

HIV AND YOUNG TRANSGENDER PEOPLE



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Resilient nations.



A TECHNICAL BRIEF

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GLOSSARY

Definitions of some terms used in this technical brief

Children are people below the age of 18 years, unless, under the law applicable to the child, majority is attained earlier.⁽¹⁾

Adolescents are people aged 10–19 years.⁽²⁾

Young people are those aged 10–24 years.⁽³⁾

“Young transgender people” in this document refers to people 10–24 years of age, including children 10–17 years and adults 18–24 years.

While this technical brief uses age categories currently employed by the United Nations and the World Health Organization (WHO), it is acknowledged that the rate of physical and emotional maturation of young people varies widely within each category.⁽⁴⁾ The United Nations Convention on the Rights of the Child recognizes the concept of the evolving capacities of the child, stating in Article 5 that direction and guidance, provided by parents or others with responsibility for the child, must take into account the capacities of the child to exercise rights on his or her own behalf.

Key populations are defined groups who due to specific higher-risk behaviours are at increased risk of HIV, irrespective of the epidemic type or local context. They often have legal and social issues related to their behaviours that increase their vulnerability to HIV. The five key populations are men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers, and transgender people.⁽⁵⁾

Transgender Transgender is an umbrella term for all people whose internal sense of their gender (their gender identity) is different from the sex they were assigned at birth. Transgender people choose different terms to describe themselves. Someone born female who identifies as male is a transgender man/boy. He might use the term “transman”, “FtM” or “F2M”, or simply “male” to describe his identity. A transgender woman/girl is someone born male who identifies as female. She might describe herself as a “transwoman” “MtF”, “M2F” or “female”. In some cultures specific terms such as hijra (India), kathoey (Thailand) or waria (Indonesia) may be used.⁽⁶⁾

Birth-assigned refers to the sex that a person is identified as being at birth. This may or may not accord with the individual’s own sense of their gender identity as they grow up.

Transition refers to the process transgender people undergo to live in their gender identity. This may involve changes to outward appearance, mannerisms or to the name someone uses in everyday interactions. Transitioning may also involve medical steps such as hormone therapy and surgeries.⁽⁷⁾

Hormone therapy (also known as cross-gender hormone therapy or hormone replacement therapy) is a health intervention used by many transgender people. Hormones can be used to feminize or masculinize one’s appearance in accordance with one’s gender identity. Physical appearance is often used to support assumptions about someone’s sex, and hormone therapy can help a transgender person to be recognized as the appropriate gender.⁽⁷⁾

Transphobia is prejudice directed at transgender people because of their gender identity or expression.⁽⁷⁾

INTRODUCTION

Young people aged 10–24 years constitute one-quarter of the world’s population,⁽⁸⁾ and they are among those most affected by the global epidemic of human immunodeficiency virus (HIV). In 2013, an estimated 4.96 million people aged 10–24 years were living with HIV, and young people aged 15–24 years accounted for an estimated 35% of all new infections worldwide in people over 15 years of age.⁽⁹⁾

Key populations at higher risk of HIV include people who sell sex, men who have sex with men (MSM), transgender people and people who inject drugs. Young people who belong to one or more of these key populations – or who engage in activities associated with these populations – are made especially vulnerable to HIV by widespread discrimination, stigma and violence, combined with the particular vulnerabilities of youth, power imbalances in relationships and, sometimes, alienation from family and friends. These factors increase the risk that they may engage – willingly or not – in behaviours that put them at risk of HIV, such as frequent unprotected sex and the sharing of needles and syringes to inject drugs.

Governments have a legal obligation to respect, protect and fulfil the rights of children to life, health and development, and indeed, societies share an ethical duty

to ensure this for all young people. This includes taking steps to lower their risk of acquiring HIV, while developing and strengthening protective systems to reduce their vulnerability. However, in many cases, young people from key populations are made more vulnerable by policies and laws that demean or criminalize or penalize them or their behaviours and by education and health systems that ignore or reject them and that fail to provide the information and treatment they need to keep themselves safe.

The global response to HIV largely neglects young key populations. Governments and donors fail to adequately fund research, prevention, treatment and care for them. HIV service-providers are often poorly equipped to serve young key populations, while the staff of programmes for young people may lack the sensitivity, skills and knowledge to work specifically with members of key populations.

Young transgender people’s immediate HIV risk is related primarily to sexual behaviours, especially unprotected anal sex with an HIV positive partner, but structural factors in addition to those already noted make young transgender people especially vulnerable to HIV. Stigma and discrimination against transgender people frequently cause them to be rejected by their families and denied health-care services, including access to HIV testing, counselling and treatment. Transgender people are almost everywhere denied legal recognition of their gender and may also be penalized by laws criminalizing same-sex behaviour. Some young transgender people have overlapping vulnerabilities with other young key populations, such as injecting drugs and selling sex,¹ which can put them at higher risk of acquiring HIV and also lead to increased stigmatization. In addition, experiences of abuse, exploitation and violence, including sexual violence, are commonplace.



Stigma and discrimination against transgender people frequently cause them to be rejected by their families and denied healthcare services, including access to HIV testing, counselling and treatment.

¹ In this series of technical briefs, “young people who sell sex” refers to people 10-24 years of age, including children 10-17 years who are sexually exploited and adults 18-24 years who are sex workers. For further information, please see HIV and young people who sell sex: A technical brief (Geneva: WHO, 2014).

This technical brief is one in a series addressing four young key populations. It is intended for policy-makers, donors, service-planners, service-providers and community-led organizations. This brief aims to catalyse and inform discussions about how best to provide health services, programmes and support for young transgender people. It offers a concise account of current knowledge concerning

the HIV risk and vulnerability of young transgender people; the barriers and constraints they face to appropriate services; examples of programmes that may work well in addressing their needs and rights; and approaches and considerations for providing services that both draw upon and build the strengths, competencies and capacities of young transgender people.

Community consultations: the voices, values and needs of young people

- An important way to better understand the needs and challenges of young key populations is to listen to their own experiences. This technical brief draws upon insights from the research and advocacy of young transgender people. It also incorporates information from consultations organized in 2013 by the United Nations Population Fund in collaboration with organizations working with young key populations, including young transgender people, in eastern Europe and South America.⁽¹⁰⁾ Reference is also made to consultations conducted with members of young key populations in the Asia-Pacific region by Youth Voices Count⁽¹¹⁾ and the Youth Leadership, Education, Advocacy and Development Project (Youth LEAD);⁽¹²⁾ and regional and country consultations in Asia with young transgender people, conducted by the HIV Young Leaders Fund.⁽¹³⁾ Since these were small studies, the findings are intended to be illustrative rather than general. Representative quotations or paraphrases from participants in the consultations are included so that their voices are heard.
- *Where participants in the consultations were children, appropriate consent procedures were followed.*

YOUNG TRANSGENDER PEOPLE

The paucity of data on young transgender people is a barrier to providing adequate health and psychosocial services tailored for them, and highlights the need for more research and attention from national governments. Estimates from countries indicate that the transgender population could be between 0.1% and 1.1% of adults of reproductive age.⁽¹⁴⁾

The severe stigma and discrimination that transgender people experience make it especially difficult to estimate the global size of the transgender population, their levels of risk for HIV and their protective behaviours. Research tends to focus on those who approach specialist clinics to seek counselling and health care related to gender transition, but these are a minority of all transgender people,⁽¹⁵⁾ and population estimates based on such sampling are likely to underestimate the true numbers and to fail to capture the diversity of transgender people's identities and experiences. In some regions of the world, for example, Africa, transgender people are almost completely overlooked.⁽¹⁶⁾ In addition, most research is conducted with transgender women, and there is very little that focuses on transgender men. The studies cited in this technical brief largely reflect this fact.

- Analysis of population-based surveys in Massachusetts and California, United States of America, suggests that 0.3% of adults in the USA may identify as transgender.⁽¹⁷⁾
- A study in the United Kingdom estimated that 0.6% of people aged over 15 identify as transgender.⁽¹⁸⁾
- In Pakistan, estimates of the numbers of transgender women (hijras) suggest that they represent 0.7% of birth-assigned males aged 15 years and above.⁽¹⁹⁾ In India, they make up an estimated 0.12–0.24% of the population.^(20,21)
- The proportion of transgender women among birth-assigned males has been estimated at around 0.6% in Thailand;⁽²²⁾ and at 0.1–0.2% in Malaysia.⁽²³⁾

It is estimated that globally there are more people who identify as transgender women than as transgender men, but there are limited data on the relative population sizes.⁽²⁴⁾

Estimating the number of young transgender people (aged 10–24 years) is even harder. Although anecdotal evidence suggests that an increasing number of young individuals are self-identifying as transgender,⁽²⁵⁾ some may not develop a full awareness of their gender identity until later in

adolescence or young adulthood. In addition, many young transgender people are particularly vulnerable to transphobia and isolation and thus less likely to acknowledge their identity to others.

There is limited understanding of the global burden of HIV and other STIs among transgender populations, and transgender people are rarely identifiable in national surveillance systems. Data are only available from middle- and high-income countries and indicate that transgender women, in particular, are at disproportionate risk for HIV infection.

- A 2012 review found that across 15 countries in North America, the Asia-Pacific, Latin America and Europe which reported data on 11 066 transgender women, the pooled HIV prevalence was 19.1%.⁽²⁶⁾
- A 2008 analysis of studies completed in 1990–2003 in the USA found an average laboratory-confirmed HIV prevalence of 27.7% across all age groups of transgender women in four studies, but a much lower self-reported prevalence of 11.7% in 18 other studies, suggesting that many transgender women living with HIV did not know their HIV status.⁽²⁷⁾
- Some transgender men engage in receptive anal intercourse,⁽²⁸⁾ and there is some evidence that transgender men are also at risk for HIV: one clinic in San Francisco, USA, found that the prevalence of HIV was similar for transgender men (10%) and transgender women (11%),⁽²⁹⁾ while a study in New York City, USA, found that 2% of transgender men were living with HIV.⁽³⁰⁾

Little data are available on the HIV burden among young transgender people, but research suggests a similarly high prevalence of HIV as among adult transgender women. A study in Chicago, USA, with ethnic-minority transgender women aged 16–25 years found that 22% self-reported being HIV positive.⁽³¹⁾ A comparable proportion (19%) of transgender women aged 15–24 years self-reported HIV infection in a study in Chicago and Los Angeles.⁽³²⁾ There is evidence that many young transgender women are unaware of their HIV status. A US-based study of transgender women who reported being HIV negative or unaware of their HIV status revealed that 8% of those aged 13–19 years were living with HIV.⁽³³⁾ This suggests that the self-reported HIV prevalence of 19–22% among young transgender women may understate the true burden.

HIV RISK AND VULNERABILITY

Compared to their age peers in the general population, and to older transgender people, young transgender people are more vulnerable to HIV. This is due to numerous individual and structural factors that are linked with specific risk behaviours – inconsistent condom use and greater use of drugs or alcohol.

Unprotected sex

Studies among transgender women in the USA and Asia indicate that they commonly practise unprotected receptive anal intercourse.^(34,35) Transmission of HIV is 18 times more likely to occur through unprotected receptive anal sex than through unprotected vaginal intercourse.⁽³⁶⁾ In a study of transgender women aged 16–25 years in Chicago, USA, 49% reported unprotected receptive anal intercourse.⁽³⁷⁾ In Chiang Mai, Thailand, a survey of transgender people attending a voluntary counselling and testing centre found that three-quarters of them had practised unprotected anal intercourse with a regular partner in the previous six months, while 55% had done so with a casual partner.⁽³⁸⁾ Transgender women may engage in receptive rather than insertive sex in order to affirm their feminine identity.⁽³⁹⁾ Like other people, some transgender women consider unprotected sex a way to demonstrate trust in their partner, even if they do not know their partner's HIV status.⁽⁴⁰⁾ For some transgender men, unequal power dynamics, low self-esteem and the desire for affirmation of their gender identity present barriers to negotiating safe sex with male partners.^(41,42)

“When it comes to our permanent partners and lovers we would not use condoms at all. We want to show them how much we trust and love them.”

Young transgender person, Pakistan ⁽⁴³⁾

Drug and alcohol consumption

In studies conducted in Los Angeles and Chicago, USA, over 90% of transgender participants aged 15–24 years had used alcohol or drugs during their lifetimes.⁽⁴⁴⁾ In the Chicago study, 57% of transgender women aged 16–25 years reported having sex under the influence of drugs or alcohol, and this was significantly associated with both

unprotected anal intercourse, and with selling of sex.^(45,46) A systematic review of studies in the USA found that 12% of transgender women in these studies reported injecting illicit drugs and that 39% of transgender men reported having sex while drunk or high.⁽⁴⁷⁾

Other forms of injecting

Apart from injecting illicit drugs, transgender people may also inject hormones or other substances for body modification. In the USA systematic review referenced above, about a quarter of transgender women reported injecting hormones or silicone,⁽⁴⁸⁾ while in a study in Thailand, around two-thirds of male and female transgender people reported doing so.⁽⁴⁹⁾

While data are still quite limited, no association has yet been found between injecting hormones and lifetime risk of acquiring HIV.⁽⁵⁰⁾ However, sharing needles can transmit blood borne pathogens including HIV and viral hepatitis. The risk of HIV transmission via shared needles is likely to be higher in settings where access to medically supervised hormone treatment is unavailable and illicit injections are commonplace.⁽⁵¹⁾ In the Chicago study of transgender women aged 16–25 years, 2% reported sharing needles to inject street drugs, while 6% had shared needles when injecting hormones or silicone.⁽⁵²⁾



Compared to their age peers in the general population, and to older transgender people, young transgender people are more vulnerable to HIV.

“At the beauty salon, they provide silicone injection for their nose, their breasts, their hips... Those who inject are not professional nurse or doctor. They just get it from the black market and try to make money from it.”

Transgender woman, 22, Indonesia⁽⁵³⁾

Changes during adolescence

Adolescence is a period of rapid physical, psychological, sexual, emotional and social change. It is often a time of reward-seeking, risk-taking and experimentation, particularly in the presence of peers, which may involve alcohol or other drugs. It is also the period when sexual activity with other people may begin. The development of the brain in adolescence influences the individual’s ability to balance immediate and longer-term rewards and goals, and to accurately gauge risks and consequences.⁽⁵⁴⁾ This can make adolescents more vulnerable to peer pressure, or to manipulation, exploitation or abuse by older people, and therefore potentially to HIV. This is especially true for those who lack stable and supportive family environments.

Some transgender people are aware from early childhood that their gender identity differs from their birth-assigned sex, but their sense of their identity as a transgender person may not solidify until adolescence, adding a layer of considerable complexity to developmental processes during these years.⁽⁵⁵⁾ Even transgender people who are clear about their gender identity before reaching adolescence are likely to feel that there is little social space available for them to safely express their identity.

The difficulty of negotiating the tension between a desire to express one’s identity and the fear of being stigmatized for doing so often has a negative impact on the emotional well-being of transgender adolescents and may deter them from seeking guidance and information about gender identity as well as sexual and reproductive health and HIV.

“Sexuality preferences and gender identity don’t start at the adolescent stage; let’s not wait [to start talking about it in school].”

Young transgender person, Uruguay⁽⁵⁶⁾

Transphobia, stigma, discrimination, maltreatment and violence

Many transgender people experience social rejection and marginalization because of their gender identity and expression, as well as their perceived sexual orientation. Transphobia can have a significant impact during

adolescence and young adulthood, when many young transgender people are struggling to develop a sense of self while addressing feelings of guilt and shame about their identities, pressure to conform to familial, peer and gender norms, and often the need for secrecy.⁽⁵⁷⁾ This dynamic affects their self-perception and sense of worth and can lead to self-stigmatization – feelings of depression, low self-esteem and anger, or self-harming acts.⁽⁵⁸⁾ Self-stigmatization is also linked to HIV risk behaviour.⁽⁵⁹⁾

Young transgender people may experience poor relationships with parents during childhood, and even physical and sexual violence from within their family or communities than non-transgender young people. Experiences of such maltreatment or violence within their family or communities may incite them to leave home. A study in Latin America estimated that 44–70% of transgender women and girls leave home or are thrown out of their home.⁽⁶⁰⁾

‘Exposure to transphobia is a mental health risk for transgender people and can result in increased levels of depression and suicidal thoughts’.⁽⁶¹⁾ Young transgender people may also be subject to bullying and harassment at school because of their gender identity as well as their perceived sexual orientation. In a study in the USA, more than 90% of transgender learners reported derogatory remarks, more than half had experienced physical violence and two-thirds said they felt unsafe at school.⁽⁶²⁾ In Argentina, transgender learners reported that they stopped studying, either because of transphobic or homophobic bullying by other learners or because they were denied entry by school authorities. Of those surveyed, 45% dropped out of secondary school and only 2.3 % completed college.⁽⁶³⁾ Apart from the physical and psychological effects, homophobic and transphobic bullying in educational institutions can undermine learning opportunities and educational achievement.^(64,65)

“When fellow students mock [us], in general teachers or head teachers do not respond, as if they don’t know what to do or how to deal with it.”

Young transgender person, Uruguay⁽⁶⁶⁾

“In my school, teachers discriminate against me more than my own schoolmates.”

Young transgender person, Uruguay⁽⁶⁷⁾

Participants in a community consultation in Asia reported that young transgender people who either identify as part of the MSM community, or are identified as such by others, face greater discrimination.⁽⁶⁸⁾ Much of the available data on the impact of transphobia focuses on ethnic-minority transgender people in the USA:

- Transgender people aged 15–20 years in a New York study reported stigma, harassment and social isolation, and concerns about potential violence.⁽⁶⁹⁾
- Among transgender women in a San Francisco study, verbal and physical abuse were reported as having been experienced more frequently during childhood than in adulthood (80% vs 37% for verbal abuse, and 64% vs 20% for physical abuse).⁽⁷⁰⁾
- For transgender women aged 16–25 years in a Chicago study, self-esteem and depression were both independently associated with unprotected anal intercourse.⁽⁷¹⁾

Young Transgender people have an elevated risk of suicidal thoughts and attempted suicide. In the USA, a study found that 45% of young transgender people had had serious thoughts about suicide, and 26% had actually attempted suicide.⁽⁷²⁾ In Thailand, transgender women aged 15–19 years had higher levels of suicidal ideation than their older peers.⁽⁷³⁾

The limited research available suggests the influence of parental guidance and support on HIV risk behaviours: young transgender women with no parental support reported inconsistent or no condom use with sexual partners, but those with at least one supportive parent reported using condoms consistently.⁽⁷⁴⁾

Social marginalization

The rejection of young transgender people by their families or in their school or work environments may lead to homelessness or living and working on the streets, irregular school attendance or drop out, unemployment and economic instability.^(75,76,77) Transgender adolescents are particularly vulnerable to such consequences because they tend to depend on family and educational institutions for support, guidance, care, protection, food, housing and other resources. Loss of stable housing has been associated with increased HIV risk behaviours, including unprotected sex and exchanging sex for money.⁽⁷⁸⁾ Living or working on the streets makes it harder for young transgender people to access health and other services.^(79,80)

In some countries, such as India and Pakistan, *hijras* may live in tight-knit communities with their own cultural behaviours and norms, under the leadership of a *guru*. While these communities often provide security and support, access to information and services may be determined by the *guru* rather than by the needs or wishes of individual transgender women, and access to the community by outsiders may be similarly restricted.

Lack of information and misconception of risk

Many young transgender people, lacking information on sexual health specifically directed at people of their gender identity, underestimate their risk for HIV. A US-based review showed that 71.6% of transgender women perceived themselves to be at low or no risk of acquiring HIV. However, there was a large discrepancy between their low rates of self-reported infection and rates of laboratory-confirmed HIV, pointing to a gap in HIV-related knowledge and awareness among this population.⁽⁸¹⁾

“Young transgenders who sell sex do not know what HIV is. They have heard about AIDS but never HIV. They don’t know where to go for testing or whom they can go with. They cannot comprehend the seriousness of HIV.”

Young transgender person, Pakistan⁽⁸²⁾

Racial and ethnic marginalization

Some studies in the USA have found that HIV prevalence among transgender women is higher in ethnic-minority groups, particularly African Americans and Latinas.^(83,84) More research is needed to understand the reason for these disparities, though it has been suggested that the social isolation and discrimination suffered by some ethnic-minority youth may be linked to lack of knowledge about HIV prevention, lack of easy access to health services, and drug and alcohol use.⁽⁸⁵⁾



Many young transgender people, lacking information on sexual health specifically directed at people of their gender identity, underestimate their risk for HIV.

Relationship status

Young transgender people in relationships, like non-transgender people, may use condoms less frequently with their main partners than with casual or commercial partners. A study in Los Angeles and Chicago, USA, found that young transgender women who sell sex were less than one-third as likely to use a condom during receptive anal intercourse with their main partner as with commercial partners.⁽⁸⁶⁾ In Thailand, 61.0% of transgender people reported inconsistent condom use with their steady partners, and 32.7% with their casual partners.⁽⁸⁷⁾

Selling sex

Evidence suggests that a significant proportion of young transgender women sell sex in some settings, often as a result of social exclusion, economic vulnerability and difficulty in finding employment.^(88,89) In the USA, sex work was reported as being a primary source of recent income for 50% of adult transgender women studied in Los Angeles,⁽⁹⁰⁾ 32% of those in San Francisco⁽⁹¹⁾ and 44% in Miami, San Francisco and New York.⁽⁹²⁾ In a study in Chicago, 59% of ethnic-minority transgender women aged 16–25 years reported they had exchanged sex for resources.⁽⁹³⁾

Selling sex places transgender people at risk of violence, and pressure from clients to have unprotected intercourse puts them at greater risk of becoming infected with HIV.⁽⁹⁴⁾ A review of studies in 13 countries¹ found significantly higher HIV prevalence among transgender women who

were engaged in sex work (pooled prevalence 27.3%) than among those who were not (14.7%). In addition, transgender women engaging in sex work were four times as likely to be HIV positive as non-transgender female sex workers.⁽⁹⁵⁾

In some South Asian countries, a decline in demand for *hijras* to perform traditional activities for payment, such as blessing births and dancing at social events, has led many to engage in selling sex instead. In a study of *hijras* in Pakistan, 84% had sold sex, and while almost all were familiar with condoms, 42% reported never needing to use one.⁽⁹⁶⁾

There is relatively little data on the relationship between selling sex and HIV risk among young transgender women. In a Chicago and Los Angeles study, 67% of transgender women aged 15–24 years reported selling sex, and HIV prevalence among those who sold sex (23%) was almost four times as high as among transgender girls and women in the same age group with no history of selling sex. Selling sex was significantly associated with low levels of education, homelessness, drug use and a perceived lack of social support.⁽⁹⁷⁾

“It’s hard to get a job. We have to work as [a] sex worker, [do] makeup or sing in funerals.”

Transgender woman, Viet Nam⁽⁹⁸⁾

“You have triple stigma if you are young, a sex worker and a transgender.”

Young transgender person, Asia⁽⁹⁹⁾

1 The 13 countries were Australia, Belgium, Brazil, India, Indonesia, Israel, Italy, Netherlands, Singapore, Spain, Thailand, Uruguay and the USA.

LEGAL AND POLICY CONSTRAINTS

The United Nations Convention on the Rights of the Child (CRC, 1989) is an international treaty that obliges States parties to protect the rights of all people under 18 years of age, with an emphasis on the four guiding principles of the best interests of the child; non-discrimination; the right to life, survival and development; and respect for the views of the child (see Annex 1).⁽¹⁰⁰⁾ With regard to the latter principle, it is important to note that the Committee on the Rights of the Child, in General Comment No. 4, stated that this principle is fundamental to implementing the right to health and development of adolescents. Public authorities, parents and other adults working with or for children, must create an environment that is based on “trust, information sharing, capacity to listen and sound guidance” which facilitates the participation of adolescents in decision-making. In addition, the CRC also recognizes the important concept of children’s evolving capacities (Articles 5 and 14), stating in Article 5 that States parties must respect the “responsibilities, rights and duties” of parents (or other persons legally responsible for the child) to provide appropriate direction and guidance, taking into account the capacities of the child to exercise rights on his or her own behalf.

In practice, significant legal and policy constraints, including weak implementation of the law by justice and law enforcement officials, limit the access of young transgender people to information and services affecting their health and well-being. The rights of children to life and health are contravened when they are excluded from effective HIV prevention and life-saving treatment, care and support services.

Criminalization

Transgender people who have sex with people of the same birth-assigned sex are often perceived as “homosexual” (for example, a transgender woman/girl who has sex with a male, particularly if she is herself perceived as being male). As a result, transgender people are often subject to criminal penalties for homosexual behaviour, which as of January 2014 remained illegal between consenting adults in 78 countries.⁽¹⁰¹⁾

While the United Nations Secretary-General has explicitly stated that human rights apply to all people, including people who identify as transgender,⁽¹⁰²⁾ gender identity is not a protected status in any binding international human-rights instrument. Although in some countries (such as parts of the USA) there are legal protections for transgender people under laws barring discrimination on the basis of sex, it is more common for transgender people to be without legal protection against discrimination or harassment, or to be protected only if given a mental-health diagnosis of “gender identity disorder”.⁽¹⁰³⁾ Laws against cross-dressing make some transgender people vulnerable to arrest. However, it is notable that a few countries, such as Nepal and, to a certain extent, India, recognize transgender identity as a third gender on administrative documents, giving transgender people some legal entitlements and protections. Argentina’s gender identity law respects the right to self-determination of all transgender people and their right to confidentiality and privacy, and allows them to change their name and sex details without requiring a medical diagnosis or specific medical interventions.⁽¹⁰⁴⁾ Portugal and Uruguay have also legislated to allow individuals to choose the gender identity that is registered on their official documents.⁽¹⁰⁵⁾

Police harassment and violence

The severe stigmatization arising from transphobia makes police harassment a danger for transgender people on the basis of their appearance alone, although transgender sex workers and young transgender people who sell sex are often also disproportionately targeted by the police in places where sex work is criminalized.⁽¹⁰⁶⁾ Transgender people may have little or no access to the justice system if they are the victims of harassment or violence, and they may be subjected to abuse, extortion, beatings or sexual violence by the police themselves.⁽¹⁰⁷⁾ In some places, for example some countries in Asia, sexual violence laws do not criminalize sexual assault on men and transgender individuals.⁽¹⁰⁹⁾

“Police is one of the biggest problems we face on the streets ... they take money and everything that we have, rape us and then leave us.”

Young transgender person who sells sex, Pakistan⁽¹⁰⁹⁾

Restricted access to services

Transgender people under the legal age of majority may be deterred from seeking HIV testing and counselling if the consent of parents or guardians is required. This is despite



Laws that do not allow official documents to be changed to match current gender identity can prevent transgender people from obtaining health care and other government services or employment.

the fact that General Comment No. 4 of the Committee on the Rights of the Child acknowledges that States parties should ensure that children have access to appropriate sexual and reproductive health information, regardless of their marital status and whether their parents or guardians consent, and that States parties should ensure “the possibility of medical treatment without parental consent.”

Discrimination can also be a barrier to accessing the rights of citizenship more generally. Laws that do not allow official documents to be changed to match current gender identity can prevent transgender people from obtaining health care and other government services or employment. Young transgender women in the community consultation in Cambodia reported that they were unable to get ID cards from the local authorities because of a requirement that they cut their hair and dress in men’s clothes to be photographed.⁽¹¹⁰⁾ In June 2014, Denmark became the first European country to allow legal change of gender without clinical diagnosis, removing previous requirements like compulsory surgical intervention and compulsory sterilization.⁽¹¹¹⁾

SERVICE COVERAGE AND BARRIERS TO ACCESS

Despite evidence of heightened HIV risks and prevalence rates among transgender people (particularly transgender women), coverage of HIV prevention programmes among transgender populations remains poor across regions.⁽¹¹²⁾ Barriers to health care among transgender people have been significantly associated with depression, economic pressure and low self-esteem, which may reduce rates of condom use.⁽¹¹³⁾

Availability and accessibility

Some participants in the community consultations identified cost as the highest practical barrier to accessing services, followed by distance from the point of service delivery.⁽¹¹⁴⁾ Young people are less likely to have financial means and mobility than older people.

Uptake of HIV testing and counselling

Demand for HIV services may be influenced by transgender people's perception of low risk for HIV, as well as lack of information. Conversely, some may fear the personal and social ramifications of testing positive for HIV. Some transgender people have competing health needs and may prioritize medical treatment related to gender transition, particularly if they perceive that HIV testing or treatment will cost money.

“Outreach workers always bring me to have an [HIV]/STI test, but they don't understand about our real problems ... Sometimes I have pain in my face because of silicone surgery [or] side-effects from injecting hormones, and we really need counselling, but no one can help us.”

Young transgender woman, Cambodia⁽¹¹⁵⁾

Access to transgender-specific medical procedures

There is evidence that hormone therapy and sex-reassignment surgery can substantially support the psychological well-being of transgender people who choose these treatments, and by improving self-esteem they may also contribute to lowering HIV risk.^(116, 117) However, access to hormone therapy is limited, and few health-care providers feel knowledgeable about transgender health care.⁽¹¹⁸⁾ Some transgender people therefore seek hormone therapy in the informal sector, despite the potential harmful

side-effects of unmonitored treatment and the risk of HIV transmission through contaminated needles.⁽¹¹⁹⁾

Sex-reassignment surgery is unavailable in most countries and is prohibitively expensive for many to obtain through private care. Where surgery or hormone therapy is not available for free or at low cost, some transgender people sell sex in order to raise money for it, which may increase their risk of exposure to HIV. There is also a lack of data on the HIV risk for post-operative transgender women with a neo-vagina.

Medical therapies (known as hormone blockers) to suppress the onset of puberty are available in some settings, allowing transgender adolescents to delay decisions about starting hormone therapy. These therapies require careful medical assessment and supervision and are best accompanied by professional psychological support.⁽¹²⁰⁾

“I read a lot of [information about using hormones on the] Internet because I cannot get any access from the medical practice, medical providers ... Illegal injections using silicone oil are quite prevalent here ... Because of the general poverty of trans people in my country, because they cannot afford gender-affirming surgery in either public or private [health systems], they opt to get illegal injections from quacks.”

Young transgender woman, Indonesia⁽¹²¹⁾

“Transgender female youth who have had gender-affirming operations need specialized services – yet often health-care providers (treat) them as male sex workers and not as transgender people.”

Young transgender person, Asia-Pacific region⁽¹²²⁾

Stigma and discrimination by service-providers

Participants in the community consultations identified discrimination by health-service providers as one of the most significant barriers to accessing testing, treatment and care.^(123, 124) Young transgender people may fear having their gender identity divulged to others by health-care providers. Those who are open about their gender identity may be denied health services. Some patients report being refused HIV treatment by doctors who clearly disapproved of their transgender identity.⁽¹²⁵⁾

“When we go to the doctor, first of all the doctor will give a smile ... then they will make sarcastic remarks, ask strange questions and make us feel embarrassed.”

Young transgender person, Pakistan⁽¹²⁶⁾

Lack of capacity among health-care providers

Where services are available, providers often do not have experience of working with young people, or the knowledge to deal with health issues specific to transgender people. ⁽¹²⁷⁾ Some transgender women are frustrated to find their sexual and reproductive health concerns conflated with those of MSM, or feel that they must educate health-care

providers about their needs. They also express concern about the lack of guidance from health-care professionals regarding interactions between HIV treatment and hormone therapy.⁽¹²⁸⁾

US-based studies have shown that transgender people who have had negative experiences with health-care providers tend to avoid accessing health care in the future.^(129, 130) Services which are not acceptable to transgender people fail to provide effective HIV prevention, treatment and care to this population.

“The government services are not free or friendly for transgender youth. If you walk into a hospital, they call you ‘Mr’. I have long hair and they are not sensitive [to my gender identity].”

Young transgender person, Thailand⁽¹³¹⁾

SERVICES AND PROGRAMMES

Around the world, programmes with young transgender people are being implemented by governments, civil-society organizations and by organizations of transgender people themselves. Relatively few have been fully or independently evaluated, but the elements of a number of promising programmes are presented briefly here as examples of

how the challenges in serving young transgender people may be addressed. These examples are illustrative and not prescriptive. They may not be adaptable to all situations, but they may inspire policy-makers, donors, programme-planners and community members to think about effective approaches to programming in their own contexts.

Creating a welcoming environment for young transgender people

Health Outreach to Teens (HOTT), Callen-Lorde Community Health Center, USA

- The HOTT programme in New York City serves lesbian, gay, bisexual, transgender and queer adolescents, homeless or unstably housed youth, and those living with HIV/AIDS, through an on-site medical suite and a mobile medical unit. HOTT provides acute and primary care, mental-health services, HIV testing, case management and health education.
- Around 11% of the 1,100 young people receiving services in 2013 identified as transgender, many of them being people of colour, homeless or at risk of homelessness, and facing other psychosocial stressors. To engage and support these youth, the programme provides a trans-affirming environment, provides free care and ensures rapid access to appointments, monitors risks and resiliencies, and connects youth to preventative services using a harm-reduction approach.
- To provide a trans-affirming environment, all HOTT staff (medical providers, nurses, case managers and HIV testers), many of whom identify as lesbian, gay, bisexual or transgender, are trained in transgender-competent service provision. Trans-inclusive programme literature and health education materials are available. Providers use a harm-reduction, trauma-informed approach to care, show clients how to manage transphobia in multiple environments (e.g., in workplace and correctional settings), and teach them self-harm prevention strategies. HOTT's weekly transgender women's support group, "The Girls Room", successfully engages this hard-to-reach population and provides a safe space to explore and support transition. A Youth Advisory Board and The Girls Room provide feedback on transgender services, and annual clinic-wide surveys evaluate services.

Website: www.callen-lorde.org/our-services/hott/

Training young key populations in leadership and advocacy

Youth LEAD, Asia-Pacific region

- In 2011, Youth LEAD, a regional network of and for young key populations in 20 countries across Asia and the Pacific, created NewGen Asia, a five-day leadership course for young key population leaders. The course was developed over a period of a year by a technical working group supported by young key populations, leaders of Youth LEAD, academic experts and United Nations partners.
- The NewGen curriculum uses a range of participatory activities to build capacity to understand the personal, familial, institutional, structural and cultural influences that lead to HIV vulnerability; improve personal leadership strengths and skills for teamwork; develop presentation and public speaking skills on sexual and reproductive health, HIV and related issues; and understand and use data and evidence to inform advocacy. More than 200 young key population members have participated in NewGen training in Bangladesh, Brunei Darussalam, Indonesia, Myanmar, Philippines and Sri Lanka. More than 50 trainers have been trained regionally, and NewGen courses are planned for Cambodia, China and Thailand.
- All stages of programme development were evaluated through multiple methods, including rapid feedback through video interviews of consenting participants; focus group discussions; in-depth interviews; and pre- and post-course evaluations. The Indonesia National AIDS Commission has adopted NewGen to train peer educators nationwide, and the International HIV/AIDS Alliance has integrated the training into its LinkedIn programme for young key populations on sexual and reproductive health. New community networks of young key populations have since been established in several countries, including Myanmar, and social media are used to sustain connections and support for participants.

Website: www.youth-lead.org

Promoting healthy transitions among young transgender people

Silueta X Association, Ecuador

- Faced with the absence of an integral health policy covering the specific needs of the transgender population, and a lack of experienced and specialized health-care providers, the Silueta X Association started a programme to promote health among young transgender people and prevent the health risks involved in non-professional feminizing hormone regimens.
- A participative process was followed to design a project to meet demand for information regarding transition. Because doctors and nurses in the public-health sector would not facilitate workshops at times when transgender community members were available, the project used a private-sector doctor and an Ecuadorean endocrinology specialist based in Chile to train the Association activists and the target group. Around 160 transgender people aged 15–29 years benefited directly. Existing peer communication was the main strategy to spread the word about the programme, via invitations on social networks and other virtual communication channels. This allowed the project to identify a new generation of potential users of feminizing hormone regimens.
- Education on the risks of feminizing hormone regimens is still needed, including with other organizations of transgender people in Ecuador. After project funding ended, Silueta X continued to incorporate information on proper feminizing hormone regimens as part of its training for those involved in HIV prevention, as well as in recreational and social events, such as beauty pageants.

Website: www.redsiluetax.wordpress.com/la-institucion/

Addressing self-stigma through an awareness campaign

Youth Voices Count, Asia-Pacific region

- “Loud and Proud” is a regional advocacy campaign led by Youth Voices Count, addressing the issue of self-stigma and highlighting its links to the HIV vulnerabilities faced by young transgender people and MSM in Asia. Through the campaign, Youth Voices Count aimed to draw attention to the need for more timely services that tackle psychosocial issues and promote self-acceptance, self-confidence and health-seeking habits for young transgender people and MSM.
- The campaign took place in four countries – Indonesia, Mongolia, Philippines and Viet Nam – and featured a series of in-country activities, community-friendly events and the production of four short videos. “Loud and Proud” built the capacity of young transgender people and MSM to do advocacy using multimedia platforms and to leverage high-tech and social networks.
- A core working group identified priority countries for the campaign and allocated a budget of approximately US \$1,000, as well as a small amount of additional funding for community events and activities. The campaign was launched to coincide with the International Day against Homophobia and Transphobia. It was disseminated online using e-list servers and social media including Facebook, as well as through national partners. The videos were also displayed at a number of community events and international conferences.

Website: www.youthvoicescount.org

Involving young people in programme feedback

MCC New York Charities, USA

- MCCNY Homeless Youth Services provides emergency housing each night for 14 lesbian, gay, bisexual, transgender, queer or intersex young people aged 18–24 years. The programme is integrated with supportive services including HIV testing and counselling, mental health, medical care, syringe access, case management, anti-violence education and job training.
- Services are developed through conversations with programme clients, who are considered the experts on their own experience and understand the services they need. Staff attend a weekly “house meeting” where clients talk about successes as well as gaps in services. Programmes are then developed in response to these conversations. For example, after transgender participants expressed a need for reliable, ongoing access to health services, the programme arranged an on-site enroller to help them access benefits through the Medicaid programme. Transgender clients also expressed a need for hormone therapy, which led to a partnership with an HIV/AIDS coalition to take referrals for hormone initiation and maintenance without waiting lists.
- Focus groups are conducted annually with programme participants to evaluate services, and they are also encouraged to discuss programming needs with the executive director. Feedback is incorporated in programme monitoring and evaluation. Many clients have maintained contact with the programme as volunteers after moving on to other housing. Some have become street outreach workers, nutritional volunteers, facilitators for self-defence training, and even programme staff: the current HIV testing coordinator and case manager are former programme clients.

Website: www.mccnycharities.org

APPROACHES AND CONSIDERATIONS FOR SERVICES

A. CONSIDERATIONS FOR PROGRAMMES AND SERVICE DELIVERY

In the absence of extensive research on specific programmes for young transgender people, a combination of approaches can be extrapolated from health programmes deemed effective for young people or for key populations in general. It is essential that services are designed and delivered to take into account the differing needs and rights of young transgender people according to their age, experiences, specific behaviours, the complexities of their social and legal environment and the epidemic setting. The below considerations are largely focused on health programmes for young transgender people, but may also be relevant to other programme types, such as welfare, protection, care, justice, education and social protection.

1) Overarching considerations for services for young transgender people

- Acknowledge and build upon the strengths, competencies and capacities of young transgender people, especially their ability to express their views and articulate what services they need.
- Involve young transgender people meaningfully in the planning, design, monitoring, implementation and evaluation of services suited to their needs in local contexts.
- Fully utilize existing infrastructure and services, e.g., services for youth that have been demonstrated to be appropriate and effective, and add components for reaching and providing services to young transgender people.
- Ensure that health, welfare, child protection, education and social protection programmes and services are integrated, linked and multidisciplinary in nature, with a strong system for referral and the continuum of care, in order to ensure they are as comprehensive as possible and address the overlapping vulnerabilities and intersecting behaviours of different key populations.
- Ensure that there is sufficient capacity amongst professionals, particularly health workers, law enforcement officials, social workers and community

workers, to interact or work with young transgender people and apply rights-based approaches and evidence-informed practice.

- Partner with community-led organizations of youth and transgender people, building upon their experience and credibility with young transgender people.
- Build robust baselines, monitoring and evaluation into programmes to strengthen quality and effectiveness, and develop a culture of learning, evidence-based practice and willingness to adjust programmes accordingly.
- Give primary consideration to the best interests of the child in the design and delivery of all programmes and services for transgender children 10-17 years with appropriate and evidence-informed services in accordance with the CRC and other relevant international treaties, including HIV and sexual and reproductive health services.

2) Implement a comprehensive health package for young transgender people

As recommended in the WHO Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations:⁽¹³³⁾

- **HIV prevention** including condoms with condom-compatible lubricants, and post-exposure prophylaxis
- **Harm reduction** including sterile injecting equipment through needle and syringe programmes, opioid substitution therapy for those who are dependent on opioids and access to naloxone for emergency management of suspected opioid overdose
- **Voluntary HIV testing and counselling** in community and clinical settings, with linkages to prevention, care and treatment services
- **HIV treatment and care** including antiretroviral therapy and management
- Prevention and management of **co-infections and co-morbidities** including prevention, screening and treatment for tuberculosis and hepatitis B and C
- Screening, diagnosis and treatment of **sexually transmitted infections**

- Routine screening and management of **mental-health** disorders, including evidence-based programmes for those with harmful or dependent alcohol or other substance use.

Additional considerations for young transgender people to ensure provision of a wide range of health services addressing their multiple and overlapping vulnerabilities:

- Primary health-care services
- As yet, there is no WHO guidance on hormone or surgical therapy for gender affirmation. However, it is important that young transgender people have information and guidance about the risk of unsafe injections and potential drug interactions, and support and counselling related to these issues.
- Trauma and assault care, including post-rape care.

3) Make programmes and services accessible, acceptable and affordable for young people

- Offer community-based, decentralized services, through mobile outreach and at fixed locations, including outreach tailored to young transgender people who sell sex.⁽⁴⁾
- Ensure that service locations are easy and safe for young transgender people to reach.⁽¹³⁴⁾
- Integrate services within other programme settings such as youth centres, drop-in centres, shelters and youth community centres.
- Promote mobile Health staffed by trained operators, counsellors, and young people themselves, to provide developmentally appropriate health and welfare information to young transgenders, as well as the opportunity for referrals to relevant services.^(135, 136, 137)
- Provide developmentally appropriate information and education for young transgender people, focusing on skills-based risk reduction, including condom use and education on drugs (including non-injecting drugs), alcohol and links to unsafe sexual behaviour. Information should be disseminated via multiple media, including online, mobile phone technology and participatory approaches.^(75, 138)
- Provide information and services through peer-based initiatives, which can also help young people find appropriate role models. Ensure appropriate training, support and mentoring to help young transgender people advocate within their communities to support them in accessing services.⁽¹³⁹⁾
- Ensure that young transgender people have access to appropriate sexual and reproductive health information, regardless of their marital status and whether their parents/guardians consent,⁽¹⁴⁰⁾ and that medical treatment without parental/guardian consent is possible and effectively considered when in the best interests of the individual.
- Develop or strengthen protection and welfare services that help parents / guardians to fulfil their responsibilities to effectively protect, care for and support young transgender people, and in the case of transgender children (10–17 years) aim to reintegrate the children with their families, if in their individual best interests, or provide other appropriate living arrangements and care options in line with the 2010 UN Guidelines for Alternative Care.⁽¹⁴¹⁾
- Provide services at times convenient to young transgender people and make them free of charge or low-cost.⁽⁷⁵⁾
- Ensure that services are non-coercive, respectful and non-stigmatizing, that young transgender people are aware of their rights to confidentiality and that any limits of confidentiality are made clear by those with mandatory reporting responsibilities or those who would like to seek assistance for young transgender people.^(3,4)
- Train health-care providers on the health needs of young transgender people, as well as relevant overlapping vulnerabilities such as selling sex or drug and alcohol use.^(3,4)



Ensure that services are non-coercive, respectful and non-stigmatizing, that young transgender people are aware of their rights to confidentiality and that any limits of confidentiality are made clear by those with mandatory reporting responsibilities or those who would like to seek assistance for young transgender people.

4) Address the additional needs and rights of young transgender people, including:

- Primary health-care services including services for survivors of violence, including physical, emotional and sexual violence.
- Immediate shelter and long-term accommodation arrangements, as appropriate, including independent living and group housing.
- Food security, including nutritional assessments.
- Livelihood development and economic strengthening, and support to access social services and benefits.
- Preventing all forms of physical, emotional and sexual violence and exploitation, whether by law enforcement officials or other perpetrators, and promote community-led response initiatives.
- Support for young transgender people to remain in or access education or vocational training, and foster opportunities to return to school for out-of-school young transgender people.
- Psychosocial support through counselling, peer support groups and networks, to address the impact of self-stigma, discrimination, social exclusion, transitioning (where appropriate), or to address mental health issues. (5,9,75)
- Available counselling for families, including parents of young transgender people – where appropriate and requested – to support and facilitate access to services, especially where parent/guardian consent is required. (9,142)
- Access to free or affordable legal information and services, including information for young transgender people about their rights, and reporting mechanisms and access to legal redress. (5,78)
- Work toward the decriminalization of cross-dressing, same-sex behaviour,¹ sex work and drug use.
- In the context of children, uphold laws, administrative, social and educational measures to protect children from all forms of sexual exploitation, illicit use of narcotic drugs and other psychotropic substances as stipulated in the CRC (Annex 1) and defined in the relevant international treaties.
- Implement and enforce antidiscrimination and protective laws, based on human-rights standards, to eliminate stigma, discrimination, social exclusion and violence against young transgender people based on actual or assumed HIV status, gender identity or sexual orientation. (4,5,78,144)
- Work for the immediate closure of compulsory detention and rehabilitation centres. (145)
- Prevent and address violence against young transgender people², in partnership with youth-led and transgender-led organizations. All acts of violence and harmful treatment – including harassment, discriminatory application of public-order laws and extortion³ – by law enforcement officials, should be monitored and reported, redress mechanisms established, (4,5,78) and disciplinary measures taken.
- Examine current consent policies to consider removing age-related barriers and parent/guardian consent requirements that impede access to HIV and STI testing, treatment and care. (3) Address social norms and stigma around sexuality, gender identities and sexual orientation through comprehensive sexual health education in schools, supportive information and parenting guidance for families, training of educators and health-care providers and non-discrimination policies in employment. (5,48)
- Advocate for removal of censorship or public-order laws that interfere with health promotion efforts. (78)
- Include relevant programming specific to the needs and rights of young transgender people in national health plans and policy, with linkages to other relevant plans and policies, such as those pertaining to the child protection and education sectors.

B. CONSIDERATIONS FOR LAW AND POLICY REFORM, RESEARCH AND FUNDING

1) Supportive laws and policies regarding young transgender people

- Work for the legal recognition of an individual's chosen gender identity. (5,145)

1 Same-sex behaviour may be criminalized under laws against homosexuality, anal sex, "sodomy", "unnatural sex" or other terms.

2 Protect transgender children from all forms of sexual exploitation and sexual abuse, criminalizing all forms of sexual exploitation including the offering, obtaining procuring and providing of children for sexual exploitation, in line with international law.

3 Ensure that the rights of children survivors and witnesses are safeguarded and that children are exempted from arrest and prosecution. Children should be treated as survivors and not as offenders, and not be placed in unlawful or arbitrary detention, and be designated with an appropriate legal guardian or other recognized responsible adult or competent public body when identified or placed in any shelter or other care facility

2) Strategic information and research, including:

- Population size, demographics and epidemiology, with disaggregation of behavioural data and HIV prevalence by age group.¹
- Evaluate the effectiveness of programmes addressing issues of young transgender people, especially services offered by transgender-led organizations.
- Research on the impact of laws and policies upon access to health and other services for young transgender people. (78)
- Involvement of young transgender people, including those who are children 10–17 years, in research activities, in a safe and ethical manner, to ensure that

they are appropriate, acceptable and relevant from the community's perspective.

3) Funding

- Increase funding for research, implementation and scale-up of evidence-informed initiatives addressing young transgender people.
- Ensure that there is dedicated funding in national plans for HIV, child protection, and sexual exploitation of children for programmes that target young transgender people, and for programmes that address overlapping vulnerabilities.
- Recognize overlapping vulnerabilities of key populations in funding and delivery of services.

¹ In some circumstances, determining population size estimates or mapping key populations can have the unintended negative consequence of putting community members at risk for violence and stigma by identifying these populations and identifying where they are located. When undertaking such exercises, it is important to ensure the safety and security of community members by involving them in the design and implementation of the exercise. This is especially important with regards to children, who are particularly vulnerable to abuse, neglect, violence and exploitation. For more information see Guidelines on Estimating the Size of Populations Most at Risk to HIV by the UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance (Geneva: World Health Organization, 2010).

ANNEX 1. THE UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD (1989)

The Convention on the Rights of the Child (CRC) is the most widely and rapidly ratified human rights treaty in history. Ratification of the CRC signifies an agreement by the State to be legally bound by the terms of the Convention, to undertake “all appropriate legislative, administrative and other measures” for the full realization of the rights it contains, and to report on these measures to the Committee on the Rights of the Child.

While children have the same general human rights as adults, the CRC enshrines additional rights for children out of recognition that children (people under 18 years of age) require unique forms of care and protection that adults do not.⁽¹⁴⁶⁾ The CRC has four guiding principles, which represent the underlying requirements for any and all rights to be realized. These are: non-discrimination (Article 2), with the Convention applying to all children everywhere; the best interests of the child (Article 3), which must be a primary consideration in all actions concerning children; the right to life, survival and development (Article 6), in order that they can survive and reach their full potential; and respect for the views of the child (Article 12), recognizing that children have the right to express their views and have them taken into account according to their age and level of maturity.

Like all human rights, child rights are indivisible and interrelated, meaning that the CRC places an equal emphasis on all rights for children, that no hierarchy of rights exists, and that the deprivation of one right adversely affects the others. However, in relation to the **children at particular risk of HIV**, there are particular rights that deserve special mention. The right to health, as articulated in Article 24, obligates States parties to ensure that no child is deprived of his or her right of access to necessary health services, stressing “the right of the child to the enjoyment of the highest attainable standard of health and to facilities for treatment of illness and rehabilitation of health”. The Committee on the Rights of the Child General Comment No. 4 on *Adolescent health and development in the context of the Convention on the Rights of the Child* highlights that Article 2, on the right to enjoy all rights without discrimination, “also cover adolescent’s sexual orientation and health status (including HIV/AIDS and mental health).”

The Committee further notes that all adolescents who are discriminated against are more vulnerable to violence and exploitation, and that their health and development are placed at further risk.

Further, General Comment No. 3 on HIV/AIDS and the *Rights of the Child* emphasizes that effective HIV/AIDS prevention requires States to refrain from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, and that, consistent with their obligations to ensure the right to life, survival and development of the child (Article 6), States parties must ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality. The Committee also points out that children are more likely to use services that are friendly, supportive, wide-ranging, geared toward their needs, give them the opportunity to participate in decisions affecting their health, are accessible, affordable, confidential, non-judgmental, do not require parental consent and are non-discriminatory.

Regarding the particular issue of the **sexual abuse and exploitation of children**, Article 19 of the CRC states that States Parties shall take “all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment or exploitation including sexual abuse while in the care of parent(s), legal guardian(s) or any other person who has the care of the child”. Article 34 specifically protects children from all forms of sexual exploitation and sexual abuse, including the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of children in prostitution or other unlawful sexual practices; and the exploitative use of children in pornographic performances and materials. The CRC also guarantees children survivors of sexual exploitation the right to receive appropriate assistance and support. Article 39, with supporting provisions contained elsewhere in the CRC, emphasizes that States Parties should take all appropriate measures to ensure that child survivors of exploitation are provided with recovery and reintegration, which “take place in an environment which fosters

the health, self-respect and dignity of the child." The Optional Protocol to the CRC on the sale of children, child prostitution, and child pornography (2000) enhances the protection of children from sale, prostitution and child pornography, requiring State Parties to criminalize all forms of sexual exploitation of children and adopt appropriate measures to protect the rights and interests of child survivors.¹

Finally, the Committee on the Convention of the Rights of the Child has highlighted in General Comment No. 4 on Adolescent Health and Development that children in sexual exploitation are exposed to significant health risks, including STIs, HIV/AIDS, unwanted pregnancies, unsafe abortions, violence and psychological distress, and that States parties must provide them with appropriate health and counselling services, "making sure that they are treated as victims and not as offenders." (147)

¹ The rights of children to protection from sexual exploitation, and the obligation of States parties to prohibit such crimes, are also reflected in other international treaties, including the International Labour Organization's Convention No. 182 on the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour (1999) and the Protocol to prevent, suppress and punish trafficking in persons, especially women and children (2000), supplementing the UN Convention against Transnational Organized Crime.

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