made to feel unwelcome at a place of worship. Many of them have experienced some form of sexual violence especially in relation to structure for instance in prisons. Anti-trans bias also puts trans people at risk for physical violence. Other trans individuals have been victims of physical and verbal assaults, as well as personal property damage, due to their sexual orientation or gender identity. Sexual Violence other than rape includes being made to penetrate, sexual coercion, unwanted sexual contact, and non-contact unwanted sexual experiences. Perpetrator can include an Intimate Partner, local authority’s personnel, family member. Intimate Partner Violence includes physical and sexual violence, threats of physical or sexual violence, stalking, and psychological aggression by a current or former intimate partner.

Transsexual people in Kenya are also subjected to psychological torture. This takes the form of being denied services (e.g. medical services) and are tossed from one institution to another. These institutions/officials erect hindrances telling transsexual people that their parents or siblings don’t want them to access surgeries; yet they are above the age of free consent. They are then told to wait- and they do wait for years with nothing being done. These are acts of degrading treatment resulting to psychological torture.

d. Stigma and discrimination

Under the constitution of Kenya all State organs and all public officers have the duty to address the needs of vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of minority or marginalized communities, and members of particular ethnic, religious or cultural communities. The trans population fall under this category and are covered by the globally recognized Human Rights. This means, they have the right to be treated equally as other citizens. Apparently, this is not the script in actualization. For instance, Article 43(a) may not be realized by this population since discrimination may be as personal as refusing to use the patient's chosen name or as structural as providers' lack of knowledge about how to provide appropriate care to transgender people. Studies of the transgender community show that transgender people have faced some type of harassment or discrimination when seeking routine health care, and many report being denied care outright or encountering violence in health care settings.

e. Un-enabling Environment

Most of the health laws and policies in Kenya do not put into consideration of the trans population. This has been contributed to the lack of information in relation to the said population, stereotyping by the society, societal norms, beliefs and cultures *inter alia*. With regard to the above statement, every day, transgender (trans) people face human rights violations that harm their health and well-being and limit their opportunities. The following are some of the challenges they face on a day to day basis due to their gender identity:

i. Identification, Registration and Documentation

Most of the identification documents in Kenya are either tagged Male or Female in relation to gender. The traditional norm nomenclature refers naming into Male names or Female names. Hence this makes it difficult to change the given names by the society in your identity documents since there are no laws and or policies governing the same. Hence if a trans individual wishes to change their names and or identity in relation to the gender, it has become a journey on thorns. The main challenge is when their appearance doesn't reflect the identity in the identification documents. This leads to them either being, arrested and or accused of impersonification, harassed, sexually, verbally or physically abused, denied services, embarrassed and or discriminated against.

Registration forms and other registration documents have only two categories for gender which is Male and Female. This isolates the trans community and makes them feel unwanted and unrecognized.

ii. Discrimination at the work place

Transgender individuals continue to face widespread discrimination in the workplace. Many if not all work policies are ignorant in relation to the trans population. These workplace abuses pose a real and immediate threat to the economic security of transgender workers. Every worker should be judged in the workplace based on their skills, qualifications, and the quality of their work. Right now,

too many of our country's transgender workers are being judged on their sexual orientation and gender identity, factors that have no impact on how well a person performs their job. Most of the trans population end up performing poorly due to the discrimination and harassment hence end up being struck out or quit.

iii. Lack of transgender conforming facilities

The outcry by the Persons with Disabilities to the government for persons with disability conforming structures and facilities back in 2008, brought out a great change in the society by the government honoring their outcry. Unfortunately, the trans community suffer the same fate in that, there are no facilities and or infrastructure conforming to their unique needs. For instance, there are no rest rooms for the trans community in that, they have to share what is their which means, if it's a MtF and gets into a male washroom, there will confusion which might arise to harassment and or even violence. This is an example of what the trans community face every day.

5.0 TRANSGENDER POPULATION AND THE LAW IN KENYA

Kenya is one of the countries with a robust constitution globally. As much as there are many challenges in Kenya with regard to the trans population, there are great laws which tend to provide an enabling and conducive environment for the population. The major issue and or problem is implementing the same. Hence there is dire and great need for the trans community to sensitize the society as well as the authorities on their issues. Discrimination and stereotyping has acted as an hindrance to realization of the trans community rights and freedoms. This has impacted fear to the community hence cannot approach the track and address their issues or access services even when they have the right. Herein are some of the supporting legislations and policies:

5.1 The Constitution under Chapter Four (Bill of rights):

Article 21 bind all state organs to uphold the bill of rights and ensure every citizen is accorded the same without favor and or discrimination. The bill of rights is globally recognized and cannot be withdrawn from any person unless otherwise. Hence this means the trans population are fully recognized and protected by the supreme law of the country.

5.2 Registration of Persons Act (Cap 107)

This act provides for the registration of persons and for the issue of identity cards, and for purposes connected therewith” This Act provides all Kenyans the right to have a National Identity card. It applies to all Kenyan citizens who have attained the age of majority. Under section 9, authority to change name and place of residence is given following the right procedures. Hence this means, it is not illegal for one to change their names to their preference. On the other hand, though, section 10 stipulates that the registration officer may refuse to change the names of a registered person where the registered person requests the change in the names appearing on his identity card to include thereon the names of a deceased person. Hence this means that the only ground for refusal is none

other than use of a deceased person's name. therefore, the trans community can change their names in the identity documents as they wish and as per the regulations stipulated therein.

5.3 The Public Health Act (Cap 242)

Under section 13, it is the duty of every health authority to take all lawful, necessary and, under its special circumstances, reasonably practicable measures for preventing the occurrence or dealing with any outbreak or prevalence of any infectious, communicable or preventable disease, to safeguard and promote the public health and to exercise the powers and perform the duties in respect of the public health conferred or imposed on it by this Act or by any other law. This means that they need not to discriminate on any citizen while attending and or giving service in relation to health regardless of gender. It binds health institutions with the responsibility of offering medical services to all irrespective of their medical conditions or status in life. There is no excuse for Kenya's health system not safeguarding the health of people with transsexualism.

5.4 The Employment Act (Cap 226)

The Employment Act under section 3 explicitly protects transsexual people from discrimination during employment, trainings and recruitments and during termination. The specific grounds are: sex, disability and mental status.

5.5 Mental Health Act (Cap 248)

The provisions of Section 21 make it illegal to cancel treatment for transsexual people or discharge them without administering requisite treatment. Section 46 guarantees transsexual people the right to have their triadic treatment covered by health insurance. There is a general assumption that sex change surgeries are cosmetic surgeries thereby not necessitating insurance companies to pay for treatment. Section 51 safeguard the dignity of patients with mental disorders.

5.6 The Penal Code under section 240

A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case

6.0 TRANSGENDER POPULATION AND HIV

Discrimination also helps drive an overwhelming burden of HIV infection among transgender populations. The same structural circumstances that marginalize transgender individuals by forcing them down through the gaps in social safety nets, health care systems, and standards for legal citizenship also systematically place them at greater risk of HIV infection.

Data from the Centers of Disease Control and Prevention (CDC) show that new HIV infections among transgender people occur at almost three times that of non-transgender men and almost nine times that of non-transgender women¹². While available data indicate that HIV prevalence among transgender men is currently low, transgender men who have sex with men report high rates of unprotected intercourse, exposing this population to heightened risk for contracting HIV and other sexually transmitted infections¹³.

According to the Kenya AIDS Strategic Framework (KASF) 2014/15-2018/19, some of the factors driving the new infections in the country include high risk sexual behavior characterized by high incidences of concurrent sexual relations linked to mobility, intergenerational sex, transactional sex, denial and marginalization of LGBT groups which includes transgender population. The framework provides an initial strategy to collect more data on the said population on the scope of the HIV epidemic among transgender populations, to better understand the effect that discrimination related to gender identity and gender expression has on HIV risk and other health disparities, and to begin to develop initiatives to connect transgender individuals with lifesaving.

In order to meet the ambitious UNAIDS 90-90-90 targets, greater understanding of and attention to the rights and needs of trans people is needed. The health and well-being of transgender people is an important emerging issue around the globe. Data on trans people are limited, however the data that are available show considerable burden of disease. Approximately 19 percent of trans women are living with HIV and, compared with the general population, trans women are 49 times more likely to be living with HIV¹⁴. Connected to their HIV risk, trans individuals are also at a heightened risk for gender-based violence (GBV) because others see their behavior as not conforming to gender norms and expectations (e.g., that someone assigned male at birth must grow up to identify and live as a man).

Though research on trans population is very minimal, there is evidence that biological risk factors for HIV/STIs are closely associated with the biological sex of the person (31). Male-to-Female (MTF) transgender, for instance, share some biological risk factors with MSM, and the rare data that do exist on transgender populations mainly include MTF studied as a subpopulation of MSM. There are no empirical data on biologic transmission risk differences comparing MTF and MSM. However, many transgender women have been exposed to exogenous hormones that may impact vulnerability

¹² Centers for Disease Control and Prevention, HIV Among Transgender People (2011) ,<http://www.cdc.gov/hiv/transgender/pdf/transgender.pdf>

¹³ S. Reisner, B. Perkovich & M.J. Mimiaga, A Mixed Methods Study of the Sexual Health Needs of New England Transmen Who Have Sex with Nontransgender Men, 24 AIDS PATIENT CARE & STDS 501 (2010); J. Sevelius, "There's No Pamphlet for the Kind of Sex I Have": HIV-related Risk Factors and Protective Behaviors Among Transgender Men Who Have Sex with Non-transgender Men, 20 J. ASSOC. NURSES AIDS CARE 398-410 (2009)

¹⁴ Baral SD, Poteat T, Stromdahl S, Wirtz A, Guadamuz TE, Beyrer C. Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *Lancet ID [Internet]*. 2013 Dec [cited 2015 Sept 11]; 13(3): 214-222. doi: [http://dx.doi.org/10.1016/S1473-3099\(12\)70315-8](http://dx.doi.org/10.1016/S1473-3099(12)70315-8)

for HIV as well as interact with ART. Further, exogenous fillers such as silicone may increase inflammation that can impact HIV disease progression and viral load.¹⁵

In Kenya, Transgender population exacerbated vulnerability to HIV can be attributed to social and systemic factors such as contexts of widespread violence, discrimination and inadequate access to housing, employment, education, and health care. These factors, combined with low social support, are associated with transgender population involvement in survival risky behaviors. According to a Technical Report: The Global Health Needs of Transgender Populations¹⁶ emerging evidence consistently demonstrates, transgender women tend to carry higher rates of HIV than other trans population. This may be because of sexual practices that relate to their gender identities which might mostly be anal sex. The systematic review demonstrated that sexual risk factors such as unprotected receptive anal intercourse and multiple sexual partners are common.

Other individual-level risk factors for HIV risk include mental health issues, physical abuse, and higher incarceration rates. Higher order risk factors have also been associated with HIV risk among transgender community, including economic marginalization, social isolation, unmet health care needs, and low HIV-related knowledge.

Few if not non health care workers in Kenya ranging from HIV counselors to nurses and physicians have received any training on addressing the specific health needs of trans population. Consequently, consistent access to competent clinical prevention, treatment, or care services is rare even in many high income settings and even more so in low and middle income settings. Hence there is the need for health care workers to receive training in transgender health, including gender identity issues and clinical management of hormone therapy and body reassignment interventions, which are one the primary health demand of transgender. Addressing these needs may enhance the chances for transgender to develop a trusting relationship with the health care system, and therefore the impact of public health interventions to reduce HIV and other STIs.

6.1 HIV and hormonal therapy

Many transgender people use or want to have access to feminizing or masculinizing hormones to align their physical appearance with their gender identity. Respondents to a qualitative study on the values and preferences of transgender people with regard to HIV¹⁷ noted that many transgender people prioritize access to and use of hormone therapy over HIV care and treatment. Therefore, access to hormone therapy is an important entry point into HIV care and treatment for transgender people. Medical uncertainty remains over whether and how hormonal contraceptives affect HIV

¹⁵ Baral SD, Poteat T, Stromdahl S, Wirtz AL, Guadamuz TE, Beyrer C. Worldwide burden of HIV in transgender women: A systematic review and meta-analysis. *The Lancet Infectious Diseases*. 2013;13(3):214-22.

¹⁶ Nataf Z, (1998). Whatever I feel. *New Internationalist*. 1998;300

¹⁷ Herbst J.H, Jacobs ED, Finlayson TJ, McKleroy VS, Neumann MS, Crepaz N. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. *AIDS Behav*. 2008;12(1):1-17.

acquisition and transmission among natal women¹⁸. As part of the body transition process, transgender people may take doses of hormones that are larger than naturally occurring.

A better understanding is needed of how hormones used for transition may affect HIV risk among transgender people. Estrogen comes in many forms, including ethinyl estradiol and 17- β estradiol. Ethinyl estradiol, the form of estrogen commonly used in oral contraceptives, has well-characterized drug interactions with antiretroviral therapy (ART)¹⁹. While guidelines of the World Professional Association for Transgender Health (WPATH) discourage the use of ethinyl estradiol for body transition, this is the only formulation of estrogen available to some transgender population. There are published data that the effect of estrogen on antiretroviral (ARV) efficacy is limited, but the concomitant use of certain antiretroviral (ARV) drugs may decrease estrogen levels. Data is lacking on additional drug interactions between ARVs and 17- β estradiol, the form most commonly used for hormone replacement therapy.

Testosterone and ARVs have been co-administered for many years with no published reports of problematic drug interactions. Testosterone use suppresses estrogen, often resulting in vaginal atrophy (that is, thinning and drying of the lining of the vagina). Concerns have been raised about the potential impact of testosterone-associated vaginal atrophy on the risk of HIV acquisition among transgender men; however, data is unavailable. Transgender people would benefit from systematic research on the impact of hormone therapy on HIV acquisition, transmission and drug interactions, as well as on other health effects.

6.2 Vulnerabilities of HIV Among the Trans Population in Kenya

HIV/STIs occur in the context of other health issues for transgender people. Situated vulnerabilities are thematically reviewed here as follows: mental health (depression, anxiety, trauma, substance use); models of care (access to health care and preventive services, external evaluation models versus informed consent models); therapeutics/surgery (gender affirmation procedures); life course (developmental issues, aging); education (provider cultural competency); social and structural issues (stigma and discrimination, violence, lack of policies and protections, limited social capital, gender inequities); social exclusion, economic exclusion and sex work; social exclusion and sexual risk-taking; and social exclusion and health.

a. Mental Health

This includes herein, depression, anxiety, trauma and substance use. Gender minority populations experience significant and pervasive mental health disparities. Evidence from systematic reviews and population-based studies in North America indicate increased risks among sexual minorities compared to heterosexuals for depression, suicidal ideation, anxiety and substance dependence. Chronic stress resulting from stigma and discrimination contributes to these mental health

¹⁸ Hormonal contraceptive methods for women at high risk of HIV and living with HIV. 2014 guidance statement. Geneva: World Health Organization; 2014.

¹⁹ Keller K. Transgender health and HIV. BETA. 2008;21(4):40-50 (http://www.sfaf.org/hiv-info/hot-topics/beta/beta_2009_sumfall_transgender2.pdf, accessed 10 N).

disparities among sexual minorities. This is more or less the situation in Kenya. Therefore, understanding risk factors for depression and other mental health disorders is key to decreasing mental health morbidity.

b. Models of Care

Models of care in this context include access to health care and preventive services and External evaluation models (e.g., regulating access to hormone therapy and surgical interventions by means of an assessment process carried out by mental health professionals to fulfill diagnostic criteria) versus informed consent models (process of information, optional counseling, and informed consent).

As much as Kenya as a country has amongst the best constitution and laws globally, inadequate legal policies have historically inhibited the delivery of best health practices for the trans population. There are numerous examples of laws — including criminalization of sex work and substance use, or criminalization of prevention practices, such as needle exchange — founded in morals, cultural relativism, and politics rather than in the results of public health science. Separately, we have laws that criminalize consensual adult same sex practices, and sometimes even anal sex more broadly. In such contexts, marginalized populations such as sex workers, people who inject drugs (PWID), and sexual and gender minority (LGBT) persons have a higher baseline risk of acquiring infectious diseases due to the lack of scientifically proven targeted prevention and harm reduction strategies tailored for this population.

The limitations in health policy for trans persons around the country, limit the health sector's ability to provide necessary focused prevention and treatment services for the trans population. National policies dictate national medical curricula for health care providers, including clinicians and clinical support staff. Often, curricula do not address sexual or reproductive health matters as the populations are automatically excluded by virtue of the illegal or ignored status of their sexual practices. Even when access to health care is present, health care providers are not trained on the health needs of sexual and gender minority populations, which facilitates inadequacy in clinical services and ultimately reluctance of those in need to seek health care. This is especially difficult in situations, where clinical care is often provided by peri-medical practitioners (nurses, midwives, nurses' aides, etc.) due to a lack of trained physicians and clinical providers. This health disparity has been shown in high income settings as well where systemic ethnic, and other differences exacerbate differences in health provision and access.

Obviously, in countries where there is legally sanctioned bias against trans people where Kenya partially falls, the sexual health education programs go beyond omitting discussion of the needs of trans people and can spawn frank discrimination. However, health disparities throughout the world imply an inherent health inequity for trans population that must be addressed in future policies, programs, and research.

To provide optimal health care services to trans persons, a health care provider should be aware of historical and current stigmatization, barriers to health care, and specific health issues and health risks among trans populations. Hence there is the need for affirmative practices which herein may include attitudes (e.g., comfort and reaction to trans persons), knowledge (e.g., terminology) and skills (e.g., not assuming client is heterosexual during assessment) to engage effectively with trans clients

This lack of knowledge may result in two specific experiences for LGBT when accessing health services. First, medical professionals may assume risks of STI or other communicable disease are or are not relevant due to their own lack of education, and may mistreat or overlook health concerns of patients. For example, a medical professional may incorrectly assume that transgender men are not at risk for STI due to assumptions of patients having limited or no intercourse with men. Second, even if a full sexual history is disclosed in a health care setting, an absence of transgender population-specific knowledge, or discomfort with transgender people in general, could facilitate insensitive or discriminatory behavior.

Health care providers should first learn to recognize and challenge their own biases and assumptions about sex and gender norms, sexuality, and other identities (e.g., religious, ethno-cultural) in order to effectively support patients. Affirmative practice approaches maintain a focus on validating clients' sexual or gender minority identity, and help clients to challenge internalized homophobia and to develop positive trans identities.

There is less information about affirmative and trans competent practice and practice guidelines towards trans persons in Kenya. Stigma by health care providers towards trans persons has been stated among trans population across the country and mostly in Nairobi. This stigma appears to be associated with sexual orientation, gender identity, and perceived HIV serostatus. HIV-related stigma research in the Caribbean has highlighted the connections

c. Therapeutics/Surgery

A range of different gender affirmation procedures have been studied. These include hormone therapy, chest reconstruction for MTFs, facial feminization for MTFs, genital reconstruction surgeries, and others. Most studies provide evidence of improvements in overall well-being and psychological well-being, and body image or cosmetic results following gender assignment surgery²⁰.

d. Education

This is in relation to provider cultural competency where by, providing culturally competent health services to the transgender population, including mental health services for the specific needs of transgender patients, continues to be a challenge not only Kenya but many other countries. Discrimination has been associated with mental health problems for transgender populations. Exposure to violence and transphobia has been associated with increased risk for depression among

²⁰ Kraemer B, Delsignore A, Schnyder U, Hepp U. Body image and transsexualism. *Psychopathology*. 2007;41(2):96-100.

transgender who engage in sex work. In addition, experiences of transphobia have been associated with substance use and HIV risk for transgender in general. One specific medical procedure that is often associated with transgender health is gender affirmation surgeries for both MTF and FTM, which remains a topic of debate for health insurance coverage and cost in Kenya.

Many transgender people experience difficulty accessing health care and those who were able to access health care stated abuse from health care providers. Specifically, most of transgender people are likely to postpone medical care when sick or injured due to discrimination and others report postponing care due to financial constraints. In Nairobi, many reported being refused care due to their transgender or gender non-conforming status and are subjected to harassment in medical settings ending up being victims of violence in the health arena.

There are several outcomes to perceived and experienced stigma for transgender in health care settings including the aforementioned limited effectiveness of targeted preventive services such as education and condom distribution. However, there is also an increasing body of evidence highlighting significantly higher rates of mental health issues, ranging from depression to suicidal ideation to completed suicides²¹

Provider attitudes towards transgender people are a barrier to care and limit access to early testing and treatment for HIV. Lack of access to legitimate medical sources for transition-related/gender affirmative care leads many transgender population to use and share syringes for illicit hormone and silicone injections, which may increase risk of HIV. The majority of individual risk factors for transgender people are compatible with access to preventive medicine, a reduction of societal stigma and discrimination, and individual education regarding health and well-being.

e. Social and Structural Issues

This includes Stigma and Discrimination, Violence, Lack of policies and protections (human rights violations, hate crimes, etc.; legal prohibition of surgery and/or cross-dressing; laws against same-sex sexual relationships), Limited social capital at micro/mesa/macro levels, Gender inequities and Social Exclusion.

Lives filled with ongoing social stigma supporting discriminatory attitudes manifesting as human rights violations and continued marginalization are the norm for most transgender population. At the social and structural levels, discrimination and social marginalization limit access to information, services, and educational and economic opportunities for transgender people. Many transgender people around the Kenya have experienced repeated physical, verbal, and sexual abuse. In addition, extreme social exclusion has been found to diminish self-esteem and sense of social responsibility, thus making it difficult to ensure uptake of safer sex messages aimed at reducing HIV-related risk among transgender population.

²¹ aas AP, Eliason M, Mays VM, Mathy RM, Cochran SD, D'Augelli AR, et al. Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of Homosexuality*. 2011;58(1):10-51

A recurrent theme for transgender population is the lack of legal access to official identification cards and passports that reflect the person's gender rather than their assigned sex at birth. Some service providers in Kenya including health care centers within the national health care system specifically exclude transgender persons, in part because of their lack of national identification cards. Lack of access to legal identification cards has also been associated with indiscriminate arrests of transgender population and police brutality. In 2005, the UNHCR reported that gender non-conforming individuals in were “frequently the victims of abuses and discrimination by the authorities. Several allegations were received against members of the National Police service as well as the county askaris.

There is imminent lack of appropriate policies for guaranteeing the rights of trans people as well as explicit legislative initiatives to provide criminal and disciplinary sanctions for discrimination against people based on their sexual orientation²². The denial of care and government-sponsored brutality both function to limit the provision and uptake of HIV preventive, treatment, and care services for transgender persons. In most settings around the world, it is legally and/or financially prohibitive for transgender persons to obtain legal documents that allow a match between their gender identity and their legal gender. For example, many states in the United States do not allow for a change of sex on a birth certificate. Often a change of sex on the birth certificate is required for a change of gender marker on identity documents. Even if such a change is allowed, government entities require documentation from a medical professional that the individual has had medical interventions to transition to female or male, and often times requires “completed” genital reassignment surgery. Access to willing and knowledgeable health care providers who can offer such treatment and documentation is out of reach of most transgender population

Lack of acceptable identity documents has a host of consequences for the health and well-being of transgender people. Encouragingly, there are examples from around the world where these needs are being addressed. For example, the 2011 census in Nepal allowed formal registration of third gender people. Separately, a 2012 gender-identity law in Argentina provides the opportunity for transgender populations to change names and official sex on government documentation without approval from a judge or doctor. Laws such as this provide a model for other countries including Kenya to follow for increasing inclusion and visibility of the needs of transgender people.

Social exclusion need not rise to the level of targeted violence, which increases HIV risk among transgender people. Institutional erasure includes the lack of knowledge that policies that accommodate transgender populations are even necessary within a comprehensive health care system. The manifestations of institutional erasure involve exclusion from bureaucratic applications such as texts and forms, ranging from referral forms and administrative intake forms to prescriptions.

²² (page 64, E/CN.4/2005/10, UNHCR).

f. Economic Exclusion and Sex Work

Without acceptable identity documents, it is nearly impossible to secure legal employment. When transgender people seek employment, they experience systematic exclusion from the workforce because of deeply ingrained stigma and discrimination, and also because their gender presentation does not match their documents. This employment discrimination severely limits their economic opportunities

Exclusions from income-generating opportunities tend to result in high rates of poverty and/or underemployment. In combination with systematic prohibitions from state-sponsored social support mechanisms including social welfare programs, transgender people have turned to risky behaviors in multiple settings. In addition to other factors, experiences of stigma in traditional workforce settings related to transgender identity influenced their decisions to enter into risky behaviors despite the risks encountered.

Because sex work is criminalized in many settings here in Kenya, transgender population who do this work face arrest, detention, and police abuse, which are additional known risk factors for HIV transmission. The legal history associated with arrests for sex work further limits employment opportunities for transgender.

6.3 Gaps, Opportunities and Challenges in relation to HIV for Transgender in Kenya

There are many gaps, opportunities and challenges for research in global transgender health, including in evidence-based knowledge and understanding of HIV/STI risk. First, research on transgender health does not necessarily address gender as a social determinant of health or elucidate the multi-dimensional ways in which gender influences health-related risk and resilience. Indeed, studies are needed that assess gender roles, gender socialization processes, gender scripts, and gender affirmation among transgender people and consider the role of these in HIV/STI risk. Further, few international studies document HIV and STI incidence in transgender people, use longitudinal cohort designs to examine sexual behaviors over time, and conduct intervention studies testing the efficacy of multi-component interventions to curb HIV/STI risk behaviors among transgender populations. Epidemiologic research that uses empirically-rigorous methods is needed.

Despite the health risks that silicone confers, few studies have examined silicone use among transgender people in different global contexts. Similarly, the prevalence and correlates of needle sharing among transgender people is under-researched. Few transgender health studies are available from middle- or low-income contexts. A review of current evidence shows that transgender women consistently bear a high burden of HIV/STIs across cultures and contexts. The evidence-base concerning. Unfortunately, none of these researches has taken place in Kenya though the information obtained there in, applies all transgender population globally.

HIV/STI burden in transgender men is weak. Rigorous research is needed to understand HIV and STIs among transgender men, especially by sexual orientation, identity, and behaviors. Also needed

are sexual health data about non-binary transgender and gender nonconforming identities. There is inconsistent measurement and operationalization of transgender identity in the research. Survey items are needed that assess gender identity in different languages, contexts, and geographic areas for HIV surveillance to monitor the epidemic globally. Across HIV/STI research, sexual risk behaviors are inconsistently measured and operationalized. Attending to the biology of HIV/STI transmission is important for transgender populations, given the diversity of identities and bodies.

Validated and standardized sexual risk assessments need to be developed that are acceptable and cognitively tested with transgender and non-transgender populations alike. These assessments should ask about specific sexual risk behaviors (anatomically) with male, female, and transgender sexual partners. Such questions will also help to understand HIV/STI risk within and “bridging” between groups. The legal environments of many countries remain either repressive of transgender people, or fail to fulfill the human rights of these men and women. Sexual practices among transgender women, including sex with another biological male, are still criminalized in a large proportion of UN member states.

However, even in countries where there are favorable legal environments, transgender people experience a range of discrimination in all aspects of life including employment, housing, education, and health care, culminating in social and economic insecurities. In the absence of full legal recognition and protection for marginalized transgender people, repressive and non-fulfilling legal environments and social exclusion significantly impede HIV responses by contributing to existing stigma in health care settings, limiting access to health and HIV services, and restricting the provision of materials and publications relating to sexuality and the promotion of sexual health.

There are guidance documents of how human rights for transgender people can be achieved, developed by a number of international bodies including enabling laws in Asia and the Pacific, the Yogyakarta Principles, and the June 2011 UNHCR non-binding resolution to support equal rights for all people, irrespective of sexual orientation or gender identity. In 2009, UNAIDS included the targeting of transgender people as a key priority area for action, stating that “by ensuring that men who have sex with men, sex workers and transgender people are empowered to both access and deliver comprehensive and appropriate packages of HIV prevention, treatment, care and support services and by ensuring that law enforcement agencies and the judicial system protect their rights”²³. In addition, UNAIDS developed an action framework highlighting a path towards universal access for MSM and transgender people²⁴. The majority of action that has resulted from these reports has focused on MSM and female sex workers rather than transgender population. This lack of response is most likely a result of the dearth of information available describing the burden of disease and associated risk factors for transgender women in comparison to the other most at risk populations. In 2009, the board of the Global Fund to Fight AIDS, Tuberculosis, and Malaria

²³ Godwin J. Legal environments, human rights and HIV responses among men who have sex with men and transgender people in Asia and the Pacific: An agenda for action Bangkok: 2010.

²⁴ Unaid. Action Framework on Universal Access for Men who have Sex with Men and for Transgender People. Geneva: 2009

approved a sexual orientation and gender identities strategy (SOGI strategy). This strategy focuses on increasing the attention and programmatic response to those most at risk for the sexual transmission of HIV, including transgender women, in national proposals submitted to the GFATM. Strategies such as this that involve multilateral funding streams such as the GFATM are important components of an advocacy strategy to increase evidence-based services for transgender population.

Depathologization and human rights perspectives are essential to guide recent research and advocacy in transgender health in global contexts. The following principles are key: (1) Depathologization perspective – transgender as identity, not as disorder; (2) Gender affirmation and gender transition is a human right; (3) Autonomy and informed decision-making in transgender health; (4) Multiple and diverse gender identities, expressions, and trajectories; (5) Right to access state-funded health care of the highest attainable quality, without a need for a mental health diagnosis; (6) Attention to the social determinants of health; (7) Harm reduction approach; (8) Cultural diversity of gender definitions, transgender identities, and gender affirmation and gender transitions; (9) Protection against non-consensual treatments (e.g., reparative or conversion therapy intended to enforce conformity to assigned birth sex and suppress gender variant identities); (10) Right to no discrimination in health care settings. Involvement of transgender communities is essential to ensure the responsiveness and cultural competency of public health efforts

6.4 Recommendations in Relation to Access to HIV Services

Access to legal change of gender and name, registration of identity documents that are consistent with lived gender, and prohibition of discrimination based on gender identity or expression would enable transgender people to more easily participate in the workforce, have access to health-care services and have recourse in the case of transphobic violence. Lawmakers and law enforcement officers need skills building trainings on how best to uphold the basic human rights of transgender people, including how to avoid unnecessary harassment, arrest, detention and incarceration, as well as how to treat transgender people with dignity, discretion and respect when searching or detaining them. In addition to legal reform, social welfare services and policies that address poverty are necessary for a holistic, effective response to the needs of transgender people.

The following recommendations are organized around access, quality, and affordability of health care services, policies, laws, and practice, and are intended to be a reference for stakeholders to help design country-specific advocacy and policy plans and service provision tailored to local conditions. This can and will enable governments, partners and donors ensure that the awareness and dissemination of evidence-based information on the epidemiology of HIV, and should be sensitized about the potentially harmful public health and human rights impacts of laws, policies, and practices relating to transgender people.

a. Health Care:

Ensure affordable, culturally competent, quality of service health care delivery for transgender people. Many transgender people experience difficulty accessing health care. Health insurance policies often exclude treatments for transgender people's health care needs, even when these needs are not related to gender affirmation. Postponement of needed/necessary care when sick or injured, as well as preventive care, is not uncommon among transgender people, due to cost as well as discrimination and disrespect by providers. Lack of access to legitimate medical sources for transition-related care leads many transgender persons to use and share syringes for illicit hormone and silicone injections, which may increase risk of HIV. Transgender people who do and can access health care often report abuse from health care providers. Few if not none of the health care providers have received education and training on the health needs of transgender people. Therefore, trainings to improve and address medical provider lack of knowledge, attitudes, and biases are needed.

The most important principle to apply in delivery of health care for transgender people is to provide care for the anatomy that is present, regardless of the patient's self-description or identification, presenting gender, or legal status, and always to provide care in a sensitive, respectful, and affirming manner that recognizes and honors the patient's self-description or self-identification. It is recommended to include a transgender identity option on patient intake and registration forms, and to ask about the patient's referred name and pronoun. It is also important to integrate primary care services, including hormone treatment and transgender-specific gender affirmation services, with HIV prevention, treatment, and care. These steps are part of a holistic approach to meeting transgender patients' needs.

b. Service Delivery:

Evaluate and implement culturally and clinically competent services to address the needs of transgender populations. If the services provided are currently not meeting the needs of the transgender populations throughout the country, what other types of service delivery models at the community level would be more appropriate for public policies to facilitate? Researchers have proposed different models for provision of services to transgender populations that could mitigate community level stigma and discrimination in many settings, including fully integrated, stand-alone, and hybrid models of services.

Given the heightened risk of HIV of transgender populations, comprehensive health services could be integrated into general HIV programs, as a type of one-stop shop for all HIV related programs. Stand-alone models create specific clinics or services that provide tailored, non-discriminatory services only to transgender populations within a community. This type of service model is debated, as some argue that the services may be non-voluntary and coercive, while others assert that in highly transphobic environments, stand-alone services could be potential targets for campaigns targeting sexual and gender minority populations, political agendas, and community level discrimination. The

hybrid model links community outreach and prevention messaging and education to friendly clinical services that serve the entire population but have providers that are well trained in transgender population health issues. This model implies that in order to reach marginalized transgender populations, outreach and available prevention services linked to established clinics will increase patient uptake and ensure retention of these men and women within ‘safe’ and de-stigmatized services. This approach has seen success in certain contexts for other marginalized populations in settings such as Malawi, Senegal, and Lesotho²⁵. Further case studies are needed that are supported by policy-makers worldwide, and it is likely that a mix of these models will be deemed appropriate based on each specific context in low or middle income countries for transgender men and women.

c. Policies:

Develop and sufficiently resource an evidence-based national HIV plan that specifically addresses the needs of transgender persons. Governments should adopt national HIV strategies that support advocacy and improvements to the enabling legal environment in line with best practices in HIV prevention, treatment, and care. National plans should ensure that HIV service providers, community-based organizations, and transgender people are not prosecuted on the basis of evidence of possession of materials properly used in promoting sexual health, such as safe sex literature, condoms and lubricants. Finally, national plans should include human rights-affirming surveillance systems that include all at risk for HIV, including transgender women, allowing the improved characterization of burden of HIV disease and associated risk factors among transgender population. These data can be used to advocate for evidence-based and rights-affirming comprehensive HIV prevention, treatment, and care programs for transgender people.

Assessing transgender status in epidemiologic surveillance and data collection systems represents a critical aspect necessary to ensure an evidence-based national HIV plan that is responsive to and addresses the needs of transgender people. The government must also ensure inclusion of HIV prevention, care and treatment activities specifically tailored to meet the needs of transgender people who may not be comfortable or feel safe accessing general population health services, and these services should be integrated in general health systems. National HIV data collection systems must also be revised to include opportunities for proper identification of transgender people.

Furthermore, governments should repeal or reform any laws that restrict community-based organizations from obtaining legal status and facilitate capacity building (including technical and financial management) and organizational development support to address gaps and build robust institutional capacity to support and sustain HIV programming for transgender individuals.

Additionally, government should support civil society to play a variety of roles in the response to HIV among transgender persons. For instance, the government should first support the

²⁵ Beyrer C, Baral S, Kerrigan D, El-Bassel N, Bekker LG, Celentano DD. Expanding the space: inclusion of most-at-risk populations in HIV prevention, treatment, and care services. *Journal of acquired immune deficiency syndromes*. 2011;57 Suppl 2:S96-9

development of civil society, supporting transgender people by adopting the aforementioned non-discriminatory laws allowing these groups to sensitize other stakeholders, including the media, churches, educators, and members of the health workforce including doctors, nurses, community health workers, and other members of health management teams. Civil society can support addressing issues of social discrimination in health practice by providing support to implementing, or directly implementing, HIV care and treatment for transgender individuals. While marginalization potentiates HIV risk, community involvement, peer education, and affirmation of transgender identities are essential mitigating components of HIV infection among transgender persons. Moreover, engaging civil society can support overcoming the dearth of education for health professionals to facilitate the access to and delivery of competent and sensitive clinical care for transgender population is essential.

d. Laws:

The government should implement comprehensive legal protections on the grounds of sexual orientation and transgender status. Specifically, the government should enact legal protections and prohibit discrimination with functional mechanisms of redress and compensation on the grounds of gender identity and sexual orientation, particularly in the areas of reducing employment discrimination, increasing access to health and wellness services, education, welfare and housing opportunities. The government must also recognize the gender identity of transgender individuals who have completed or have not gone through sex reassignment surgery and work to reduce barriers to receiving legal recognition for purposes of identification documents, including passport and other social services. Furthermore, it should repeal any laws that prohibit or criminalize the expression of gender identity or expression, including through dress or speech. The June, 2011 non-binding resolution by the UNHCR provides guidance for countries to develop such protections for transgender people.

7.0 HEALTH SECTOR AS THE ENTRY POINT FOR ADDRESSING TRANSGENDER ISSUES IN KENYA

Trans population face distinct health risks but share many key issues. As outlined in the concepts below, at their most basic, these risks can be traced back to stigma (also called transphobia) against trans people. The stigma manifests in human rights violations that affect trans individuals' opportunities for happy, healthy lives and ultimately their behaviors. Many of the issues described herein below relate to health and access to the same as prescribed under Article 43 of the Constitution.

The end result is high rates of HIV infection and consequent disease burden for trans population whom are mostly mistaken to be gay and or lesbians. Trans men who have sex with men are also likely to be at increased risk, and it is not known how the adoption of masculine norms and behaviors may affect all trans men's HIV vulnerability (for example, the desire to prove one's masculinity through aggression or risky sex). The concepts can be summarized by a common refrain

among trans population activists, “I am not a high-risk person; I am a member of a community that is put at high risk.”

7.1 Essential Health Sector Interventions for Transgender in Kenya

a. Comprehensive condom and lubricant programming

It is important for condoms and lubricants to be available for all transgender people who have penetrative sex, regardless of the gender identity of their sexual partners. Sexual behavior and identity vary among transgender people, as it does in the non-transgender population. Condom programmes should avoid making assumptions about the sex of transgender people’s partners as well as about their sexual positioning or orientations. Partners of transgender people can be transgender or non-transgender and of any sex or sexual orientation. A transgender woman who has a penis may be either the insertive or receptive partner during sexual intercourse. Transgender women with a neovagina may have oral, vaginal or anal sex, or all of these. Transgender men with male partners may have oral sex or be the insertive or receptive partner (or both) during sexual intercourse. For some transgender people condoms may serve as triple protection for HIV prevention, for prevention of other sexually transmitted infections (STIs) and for contraception.

Transgender women who take feminizing hormone therapy may experience loss of spontaneous erections and decreased tumescence as a side-effect. Loss of tumescence and difficulty maintaining an erection can interfere with condom use and contribute to condom slippage or breakage. Transgender men who take masculinizing hormone therapy may experience an increase in sexual drive, which may lead to a greater number of sexual encounters, and a need for more condoms for penetrative sex. In addition to condom distribution, condom programming should include interventions to address correlates of low condom use, such as insufficient condom negotiating skills, potentially compounded by low self-esteem. Sexual desirability may be gender-affirming for some transgender people, and they may be willing to have condom less sex to avoid rejection. Some transgender sex workers may not use condoms during sex with their primary partners as way to distinguish it from sex with clients.

Anal sex has a much higher risk of HIV transmission than vaginal or oral sex. However, the HIV acquisition and transmission risks for surgically constructed neovagina are unknown and may depend on the type of surgical procedure used. Research is underway that may provide more information about the immunology of the neovagina²⁶. Similarly, there is a lack of data on the risk of HIV acquisition or transmission with a surgically constructed penis. Condom-compatible lubricant should be used with condoms for all penetrative sex. Technical experts discourage the use of lubricants that contain spermicides and also ones that are medicinal, oil-based or contain other active substances.

²⁶ van Griensven F, Na Ayutthaya PP, Wilson E. HIV surveillance and prevention in transgender women. *Lancet Infect Dis.* 2013;13(3):185–6.

Tumescence usually refers to the normal engorgement with blood (vascular congestion) of the erectile tissues, marking sexual excitation and possible readiness for sexual activity. Access to condoms and lubricants, as well as their frequency of use, varies greatly from one context to another. In Kenya where sex work is criminalized, transgender people may be unwilling to carry condoms because they have been used by police as “evidence” of sex work. Even where condoms may be readily available and accessible, lubricants often are not. It is important that both condoms and lubricant are part of a comprehensive HIV prevention package, as it is for other populations. Because “male” condoms may not be acceptable to transgender women, nor “female” condoms acceptable to transgender men, transgender-specific marketing may be needed. Programmes should provide condoms and lubricant that are acceptable and accessible to transgender people with appropriate marketing strategies.

b. Harm reduction interventions for substance use and safe injection

Transgender people may be more likely to use psychoactive substances than non-transgender people. Substance use is associated with discrimination and HIV transmission. Transgender people who use drugs (injectable and non-injectable) should have the same access to harm reduction services as non-transgender people. Needle and syringe programmes (NSP) and opioid substitution therapy (OST) like the medically assisted therapy by the use of methadone programmes should be accessible and acceptable to transgender people. Providers of NSP and OST services should be trained in providing in non-judgmental and competent care for transgender individuals.

Transgender people who inject substances for gender affirmation should use sterile injecting equipment and safe injecting practices to reduce the risk of infection with blood borne pathogens such as HIV, hepatitis B (HBV) and hepatitis C. In addition to injectable opioids, transgender people may inject hormones obtained outside of the formal health system. Emerging information suggest that many transgender women use feminizing hormones obtained outside the formal health sector due to lack of access to appropriate medically prescribed gender affirmation care²⁷. For transgender men injections are the most common way of taking hormones. Little information is available, however, on the prevalence of self prescribed hormone injections.

Transgender People may share needles and syringes for injection of hormones due to lack of access. Needles and syringes used for hormone injections often differ in size, shape and gauge from needles and syringes used for injecting opioids. Harm reduction services need to be aware of and responsive to these specific needs. The injection of soft tissue fillers for feminization of the body is common. The types of fillers used vary and may include industrial grade silicone, oils and other substances. Unlicensed providers may inject fillers without using sterile techniques, risking transmission of blood borne pathogens. In addition, because they are injected without being encapsulated, the substances may migrate through the body, causing inflammation, disfiguration and even sudden death from emboli. While access to sterile equipment for soft-tissue filler injections is important to

²⁷ Guadamuz TE, Wimonstae W, Varangrat A, Phanuphak P, Jommaroeng R, McNicholl JM et al. HIV prevalence, risk behavior, hormone use and surgical history among transgender persons in Thailand. *AIDS Behav.* 2011;15(3):650–8.

reduce the risk of blood borne pathogens, there is no known way to reduce the harm from the injection of loose silicone and other fillers. Ideally, transgender people should have access to competent cross-sex hormone therapy by a licensed medical professional.

Transgender who need OST to treat opioid dependence may be taking estrogen-containing substances for feminization. While there is no evidence of drug interactions between estrogens and OST, research is very limited in this area. It is important for OST providers to assess carefully all medications for drug interactions to ensure appropriate dosages – not too low to be effective and not so high as to cause side-effects.

c. Behavioral interventions

A variety of factors at the structural, social, community and individual levels influence vulnerability to HIV. Transgender people benefit most from interventions that work at multiple levels. Evidence-based behavioural interventions can increase safer sex and HIV testing and counselling among key populations overall. Only a few of these interventions have been adapted for transgender people, however. When delivering health promotion messages and implementing behavioural interventions, it is important to ensure that messages are acceptable and relevant to transgender people. For example, interventions for men who have sex with men should be inclusive of transgender men who have sex with men. Interventions for transgender women should not be subsumed under men who have sex with men.

Peers, the transgender community, the Internet and social media are common sources of health information among transgender people. Therefore, peer-led interventions are likely to be more effective than behaviour change messages delivered by non-transgender people. The public health literature describes promising examples of Internet-based interventions, often led by peers. When engaging transgender communities in behaviour change interventions, it is important to understand the social structure of the community so as to best align interventions with community norms.

d. Pre-exposure prophylaxis (PrEP)

Kenya has recently been running a pilot for PrEP to understand and see the feasibility of the same among the Key Population. The same has received a good welcome in the society though the findings are yet to be unleashed. While several studies have demonstrated the efficacy of pre-exposure prophylaxis (PrEP) among men who have sex with men, the number of transgender women included in these studies was too small to determine if there are differences in acceptability, use or pharmacokinetics for transgender people prescribed PrEP²⁸. However, where acceptable and appropriate, PrEP may be considered an additional intervention in the HIV prevention package for transgender people who have sex with male partners and those who are in serodiscordant relationships.

²⁸ Grant RM, Anderson PL, McMahan V, Liu A, Amico KR, Mehrotra M et al. Uptake of pre-exposure prophylaxis, sexual practices, and HIV incidence in men and transgender women who have sex with men: a cohort study. *Lancet Infect Dis.* 2014;14(9):820–9.

f. HIV testing and counselling

Voluntary HIV testing and counselling (HTC) should be routinely offered to transgender people in both the community and clinical settings. In addition to provider-initiated testing and counselling, community-based HIV testing and counselling is recommended and should be linked to prevention, care and treatment services. These services should be acceptable to and accessible by transgender people. Transgender people should be involved in the design and implementation of services. Services led by transgender people may be more acceptable to the community.

HIV testing counsellors should be trained on and sensitized to transgender health issues in order to deliver transgender relevant messages. HIV testing staff who are able to provide information or referrals about gender-affirming care facilitate utilization of HIV testing services by members of the transgender community. Locations and hours of testing should respond to the needs of the transgender community. Both mobile and fixed sites should be available to maximize the accessibility of HTC services. Forms used to collect data at HIV testing sites should include options for people to disclose that they are transgender, if they choose, knowing who will have access to that information. For example, some HIV testing sites forms may ask both the sex assigned at birth and current gender. The response options available for the current gender questions should include locally relevant, respectful (non-derogatory) terms for transgender people.

HIV self-testing kits are available for use in many clinics and sites. Though, guidelines for normative guidance on HIV self-testing, WHO and UNAIDS have issued a short technical update discussing important legal, ethical, gender and human rights considerations for entities that are considering or already implementing HIV self-testing²⁹. As a key population, transgender people may be particularly vulnerable to coercive or mandatory testing. Most guidelines are clear that all types of HIV testing must be fully voluntary and never coerced or mandatory.

g. HIV treatment and care

Transgender people should have the same access to HIV care and treatment as other populations. These services should be welcoming and competent in the care of transgender individuals. Barriers to engagement and retention in HIV care include stigma, past negative experiences, prioritization of hormone therapy and concerns about interactions between ART and hormone therapy. Facilitators of engagement and retention in care include having a health care provider who is knowledgeable about transgender medical issues, the ability of the health facility to provide and integrate hormone therapy and HIV care and clinic staff who are respectful and sensitive to transgender issues. Studies of correlates of adherence and viral suppression among transgender persons have found that less stress, due to less discrimination, was associated with better adherence and lower viral load. Adherence to hormone therapy was correlated with adherence to

²⁹ Buchbinder SP, Glidden DV, Liu AY, McMahan V, Guanira JV, Mayer KH et al. HIV pre-exposure prophylaxis in men who have sex with men and transgender women: a secondary analysis of a phase 3 randomised controlled efficacy trial. *Lancet Infect Dis.* 2014;14(6):468–75.

ART³⁰. Non-discriminatory and trans-inclusive ART services, in which transgender people's need for both ART and hormone use are addressed, may help improve uptake and ART adherence by transgender people. Members of the transgender community assert that education and empowerment of transgender people is essential to encouraging them to seek treatment.

Antiretroviral drugs may have drug-drug interactions with the hormones found in oral contraceptives (ethinyl estradiol particularly). While not recommended, transgender women often use oral contraceptives for feminization, especially where safer formulations of estrogen (17- β estradiol) are unavailable or more expensive. Limited data suggest that contraceptive hormones used by natal women may interact with some non-nucleoside reverse transcriptase inhibitors (NNRTIs) and ritonavir (RTV)-boosted protease inhibitors (PIs). These interactions have the potential to alter the safety and effectiveness of either drug. In particular, ethinyl estradiol is known to be more thrombogenic than 17- β estradiol. When used in combination with ARV drugs that potentiate metabolic abnormalities, the risk of thrombotic events may be higher.

However, current WHO contraception guidelines conclude that no drug interactions between hormonal contraceptives and currently recommended ART or PrEP are significant enough to prevent their use together. Most interactions between oral contraceptives and ARV drugs decrease the blood levels of estradiol but not of ARVs. Starting, stopping or changing ART regimens may lead to hormonal fluctuations among transgender women taking gender-affirming medications; therefore, close monitoring is recommended. There are limited data on the interactions between ARVs and other drugs that transgender women use in feminizing hormone therapy, particularly anti-androgens (for example, cyproterone acetate or flutamide). The same is true for androgens (for example, dihydrotestosterone) commonly used by transgender men. Currently, there are no documented drug interactions between these medications and ARVs. However, more research is needed. Self-medication with products and doses that are not recommended is common, and health-care providers should be aware of such self-medication, alert clients to possible risks and monitor potential side-effects.

h. Sexual and reproductive health

Health-care providers should be sensitive to and knowledgeable about the specific sexual and reproductive health needs, concerns and desires of transgender people. Routine STI screening, diagnosis and treatment is an important part of comprehensive HIV prevention and care for transgender people. Taking a sexual history is an important part of performing an appropriate sexual health exam; it is particularly important when determining what parts of the body need to be screened for STIs. When discussing sexual practices, health-care providers should avoid making assumptions about the anatomy or sexual behaviour of transgender people. Open-ended questions allow for responses that the provider may not have anticipated.

³⁰ Sevelius JM, Saberi P, Johnson MO. Correlates of antiretroviral adherence and viral load among transgender women living with HIV. *AIDS Care*. 2014;26(8):976–82.

At the same time, it is important with transgender people, as with all others, to only ask questions that are relevant to providing health care to the person. Likewise, the physical exam should be conducted in a respectful, private setting and only when indicated. In particular, genital examination and specimen collection can be uncomfortable or upsetting, whether or not the person has undergone genital reconstructive surgery. Some transgender people may be uncomfortable with their anatomy or use terms to refer to their genitals that may be unfamiliar to the provider. Whenever possible and appropriate, providers should consider using language that the transgender person uses to describe themselves and their body. Many transgender people have been victims of physical and sexual violence and may find genital exams particularly difficult physically and psychologically. Health care providers should take this into consideration when providing care to transgender people.

i. Contraceptive services

As noted above, transgender women may use oral contraceptive pills for feminization when safer alternatives are not available or accessible. Counselling on sexual and reproductive services for transgender women should discuss the possibly higher risk of thrombosis with ethinyl estradiol found in oral contraceptives compared with 17- β estradiol. For transgender women who retain a penis and testes and who have female partners, it is important to discuss fertility desires. While estrogens may significantly reduce fertility, they may not entirely prevent pregnancy. It is important that transgender women who desire biological offspring have the opportunity to discuss their reproductive options prior to initiating feminizing hormone therapy, since it is unclear whether viable sperm will be produced after continued exposure to estrogen.

Counselling of transgender women with female partners who can become pregnant needs to address contraception if pregnancy is not desired. It is also important to discuss fertility desires with transgender men. Transgender men who retain a uterus and ovaries may still be able to become pregnant when having vaginal intercourse, even while taking androgens. Therefore, transgender men with male partners who do not wish to become pregnant need to be offered contraceptive options if desired.

Access to gender-affirming therapy is an integral part of primary care for many transgender people. When transgender people do not have access to medically supervised services, they may self-medicate with products and doses that may not be safe. Health-care providers should be informed about transgender health-care needs and rights and aware of resources for medical protocols. The World Professional Association for Transgender Health publishes guidelines for the care of transgender patients that is available online at <http://www.wpath.org>³¹. These guidelines include some medical information but focus more on psychosocial aspects of transgender health care. The Center of Excellence for Transgender Health at the University of San Francisco in the USA has a

³¹ Coleman E, Bockting W, Botzer M, Cohen-Kettenis P, DeCuypere G, Feldman J et al. Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. In *J Transgend*. 2011;13:165–232.

website that provides medical protocols for the primary care of transgender patients, including hormone therapy, at <http://transhealth.ucsf.edu>.

Access to gender-affirming surgery is limited, even in high-income countries. Few providers worldwide have been trained in gender-affirming surgeries, and the cost of surgery is often beyond the reach of many transgender people. For transgender people who are planning to or who have recently undergone surgery, their primary care provider should communicate with the surgeon, if possible, concerning appropriate pre-operative and post-operative care.

8.0 CONCLUSION

A nation with good structural interventions and enabling environment for the key population, research shows that they have low HIV prevalence. Hence it can be stated that there is the concomitance between good and enabling environments and low HIV prevalence. Hence, this is the reason as to why this report reflects the health aspect as an entry avenue for the trans population in Kenya. Many actions can be taken to improve trans individuals' health and well-being, both to prevent the human rights violations they experience and to lessen their impact.

a. Encourage meaningful participation of trans community members:

In any effort to better understand and meet the needs of transgender community members, strong transgender voices must be included. Meaningful participation of and partnership with trans people is essential to advance transgender health and human rights agendas and to promote gender equality. In areas where progress has been made in meeting trans people's needs, community organizing has been key to developing a response designed to specifically address what transgender people want and require.

b. Collect accurate information:

Accurate data are needed to better understand and serve the trans community. To correctly identify trans women and men, researchers, programmers, and clinic staff should ask about both gender identity and sex assigned at birth. The understanding of gender and transgender differs around the world, so it is necessary to assess gender identity in different languages, contexts, and geographic areas.

c. Conduct rigorous research:

Evidence is also needed on HIV incidence, sexual behaviors, and the efficacy of multicomponent interventions to reduce HIV risk behaviors and violence against both trans women and trans men.

d. Change laws and policies to protect and respect human rights:

To improve transgender people's access to health, education, and social welfare services, governments must enact laws that recognize the gender identity of trans people. Governments should also enact legal and nondiscrimination protections on the grounds of gender identity to

reduce employment discrimination and increase access to services. Two important first steps are decriminalization— of gender impersonation and homosexuality, a charge often used against trans people in contexts where homosexuality and transgender identity are conflated — and the provision of legal identification that matches transgender people’s gender identity.

e. Prevent violence:

Violence is a common human rights violation for trans people. In order to support the improvement of law enforcement practices, countries should work cooperatively with civil society, including trans people, to design and implement locally adapted awareness campaigns and training curricula on the relationship between HIV and human rights.

f. Hold perpetrators accountable:

The government should also take steps to improve systems to monitor, report, and investigate incidents of harassment, mistreatment, discrimination, and violence, and to hold perpetrators accountable — including those, such as the police, who are state actors.

g. Offer support to survivors of violence:

Health and other support services should be provided to transgender people who experience violence. Trans people who experience sexual violence should receive timely access to post-rape care, including emergency contraception (for trans men), post-exposure prophylaxis, and psychological care and support, as well as referrals to police and legal services.

h. Train pre- and in-service providers to offer trans-competent care:

To provide optimal health care services to trans people, health care providers should be aware of historic and current stigmatization, barriers to health care, and specific health issues and health risks experienced by transgender men and women. Trainings are needed to improve and address provider knowledge, attitudes, and biases.

i. Offer gender-affirming services in conjunction with HIV services:

To meet trans clients’ needs, it is important to integrate primary care, including hormone treatment and other trans-specific gender affirmation services, with HIV prevention, treatment, and care and sexual health services. Addressing these needs may offer opportunities for trans people to develop a trusting relationship with the health care system, and therefore strengthen the impact of public health interventions on HIV prevention, care, and treatment.

j. Address co-occurring risks through trans-specific programming:

Often, transgender people are served only when they are reached through programs targeting sex workers or MSM. Specific programming for transgender women and men should be developed that integrates evidence-based biomedical, behavioral, and structural interventions to address the risks that are common within transgender communities (e.g., substance use, violence, and economic marginalization).

9.0 ANNEXURE

9.1 A Case Study for Transgender in Kenya

1. Kimberlee J. Jackson

My name is Kimberlee J. Jackson and I am a transgender Kenyan. Ever since I was four years old I knew that I was a girl – a woman. Yet everyone saw me as a boy – a man. I suppressed these feelings for years feeling nothing but guilt and shame. I even became suicidal. I am part of the 41% of Transgender people that has attempted suicide due to the conflict between their mind and body. You cannot begin to imagine what life is like when you know you are a female but everyone else believes you are a man.

Around age four, I recognized that something didn't feel right within me. My family kept referring to me as a boy but my brain kept insisting that I was a girl. This left me in a state of perpetual confusion. As a child, you want to please your parents. But I kept wanting something different from what they expected. They gave me toys that were "gender-marked" for boys, but I wanted to play with dolls, play dress-up, jump rope and play catch like the other girls were doing.

Around age five or six, guest speakers came to school to speak about careers in the medical profession. Specifically, they spoke of nurses and doctors. The speakers said boys become doctors and girls become nurses. They then passed around a doctor hats with the mirror on it and blue masks to all the boys, and nurse caps and pink masks to all the girls. I eagerly anticipated the nurse cap and pink mask and was crushed when I was given the doctor hat and blue mask. I threw a little temper tantrum and requested the nurse cap and pink mask until they relented and gave me what I asked for. Everything felt "right" when I had these items. I remember crying a lot when I was a child because things just did not feel right. I knew I was a girl even though everyone else kept telling me I was a boy. Every night, when I went to sleep, I prayed that I would wake up as a girl. I was disappointed every morning to find that my prayers were not answered. My birthday wishes were to wake up as a girl, but that never happened.

My family was not aware of what was going on. They noticed I was stubborn, had to have things my way, and that I was in trouble frequently for small things. Occasionally, they corrected me on my feminine gestures and/or interests, but they did not think anything of it. Looking back, my mom noticed that some of my behaviour was different from my male cousins and friends. I always wanted to spend time with my mom, following her around in her kitchen, desiring to be just like her. My uncles wanted to model me in their behaviour but I was not interested. Several attempts were made

on my part to avoid detection from others. One of my greatest fears was having others discover that I was a female. I made several valiant efforts to hide my feminine identity by acting gay. My high school years were filled with Type A testosterone-loaded male personalities.

We lived in Eastlands and there were no females with whom I could interact with. As a result, I felt as if I could not relate to anyone apart from two of my best friends in high school. It did not take long for me to realize that my female gender identity was persisting. I could not get away from it no matter how much I immersed myself in normal society. I became active in church activities leading praise and worship as an escape because I loved music. I would pray every day for the miracle to happen or have the almighty change what I was feeling inside. This was another attempt to prove my manhood to myself and others. When I was not immersed in church activities, I observed the behaviour, gestures, mannerisms, word choice of men so I could model and others would not know what I was really experiencing. Meanwhile, my brain naturally moved me to walk gently, choose softer catch phrases, and gesture frequently as women often do. I noticed it was becoming increasingly difficult to suppress the natural feminine behaviour and to behave according to male gender norms. Yet, I continued to play the part of “guy”. The main reason I followed cultural norms and expectations of men was because of numerous corrections from parents and other authority figures. My peers and siblings made fun of me for “being gay”.

I wanted to attract little attention especially when I inadvertently reverted back to the natural feminine behaviour. My goal was to fly under the radar so people would not know I was truly a female. However, I was always in the public eye, because I was in the fashion world as a model choreographer and fashion stylist. I did not want to be subjected to any more bullying during my childhood years or ostracized by my fellow school mates or other colleagues on the other jobs that I took up. Against my better judgment, I conformed to what society said I was as opposed to what my brain told me I am. As a child, I was bullied a lot in school. I was repeatedly harassed for doing things “like a girl”. One specific instance I remember was being ridiculed by many school mates because as a member of the drama club I always wanted to play female characters even as young as 10 years.

I always kept an autograph book that I had started keeping when I was in London and one of the autographs had been signed by a member of the comedy group ‘*Redykulous*’ crew John Kiarie. He had come to the British Council auditorium where we were putting up a play and I was acting as a woman. He wrote, “Have you ever considered a sex change?” There was always the “You run like a girl!” “You dress like a girl” statements coming from everywhere. After school, I would go home and snuggle as I cried. I have always loved dogs and felt as if my dog was the only one who truly loved me and who would help me through countless rough patches in my life. I hid the bullying from my family because I did not know how to tell them what was really going on. If I told them about the bullying, then I would have to tell them my secret too, and I could not bear to have that happen. Truth be told, I thought something was significantly wrong with me. I felt like a pervert. In my mind, my family would be so ashamed if they found out.

I have attempted suicide multiple times and have thought about suicide more times than I can count. The greatest personal challenge I have encountered are the thoughts of suicide. I had my first suicidal thought at a very young age. My first suicide attempt was a few years ago. One incident happened in March 2014. My Gender Dysphoria decided to choose that day to ramp up, just as my best friend was preparing to go to work. I lied that I was not feeling well and was going to stay home. Physically, I felt fine, but emotionally I was a complete wreck. After he left, I sat in the room and bawled for 30 minutes, reeling in the thoughts of feeling completely trapped.

My friend and housemate was unaware of my inner turmoil. There was no way I could tell him what I was going through. If I told him I was suicidal, he would have wondered why. That would mean revealing the secret that I swore I would take to my grave. As it turned out, that is exactly where I wanted to be. I could not imagine telling him I was a Transgender. What would he think? Would he help me transition? Would he kick me out of the house? I believed he would be ashamed of me and what people would think of him since we stayed together. So I kept the secret to myself.

However, this is the type of secret that needs to be set free. Since I could not open up, I became increasingly depressed. Exhausted from crying, I walked to the kitchen, picked some pills and sat on the floor. I could not deal with the awful feelings anymore. There was no way I could resolve it. I believed no one would care, be interested to hear or even try to understand what I was going through. I swallowed all the pills and washed them down with vodka. Suddenly, fear took over and I ran to the bathroom and purged forcefully sobbing uncontrollably. I have no idea how long I was in that state, wishing for everything to be over. My housemate was coming home from work soon and I needed to gather myself together to avoid suspicion that anything was wrong, besides feeling “sick”. I retreated to the safety of my room. These suicidal thoughts have persisted on and off for years and typically correlated with the ebbs and flows of the Gender Dysphoria.

Currently I am on Hormone Replacement Therapy for one and a half years. Then there is the work that goes on to make the full transformation like several rounds of full facial electrolysis, four months of voice therapy, facial feminization surgery (hairline advancement, eyebrow lift, forehead/orbital rim contouring, rhinoplasty, cheek implants, chin implant, and a tracheal shave), and three rounds of genital electrolysis. Facial feminization surgery is necessary for many male-to-female Transgender individuals as it allows them to easily fit into female culture. There are structural bone differences in the faces of males and females. People notice these differences and assign a gender to a person because of the structure. Therefore, male-to-female individuals with masculine bone structures often require facial feminization surgery to make it easier to blend into society.

One more significant surgery before I physically become female is the gender confirmation surgery and breast augmentation, in addition to two years of counselling, (legal name and gender marker change), coming out to family, friends, healthcare professionals, and colleagues, not to mention acquiring an entirely new wardrobe. One overlooks how many items are included in a women’s wardrobe: shoes (dress boots, casual boots, dress shoes, casual shoes, sneakers, sandals), pants

(jeans, dress pants of all colours, leggings, capris), skirts, dresses, tops (long-sleeve, short-sleeve, sleeveless, sweaters, tank tops, fleeces, sweatshirts), undergarments (underwear, bras, camisoles, nylons, socks), coats (dress coats, casual coats for every season), jewellery (necklaces, earrings, bracelets, rings, watches), and other items that women prefer (make-up, nail polish, hair supplies, hygiene supplies...). These are items that most women accumulate over a lifetime and I needed to accumulate these items over the course of even my styling career. Two years is about the fastest one can transition according to the standards of care set forth by the World Professional Association for Transgender Health. My Gender Dysphoria is significantly severe pushing me to take the “fast track” to transition.

I never thought the day would happen when I would actually feel happy, genuine, and at peace with myself. It was always a dream to me, albeit a far-reaching dream. With every forward step I take through transition, I feel as if the person I was always meant to be is finally gaining life. The shame I felt for so many years is finally lifting. No longer do I have to live a lie by pretending to be somebody I am not, and now I can just allow myself to engage in situations authentically rather than constantly second-guessing whether I am fitting in with gender norms. For the first time in 32 years, I am living an authentic life.

The most pivotal moment in my transition was the day I will go “full-time”. During transition, most Transgender individuals go “part-time” which means that sometimes they are living their life according to the gender norms associated with their anatomical sex and other times they are living their life and practicing the gender norms associated with their identified gender. When Transgender individuals transition, they usually spend a good period of time practicing makeup, walking and sitting, experimenting with clothing styles..., usually in the comfort of their home and will go out in public for short periods of time. Part-time can last for months or even years. For me, I went part-time for years before going full-time a few weeks ago. I decided to go out in public presenting as Kimberlee, believing that this would be one aspect of my part-time experience. Everywhere I went, which included the grocery store, a restaurant, and boutiques at the mall, I was addressed as “lady”, “miss”, or ma’am”. Hearing those words, “lady”, “miss”, and “ma’am”, was the best feeling in the world. It is that very moment when I went full-time and I have not looked back since.

Besides my therapist, my best friend was the first person to whom I came out. After that, my friends they have consistently demonstrated their support, love, and acceptance of me through verbal confessions of loving me for everything that I am, and that the gender didn’t matter. Their perspective is that I am still the same person, the personality, the heart, and the soul and those pieces do not change through transition. The gender itself does not matter to them. The only choice I have had in this whole experience is how I want to transition and whether or not I need to transition. Having this condition is not something I chose, nor is something I want. However, the severity of my condition, of my Gender Dysphoria, warrants that I transition or live miserably for the rest of my life.

Despite the dilemma, I have received tremendous support from some family and friends. My sister and brothers, my friends have remained in my life and are putting forth the effort to understand more about Transgender and Gender Dysphoria. Even strangers are sending me emails and blogging on social media. I feel very fortunate to have such great support from my family and friends who check on me to see how I am doing. I am very much aware that my experience is definitely not the norm for most Transgender people. There has been protests from people across all platforms on social media, also from distant family members on both sides of the family. A few other extended family members, in turn, have followed the protest. However, I was never close to those family members; therefore, the loss really has minimal impact. Nevertheless, it is unfortunate that there continues to be a significant portion of people in the world who judge a condition and the person who has the condition before they know anything about it.

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