

FACTSHEET

Sexual orientation, gender identity and HIV

Background

Everyone has a sexual orientation and a gender identity (SOGI), both of which may shift and change during the course of a lifetime. People across the world face discrimination, abuse and violence because of their gender expression, who they love, who they have sex with and how they look.

Intersectional forms of discrimination, abuse and violence based on sexual orientation, gender identity, gender, actual and perceived HIV status, socioeconomic status, race, age and/or other diversities, diminish the ability of lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals to realise their human rights, including their right to access health care. Limited or no access to appropriate health care services makes LGBTI persons particularly vulnerable in the context of HIV.⁴

This can result in an increased likelihood of acquiring HIV.⁵ Transgender people, for example are 49 times more likely to acquire HIV compared to the general population, with a global estimate of 19% of transgender women living with HIV.⁶ Living with HIV can, in turn, exacerbate violence and mental health issues respectively for those whose SOGI does not conform to the norms of mainstream society.^{7,8}

DEFINITIONS

Sexual orientation

The term sexual orientation refers to each person's capacity for profound emotional, affectional and sexual attraction to (and intimate and sexual relations with) individuals of any sex.¹

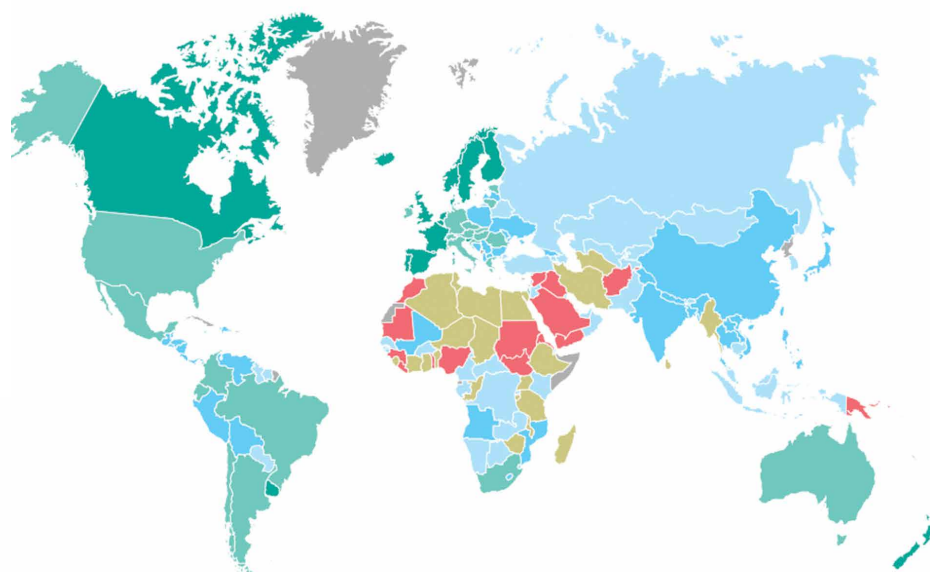
Gender identity

Gender identity refers to a person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. It includes both the personal sense of the body – which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means – as well as other expressions of gender, including dress, speech and mannerisms.²

Violence on the basis of a person's (actual or perceived) SOGI is arguably both a cause and a consequence of laws that criminalise same sex sexual activity across a number of countries, including in 36 of the 52 Commonwealth countries.⁹ The criminalisation of homosexuality legitimises prejudice and exposes people to hate crimes, police abuse, torture and family violence.¹⁰

HOMOPHOBIC CLIMATE INDEX 2016

The Homophobic Climate Index incorporates institutional and social components of homophobia. Institutional homophobia was based on the level of enforcement of laws that criminalise, protect or recognise same-sex relations. Social homophobia was based on the level of acceptance and justifiability of homosexuality.



Source: Lamontagne, E et al. (2016)
"A socioecological measurement of homophobia for all countries and its public health impact". *European Journal of Public Health*.³

Laws and policies have been created on the whole by and for heterosexual, gender-binary populations, and thus there are often a number of other vulnerability factors faced by people who do not identify as heterosexual or who do not identify with the sex they were assigned with at birth. These include the absence of, or exclusion from, laws at national level which promote equality and non-discrimination (or the existence but lack of enforcement of such laws) and the lack of recognition of the vulnerability and the importance of inclusion of LGBTI populations in national HIV and AIDS responses.¹¹

Transgender people and men who have sex with men*

Transgender people and men who have sex with men (MSM) are included in the UNAIDS definition of key populations, which are groups that are disproportionately affected by HIV.¹²

There are biological, behavioural and legal factors which mean MSM are 24 times more likely to acquire HIV compared to the general population. One significant biological reason for high vulnerability to HIV among this group is that unprotected anal sex carries a higher risk of transmission than vaginal sex.¹³

As mentioned above transgender people are 49 times more likely to acquire HIV compared to the general population. Generally, HIV prevalence among transgender women (people who are assigned male at birth but identify as being women) is higher than transgender men (people who are assigned female at birth but identify as being men). Transgender people often face social and legal exclusion, economic vulnerability, and are at an increased risk of experiencing violence. Disempowerment and low self-esteem make transgender women, in particular, less likely or less able, to negotiate condom use.¹⁴

Key populations face high levels of stigma, discrimination and violence and in many countries people from key populations are criminalised. This is the case of transgender people and MSM in many countries globally.^{15,16} In this context, as mentioned above, key populations will face high barriers to accessing HIV and (other) health services.

UNAIDS data suggest that more than 90% of people who newly acquired HIV in central Asia, Europe, North America, the Middle East and North Africa in 2014 were among people from key populations and their sexual partners. This is equivalent to 45% of people who acquired HIV in that year worldwide.¹⁷ An effective HIV response will protect and promote the human rights of key populations and prioritise evidence-based interventions, led by the communities most affected by HIV.

Cisgender women who have sex with women

Cisgender (people who identify with the sex they were assigned at birth) women who have sex with women are often perceived to be at low risk for HIV transmission. However, studies in several countries have found that some lesbian women engage in behaviors that place them at risk for HIV transmission, such as using injecting drugs and having sex with HIV-positive men. Additionally, lesbian and bisexual women face severe

gender-based, ethnicity-based, and class-based violence and discrimination.¹⁸

Indeed, gender-based violence and sexual violence driven by the perverse motivation to 'correct' the sexual orientation of lesbian, bisexual, and other gender non-conforming women is a key factor in HIV risk. A survey of 591 women who in the preceding year had had sex with a woman in Botswana, Namibia, South Africa and Zimbabwe found that forced sex was the most important risk factor for self-reported HIV infection.¹⁹ Efforts to combat gender-based violence and sexual violence can and should be used as an entry point to raise issues relevant to women who have sex with women in national strategic plans to address HIV.^{20,21}

In addition, applying criminal law to HIV exposure or transmission does nothing to address the epidemic of gender-based violence or the deep economic, social, and political inequalities that are at the root of women's and girls' disproportionate vulnerability to HIV. Criminalisation is likely to heighten the risk of violence and abuse women face; strengthen prevailing gendered inequalities in health care and family settings; further promote fear and stigma; increase women's risks and vulnerabilities to HIV and to HIV related rights violations; and have other negative outcomes for women.²²

Intersex people

Many intersex people experience various forms of discrimination and violence directed towards them. An intersex person's identity, possible ambiguous genitalia and gender presentation puts them at risk of various hate crimes directed at them, for example rape on the basis of their gender presentation, the false notion that their identity can be 'corrected'.

This drives many intersex people away from services, including health care, compromising their access to HIV prevention, testing and treatment services. Intersex people may be afraid to ask health care workers for information and services related to HIV prevention in case they face further stigmatisation. HIV and gender-based violence are still applicable, and intersex people need to be equipped with the correct information on how to protect themselves and their partners.

What we know and what we are missing

It is clear that reasons for increased transmission across different groups will vary. Understanding the reasons behind increased likelihood of acquiring HIV across diverse communities will lead to better and more targeted prevention, care and support. However, there is a dearth of data on HIV prevalence and incidence among transgender men and intersex people. Transgender MSM may face the same risk vulnerabilities as cisgender MSM²³ but very little is actually known about transgender men and their vulnerability to HIV.²⁴ Many argue that within people with diverse SOGI expression and sex characteristics, including LGBTI people, the 'I' for intersex or diverse sex characteristics have been given the least attention which goes some way to explaining why there is such a lack of data.

* Transgender people and men who have sex with men (MSM) are discussed collectively here in the context of key populations. However, this categorisation should not detract from each groups' distinct challenges and needs.

The 'invisibilisation' of LGBTI communities

Recent research conducted in America suggests that 11% of American adults acknowledge at least some same-sex attraction. 8.2% report that they have engaged in same-sex behaviour, but only 3.5% identify as lesbian, gay, or bisexual. This shows that what people feel or do is not always the same as how they identify themselves or speak about themselves with others.²⁵

As mentioned above, having accurate data about LGBTI populations is vital for programmes and service delivery, in order to identify the scale and scope of need and to deliver effective care and support to those who require and request it. The pervasive invisibilising through violence against and criminalisation of gender-diverse people and LGBTI people creates an environment which stifles disclosure, 'others' people and alienates individuals. For example, historically transgender people have not been involved in the design or implementation of prevention campaigns. This weakens the campaigns' ability to reach transgender people as they do not have sufficient cultural awareness in their approach and messaging. Transgender and intersex organisations have raised concerns about the relative 'invisibility' of discrimination and violence against intersex people in particular.

To counter this, services and programmes must demonstrate active acceptance, including content reflecting and relevant to a diversity of sexual orientations and gender identities, available through and in community health centres. Health services

should also actively seek staff from diverse communities, making space for and providing platforms for gender diversity and LGBTI persons wherever possible.²⁶ This is made more difficult, if not impossible, in contexts where people from these groups are criminalised for their behaviour and would be breaking the law in their countries to express their identity(ies) and live openly as LGBTI.

Localised and cultural understandings of SOGI

Some countries and communities have localised or cultural understandings of sexual orientation and behaviour and gender identity. Seven countries recognise a third gender or allow citizens to change their legal documents to reflect an undetermined or unspecified gender. Programming in contexts where this is the case will require a nuanced approach that appropriately addresses the local context and works sensitively within local structures and systems.

For example, within India, there are many examples of regionally specific and culturally unique understandings of gender non-binary people and communities. The law changed in 2014 to recognise a third gender category, which means anyone who does not identify with the sex they were assigned at birth can identify as third gender on official documentation, including voter registration forms. The 2014 legislation also included a ruling for equal access to education, health care and welfare programmes for transgender people.



A rainbow flag hangs in the office of Men Against AIDS Youth Group (MAAYGO) in Kisumu, Kenya.

Demonstrating best practice of SOGI and HIV programming around the world

STOPAIDS members are working with and through organisations that support LGBTI people living with HIV around the world through complex and difficult challenges. Examples of their work include:



WORKING WITH LOCAL PARTNERS TO STRENGTHEN EMPATHY, UNDERSTANDING AND AWARENESS OF THE ISSUES FACING KEY POPULATIONS



Looking In, Looking Out

The KP Connect project (2014–2017), was implemented by the International HIV/AIDS Alliance in partnership with Positive Vibes Trust and Swedish International Development Agency through Linking Organisations (LOs) and key partners in Africa. The project aimed to strengthen LOs institutionally and programmatically, so that they were

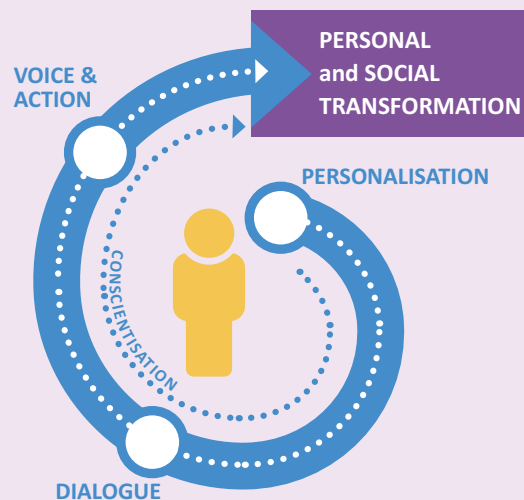
better able to contribute to changing the situation facing key populations on the continent.

A key element of the programme was the delivery of workshops from the suite of Looking In, Looking Out (LILO) methodologies. LILO, developed by Positive Vibes, was initially designed to support people from marginalised and vulnerable groups. LILO workshops and processes activate the Inside-Out process, which is the basis of Positive Vibes' approach.

LILO Identity is a personalised approach to exploring gender identity and sexual orientation. It involves a facilitated process of support for LGBTI people by LOOKING BACK on their lives; LOOKING IN to some of the things that are happening internally; LOOKING OUTWARDS to the world around them and then LOOKING FORWARD in order to move confidently and positively into the future. The workshop assumes that participants have deep personal knowledge and experiences that can be shared with others to assist one another with the common challenges that many LGBTI individuals face. The process is designed to unpack feelings, needs and desires, and to help participants make choices and plans for themselves going forward.

KP Connect has expanded the LILO series by developing and rolling out LILO Connect – a three-day workshop that positively influences public attitudes towards key populations.

LILO Connect is a workshop that aims to assist participants to move towards more positive levels of attitude (support, admiration, appreciation and nurturance) towards LGBTI people. It is a personalised approach to exploring gender identity and sexual orientation. Participants are asked to think deeply about their own attitudes and explore the source of these in self-reflective ways.



The Inside-Out process

Source: KP Connect: Strengthening the Alliance Response to Key Populations in Africa. www.aidsalliance.org/assets/000/002/715/KP_Connect_brochure_original.pdf?1471425048

Participants have included government officials, religious leaders, AIDS Council members, health workers and much wider application is possible. This workshop has been effectively implemented with all LO leaders, as well as most staff. Many LOs have begun to integrate LILO Connect into their own programming and advocacy plans.

The programme enabled LOs to become significant forces for change in their own countries: Reducing the denial of rights, addressing exclusion from services, and challenging social stigma and systemic discrimination suffered by people who belong to key populations, including members of the LGBTI community. In at least six implementing countries there is increased engagement of national policy makers in key population issues as a result of the programme. To complement this there has also been improved technical capacity among civil society organisations to promote key population access to HIV health and rights services.

www.positivevibes.org



PROVIDING AND TARGETING FUNDING TO CATALYSE SUPPORT FOR LGBTI COMMUNITIES

The Rapid Response Fund

In partnership with the Elton John AIDS Foundation (EJAF), the International HIV/AIDS Alliance's Rapid Response Fund is principally available to LGBTI civil society organisations, community-based organisations and non-governmental organisations (NGOs) to implement rapid responses to situations or events that threaten the provision, access and uptake of HIV services for LGBTI people.

Grants of up to \$20,000 are available in 30 countries across Sub-Saharan Africa and the Caribbean, where MSM and the LGBTI community are at high risk of experiencing human rights violations.

Supporting LGBTI migrants living with HIV

Migration is widely acknowledged as a strong determinant of people's health and wellbeing, and people's migration status is often politicised as a drain on public health resources or as a source of disease transmission, including HIV. Gender diverse and LGBTI migrants face these challenges in addition to those associated with their sexual orientation and gender identity in accessing health care. They are therefore at increased risk of acquiring HIV, and missing essential treatment and care options.²⁸

The Rapid Response Fund was contacted by the Jesuit Refugee Service (JRS) in South Africa to enable them to provide support to migrants like Jessica. Self-identifying as a trans woman, Jessica fled her country of birth, Nigeria, in 2014 following the country's notorious new 'anti-gay' bill. Jessica had already experienced arrest and detention prior to the introduction of the 2014 legislation, and so felt she had no choice but to move to South Africa. Following Rapid Response funding, JRS helped her to pay her rent and referred her to a health clinic so she could resume her antiretroviral treatment. She now has a job



Jessica Albert highlights the stigma and discrimination experienced by transgender women.

as a waitress and a community around her through the JRS support group.

In many parts of the world, LGBTI people are either criminalised or socially marginalised. This limits access to effective HIV and prevention services, while also leaving LGBTI people vulnerable to human rights violations. The impact of these circumstances can be felt most acutely in times of crisis. The Rapid Response Fund is intended to provide a fast emergency support in such instances, where other funding mechanisms or programmes may not have the capacity or flexibility to do so.

www.aidsalliance.org/rapidresponsefund



PROVIDING SERVICES FOR LGBTI PEOPLE, LED BY LGBTI PEOPLE

CliniQ Community Interest Company is a trans-founded and trans-led award-winning partnership between trans communities,

56 Dean Street and the Chelsea & Westminster Hospital NHS Foundation Trust, London Friend and a range of other trans-aware voluntary sector organisations. The partnership aims to offer a queer inclusive and non-judgemental sexual health and well being service to trans clients, members of the trans community, their friends and families.

It is a service that enhances clients' physical and mental health; respects clients' differing lifestyles, way of presenting

and chosen pronouns; and supports and empowers clients in their journey through life. They offer a range of services from trans-inclusive HIV care and support to other holistic well being sexual health services.

CliniQ's approach is built on the understanding that trans-led and delivered services are very important when engaging with trans people. They work to build trust amongst the trans community and provide a service delivered by competent and culturally aware professionals. CliniQ have a proven track-record of delivering services that meet the needs and expectations of the trans community. Their model and approach has been taken up by sexual health centres in other countries around the world.

<https://cliniq.org.uk/>



SHINING A LIGHT ON THE SPECIFIC NEEDS OF KEY POPULATIONS – BACKUP AND IPPF

Shadows and Light

'Shadows and Light', a three-year project (2012-2015) funded by BACKUP Health, aimed to address the linked sexual and reproductive health (SRH) and HIV needs of key populations within IPPF Member Associations in four countries – Cameroon, India, Kenya and Uganda.²⁹

The project recognised that a comprehensive response to HIV must include initiatives that meet the needs of those who are marginalised, vulnerable, socially excluded and under-served. Based on these linkages, addressing SRH within HIV programmes and services funded by the Global Fund was identified as a key opportunity to ensure sustainable service provision to key populations.

In Cameroon, the Cameroon National Association for Family Welfare (CAMNAFAW) was supported to scale up its work providing and campaigning for integrated services to gay men and other MSM.

Recognising the serious barriers that people of diverse sexual orientations, gender identities and sex characteristics face in accessing SRH information and services, CAMNAFAW broadened their project scope beyond MSM to provide comprehensive and integrated services to lesbians and other women who have sex with women, transgender, and intersex individuals.

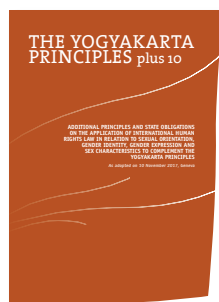
This included challenging stigma and discrimination by changing attitudes of service providers and strengthening delivery of comprehensive SRH and HIV services by working with the LGBTI community to identify the required services in a 'one stop shop'. Critical to this was the development of strong partnerships with various LGBTI-led civil society organisations, and meaningful engagement in the design and implementation of the project and in further advocating for their needs and inclusion in various fora. Efforts were also made to strengthen the institutional capacities of LGBTI-led organisations in delivery of SRH and HIV services.

Abhina presents at a STOPAIDS conference.



Best practice principles

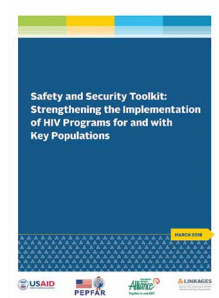
Examples of best practice principles for working with and alongside LGBTI communities can be found in various international guidelines and commitments. Spotlighted here are two different sets of principles that have been launched recently, one designed for governments and one for organisations to use when designing and implementing programmes.



1. The Yogyakarta Principles³⁰

This broad set of principles (the Yogyakarta Principles) was developed in response to well-documented patterns of abuse targeted towards persons because of their actual or perceived SOGI.

The Yogyakarta Principles were updated in November 2017 and 10 new principles were added to the original list. In the update they adopted Principle 33 – The Right to Freedom from Criminalisation and Sanction on the Basis of Sexual Orientation, Gender Identity, Gender Expression or Sex Characteristics (see box ‘Principle 33’).³¹



2. Strengthening the safety and security of HIV programmes for key populations

USAID, PEPFAR, International HIV/AIDS Alliance and Linkages recently launched a new comprehensive publication, *Safety and Security Toolkit: Strengthening the Implementation of HIV programs for and with Key Populations*.³² This toolkit was developed to inform organisations of how to strengthen the safety and security of

HIV programmes for key populations.

Within tool one there are 12 recommendations that emerged from lessons learned about responding to safety and security challenges in HIV programming for and with key populations.

1. Maintain good practice principles
2. Never assume safety and security. Make it a priority.
3. Provide a safe and secure workplace. It is the employers responsibility.
4. Plan your response.
5. Invest in your response.
6. Understand risk and risk appetite.
7. Understand the drivers and the context.
8. Be mindful of the personal.
9. Take a differentiated approach.
10. Get to know your foes, not just your allies.
11. Take a holistic, comprehensive and flexible approach.
12. Be together. Find strength in knowledge and working collectively.

PRINCIPLE 33

Everyone has the right to be free from criminalisation and any form of sanction arising directly or indirectly from that person's actual or perceived sexual orientation, gender identity, gender expression or sex characteristics.

States shall:

- A. Ensure that legal provisions, including in customary, religious and indigenous laws, whether explicit provisions, or the application of general punitive provisions such as acts against nature, morality, public decency, vagrancy, sodomy and propaganda laws, do not criminalise sexual orientation, gender identity and expression, or establish any form of sanction relating to them;
- B. Repeal other forms of criminalisation and sanction impacting on rights and freedoms on the basis of sexual orientation, gender identity, gender expression or sex characteristics, including the criminalisation of sex work, abortion, unintentional transmission of HIV, adultery, nuisance, loitering and begging;
- C. Pending repeal, cease to apply discriminatory laws criminalising or applying general punitive sanctions on the basis of sexual orientation, gender identity, gender expression or sex characteristics;
- D. Expunge any convictions and erase any criminal records for past offences associated with laws arbitrarily criminalising persons on the basis of sexual orientation, gender identity, gender expression and sex characteristics;
- E. Ensure training for the judiciary, law enforcement officers and healthcare providers in relation to their human rights obligations regarding sexual orientation, gender identity, gender expression and sex characteristics;
- F. Ensure that law enforcement officers and other individuals and groups are held accountable for any act of violence, intimidation or abuse based on the criminalisation of sexual orientation, gender identity, gender expression and sex characteristics;
- G. Ensure effective access to legal support systems, justice and remedies for those who are affected by criminalisation and penalisation on grounds of sexual orientation, gender identity, gender expression and sex characteristics;
- H. Decriminalise body modification procedures and treatments that are carried out with prior, free and informed consent of the person.

Conclusions

- ✳ Including LGBTI communities in HIV programming design and implementation is vital to ensure their voices are heard, their needs are met and their rights are upheld.
- ✳ More data and evidence is emerging about how to work with LGBTI communities and what their specific needs are, but there is still a significant dearth of information available on certain SOGI groups. All organisations should work alongside and with these communities to address these gaps in research and data, and commit to sharing their learning of what works.
- ✳ Until LGBTI identities are fully decriminalised, the heightened vulnerability of those in these communities to HIV will continue.



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Endnotes

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