Phylesha Brown-Acton

Co-Chairperson, Asia Pacific Transgender Network (APTN)

Human Rights Council Social Forum

Palais Des Nations, Geneva

Date: 2 October 2017, Time: 16h30

Panel: ***“Leaving no one behind: Discrimination and the realization of the right to health”***

Moderator, thank you for the opportunity, I must state I’ve heard very few mentions of trans or indigenous people’s today and I am feeling invisible here***.***

Chairperson, Moderator, Fellow panelists, Friends and Allies,

<Formal greeting in the Niue Island language>

Fakaalofa lahi atu, kia tautolu oti,

Moderator, many statistics about trans people are discussed in these spaces. Our bodies, our stories, our voices are often reduced to a single statistic. We have likely all heard that trans women carry 49 times the HIV burden compared to the general population. This number is terrifying, of course, but as the only number we know, it leaves many unanswered questions.

I ask, what does it mean in the everyday lives of trans people?

How do we change it?

What are we missing when we focus on HIV burden alone?

Health metrics for trans communities very regularly come down to HIV burden, and we talk endlessly about the need to generate disaggregated data on trans people. These issues are important, but for trans people in accessing our right to the highest attainable standard of mental and physical health, a much broader and more nuanced discussion is needed.

Two weeks ago, my organization, the Asia Pacific Transgender Network, hosted the first-ever regional trans health conference in Asia. There were delegations from more than 15 countries, with nearly every country sending trans community members as well as healthcare providers, government officials, and members of national human rights institutions. From this conference came action plans for each country on improving health metrics for trans populations, but what we also were able to do was collect baseline data on access to health in 16 countries across South Asia, Southeast Asia, East Asia, and the Islands of Southeast Asia. These data were, put shortly, bleak.

In 75% of the countries in our mapping, trans people indicated having access to trans-competent sexual and reproductive health care - typically this appears to have grown from the HIV response in the region, with trans women often the focus of targeted programming. However, in only half of responding countries were trans people able to access trans-competent general or mental health care.

In 11 of 16 countries, trans people had some access to hormone therapies, but only 8 had infrastructure for continuing care and hormone monitoring. While access levels seem high, all too often this access comes through informal economies, exposing trans people to fake hormones, word-of-mouth information on dosages only, and increased risk of heart, liver, immunological, and other health risks as a result.

Gender affirming surgeries were available in 9 countries in our mapping, but in only 4 of those did trans people report that the surgeries were both affordable and of high quality. This means that 75% of responding countries place trans people at risk of poorly-regulated or high cost surgeries, or even no surgery options at all.

I’ve provided you with these data to start to answer the question: how can the Human Rights Council and other human rights mechanisms help in our work to improve the lives of trans and indigenous people?

Fundamentally, as the Special Rapporteur on the right to health, Dr. Dainus Puras, has highlighted, access to health is a complex issue, and the most important role, I believe, that the Human Rights Council can play is to continue to question the boundaries of the right to health. If I am able to access a hospital that is affordable, but I risk exposure to transphobia, anti-trans violence, or even death, does that mean that I can fully exercise my right to health? Surely not.

If I am able to access trans-competent health care - with both trans clinical ***and*** trans cultural competency - but I must travel far from home, pay entirely without insurance coverage or subsidies, or must save money for years to be able to afford the procedures that I need, does that mean I can fully access my right to health? Again, surely not.

APTN, in our work on the right to health for trans people and communities, desperately needs the support of international human rights mechanisms to affect change. We need trans-positive interpretations of human rights law and jurisprudence, we need strong commitment to enforcement of international obligations, and we need space for our voices throughout the process. How many trans people are part of the missions that make up the UN Offices in Geneva? And how many of those people will have the opportunity to sit as official representatives on UN treaty bodies, as UN special rapporteurs, or as the executive of the Human Rights Council?

Moderator, I speak about trans and indigenous peoples hand in hand, as it is important to recognize that trans people exist in countries also with their own indigenous identity terms, such as fa’afafine in Samoa and American Samoa, Mahu in Hawaii, Palopa in Papua New Guinea, Kathoey in Thailand, Leiti in Tonga, Takatāpui – Tāhine in Aotearoa – New Zealand and so on. When we fail to use these indigenous identities or terms in the language we use at forums like this and in documents, we fail to acknowledge the very existence of these trans peoples in their respective countries, when we fail to acknowledge indigenous terms in declarations, systems, mechanisms and processes it gives permission to framing trans peoples in ways that are not relative, demeaning and dehumanizing to them, such as referring to trans women as men or as men who have sex with men. Continued exclusion or non-acknowledgment of these indigenous terms prohibit effective country responses and mechanisms and sets up failure in seeing fast track targets from ever being fully reached.

Moderator, the lack of data on indigenous and trans people’s, is not a legitimate excuse to ignore the existence of indigenous and trans people’s, as long as we are not counted we will continue to be invisible and indigenous and trans people’s will be the 10-10-10 of your fast track targets, someone or some groups will be left behind, please let this not be the case for indigenous and trans people’s.

**When I look toward a future** in which trans people have full access to our right to the highest attainable standards of mental and physical health, the world I see has trans doctors, trans nurses, and trans patients; trans legislators, trans judges, trans lawyers, trans researchers and trans scientists.

The system that keeps so many of us from positions of authority or power, starts young, and that is where we need the most help to achieve a brighter future and success for the right to health for trans and indigenous peoples globally.

Our youth and our elders, our families, our poor and our indigenous, our people of color, our people living with HIV/AIDS and our people with disabilities live at risk, while the most privileged of us are allowed perhaps 5-7 minutes to speak in a space such as this.

Thank you.