“Transgender” is an umbrella term that encompasses many different identities, experiences, and ways of expressing gender. Although transgender communities are diverse and complex, one thing that they have in common is that transgender people are people whose gender identity and gender expression do not match social expectations for the sex that they were assigned at birth.

HIV has had a significant impact on transgender communities, but lack of attention to the existence and concerns of transgender people in research and data collection has hampered efforts to serve this community’s HIV prevention and treatment needs better. More recently, there has been a widespread effort to understand and appropriately address the needs of transgender people—especially women—living with or at risk for HIV.

This issue of Perspectives examines how transgender people have been ignored in some key areas of HIV research and service provision. It also discusses how this trend can be reversed—in part through improved methods of data collection. We will review the available research on transgender people and their risk for HIV, and will examine the factors, especially social factors, that put people in this community at especially high risk. Finally, we will discuss some of the ways that HIV service providers can provide a sensitive and welcoming environment for transgender clients, particularly in the arena of HIV testing.

Most research on HIV infection in the transgender community has studied HIV among transgender women, and researchers believe that infection rates are much higher among transgender women than among transgender men.1 For these reasons, this article focuses primarily on the social factors that increase HIV risk for transgender women. The second article in this issue, “What About Transgender Men?” [Page 12] explores what we know about HIV and its prevention among men in this community.

Overcoming Invisibility in Research

The dearth of research on the impact of HIV on transgender people is due in part to the difficulties in studying this community. There are no reliable estimates of the size of the U.S. transgender population, and, because of stigma or for other reasons, many transgender individuals do not wish to be identified as transgender.2 It is also due in part to the failure of many research, surveillance, and government organizations to attempt to count transgender people.

Until recently, many agencies did not keep categorical statistics that would define the scope of the HIV epidemic in the transgender community. For example, in 2011, the Centers for Disease Control and Prevention (CDC) announced that it was revising its practice of counting transgender women as “men who have sex with men” in reporting the impact of HIV on different populations.3

This invisibility has prevented policymakers from accurately gauging the need for transgender-specific HIV interventions, because programs are typically targeted to and funded for the most affected groups. Furthermore, lumping transgender women together with men who have sex with men means that interventions are misdirected from the start—since transgender women don’t identify as men. It is also incredibly invalidating of a person’s gender expression to categorize them as a member of a gender with which they do not identify.
Some Terms to Get Started

Here are a few terms that you may hear or see that can relate to transgender experience. Since transgender communities are diverse, people define terms in different ways—perhaps differently from what you see here. Stay client-centered, and ask which term the person in question prefers that you use. Remember that “transgender,” “transsexual,” and “trans” are adjectives, not nouns. That means that you would not want to refer to a person as “a trans,” “a transgender” or “a transsexual.” Rather, you would say “a trans man,” “a transgender woman,” or “a transsexual person.”

**Gender Identity:** A person's own concept of whether they are male or female or another variation of gender. This can be different from biological sex—which is based, for example, on the shape of a person’s genitals or their sex chromosomes.

**Gender Binary:** The idea that there are only two genders, male and female, and that they represent “opposite” sexes.

**Gender Spectrum:** Sometimes called the “inclusive gender model,” this is the idea that gender is more complex and varied than a simple division of opposites between male and female—that there is a potentially infinite variety of gender.

**Gender Presentation:** The expression of gender. People may present or express gender in a variety of ways that may or may not correspond with their gender identity. If a person says they are transgender, the gender they are expressing through their dress, hairstyle, mannerisms, or other behaviors may or may not correspond to the gender an observer might perceive through their presentation. Most people who are NOT transgender dress and comport themselves in ways that reinforce their gender identity. Transgender people usually do the same, but often they are unable to do so without social and/or medical support.

**Gender Variant:** Gender behavior or expression that does not conform to dominant gender norms. For example, men who are (or are perceived as) feminine, and women who are (or are perceived as) masculine.

**Assigned Gender or Birth Gender:** The gender that doctors or others gave to a person at birth. Usually, this is the gender that the person was raised with before coming out as trans.

**Transgender:** An umbrella term for people whose gender identity and expression do not conform to norms or expectations for the sex they were assigned at birth.

**Transsexual:** People who identify with a gender different from the one they were assigned at birth. Some use this term only to refer to those who have had or intend to have genital reassignment surgery, but for others the term includes those who have not had surgery.

**Trans:** The abbreviated term for “transgender” or “transsexual.”

**Genderqueer:** One who defies or does not accept stereotypical gender roles and may choose to live outside expected gender norms. Genderqueer people may or may not avail themselves of hormonal or surgical treatments.

**Transgender Woman:** A trans person who identifies herself and understands herself to be a woman. She may also refer to herself as male-to-female, M-to-F, or MTF.

**Transgender Man:** A trans person who identifies himself and understands himself to be a man. He may also refer to himself as female-to-male, F-to-M, or FTM.

**Transphobia:** Stigma, hatred, fear, violence, or discrimination directed at a person or people because they are transgender or gender nonconforming.

**Self-Identified Gender:** The gender a person feels most comfortable identifying with.

**Sexual Orientation:** The way a person identifies their sexual desires, feelings toward other people of the same or different genders from oneself. Gay, lesbian, bisexual, queer, and straight are all examples of how people might identify their sexual orientation.


Sometimes people wonder what the difference is between the terms “transgender” and “intersex.” Here’s a slightly adapted version of the explanation from the Intersex Society of North America:

**Intersex:** A general term used for a variety of conditions in which a person has a reproductive or sexual anatomy that does not seem to fit the traditional definitions of female or male. For example, a person might be born with genitals that look female on the outside, and also have mostly male anatomy inside their body. Or a person might have genitals that have both typically male and female features, such as a girl with a larger-than-usual clitoris, no vaginal opening, or a boy with a very small penis and a scrotum that is divided, shaped similar to labia. Some people have both male (XY) and female (XX) genes. Often the condition is discovered at birth, but sometimes it becomes apparent during puberty. People who have intersex conditions have anatomy that is not considered typically male or female. Most people with intersex conditions come to medical attention because doctors or parents notice something unusual about their bodies. In contrast, people who are transgendered have an internal experience of gender identity that is different from most people. (http://www.isna.org/faq/transgender)
Sensitivity to the health concerns of transgender people begins by acknowledging their existence, naming their gender expression respectfully, and assessing their needs. Yet historically, most data collection forms have ignored and denied the existence of trans people—there is literally no place for them on intake or medical history forms that offer only the choices “male” and “female.”

That is not to say that all transgender people identify as transgender. For example, a transgender woman may identify simply as a woman. In addition, fear of marginalization prevents some people from identifying as transgender. However, it is still important to ask about gender in a way that is open enough to provide valuable information to treating professionals, and that lets transgender clients know that they are seen, that they are welcomed, and that their provider is somewhat knowledgeable about gender diversity, so that the client can feel comfortable sharing information.

In response to recommendations for collecting data from transgender people, the CDC is currently revising the national system for reporting HIV cases to capture sex assigned at birth and current gender identity. This will improve the likelihood of accurately identifying diagnoses of HIV infection among transgender people.

As early as 2001, researchers in San Francisco noted that the HIV rates among transgender women in that city were higher than those of any other risk group at the time. The state of California began collecting data on transgender-identified HIV testers at publicly funded testing sites in 2002, and by 2003 researchers found that transgender-identified testers had a far higher rate of HIV diagnoses (6.3 percent) than other risk categories, including men who have sex with men (4.2 percent) and partners of HIV-positive people (4.8 percent). In other words, more than one in four transgender women in these studies was HIV-positive. In contrast, the HIV prevalence rate for the U.S. population as a whole between 1999 and 2006 was .47 percent—or one in every 212 people.

The CDC began collecting transgender-specific testing data for the year 2008. Data collected by the CDC from its HIV testing programs nationwide show that in 2009 (the

**Figure 1: How to Accurately Capture Data on Trans Clients**

We strongly encourage the use of a two-question method to accurately collect data. Change ALL intake forms in the agency to contain at least the following two questions:

1. **What is your current gender? (Check all that apply)**
   - Male
   - Female
   - TransMale/Transman
   - TransFemale/Transwoman
   - Genderqueer
   - Decline to State
   - Additional Category (Please Specify): ________________________________

2. **What sex were you assigned at birth?**
   - Male
   - Female
   - Decline to State

This may be more information than your funders require. But we want to encourage you to collect such information since it is better to collect more information in order to capture the data correctly, communicate inclusivity to your clients, and accurately reflect the clients you are serving. This extra information can be condensed later for reporting purposes.

Reproduced from http://transhealth.ucsf.edu/tcoe?page=lib-trans-count
latest year for which statistics were available), new HIV infections were three times more common among transgender testers than among non-transgender men, and almost nine times more common than among non-transgender women. The highest percentages of new infections are among Black and Latino transgender people, mirroring the impact of HIV on communities of color in general.

**Discrimination in Employment**

In addition to noting the impact of the interaction of race and gender, most research on HIV infection in the transgender community has highlighted the social factors that make transgender women especially vulnerable. At the top of the list of hardships that many transgender people face is the problem of pervasive stigma and discrimination because of their gender identity. In a 2011 national survey of more than 6,000 transgender respondents, 63 percent of participants reported a “serious act of discrimination,” such as having been terminated from a job, evicted from housing, bullied at school, physically and sexually assaulted, or rejected by family due to their gender expression. Often this discrimination falls especially heavily on people whose gender identity does not match social expectations for their visible physical characteristics—for example, a tall, large-boned, “masculine” transgender woman, or a short, slight, “feminine” transgender man with breasts.

Researcher Walter Bockting notes that discrimination in educational and employment settings severely undercuts the job prospects of transgender individuals. Some people are afraid to be open about their gender identity as job applicants, and some fear taking on a gender role transition at work because of fear of job repercussions. These fears are not unfounded: many people have lost their jobs after coming out as transgender.

## Figure 2: HIV Incidence by Gender

**Percentage of HIV-Positive Test Results at CDC-Funded Test Sites 2009**

The length of each bar in the graph below represents only the percentage of people with HIV within that population. The bars do not compare actual numbers of people with HIV. The chart shows three things: 1. Transgender populations have much higher HIV incidence rates than non-transgender populations. 2. Disproportionately high rates of HIV in Black and Latino transgender populations match disproportionately high HIV rates among all testers in these communities. 3. The bars represent percentages—very important for allocating HIV care and prevention resources—but longer bars do not necessarily represent more people.

### ALL TESTERS

- **Transgender Testers**: 2.6% HIV+
- **Non-Transgender Male Testers**: 0.9% HIV+
- **Non-Transgender Female Testers**: 0.3% HIV+

### BLACK TESTERS

- **Black Transgender Testers**: 4.4% HIV+
- **All Black Testers (incl. Transgender)**: 0.8% HIV+

### LATINO TESTERS

- **Latino Transgender Testers**: 2.5% HIV+
- **All Latino Testers (incl. Transgender)**: 0.6% HIV+

### WHITE TESTERS

- **White Transgender Testers**: 0.7% HIV+
- **All White Testers (incl. Transgender)**: 0.5% HIV+

This lack of employment options makes it more likely that some transgender people will take part in sex work. And for transgender people, both sex work and unemployment are associated with HIV infection. At the same time, it is important to remember that the media stereotype that all transgender women engage in sex work is inaccurate, and ignores the complexity, diversity, and resilience of transgender women.

Health Care Barriers

Access to adequate and appropriate health services is also a challenge. Health insurance is often associated with employment—thus, unemployment undercuts the ability to access health care. Even transgender people with access to medical professionals face substantial obstacles in obtaining appropriate care. For example, transgender-specific health care—such as hormone therapy, and reconstructive surgery on breasts or genitals—can be expensive, difficult to obtain, and is often not covered by insurers.

In the 2011 survey of 6,000 transgender people cited above, 19 percent of participants reported being refused some type of medical care because of their gender nonconformity, while 50 percent of those surveyed reported having to teach their doctors about transgender care. Twenty-eight percent of respondents reported that they postponed medical care when they were sick or injured because of discrimination or concerns about discrimination, while 48 percent said they postponed accessing health care when they needed it because they could not afford it. Delays in seeking care are associated with poor health outcomes. People who have had negative experiences with the health care system may also be less likely to seek preventative services, to disclose their transgender status to their physician, or to share other concerns about their sexual or overall health.

Mental Health and Mental Health Care Concerns

As a result of trauma, harassment, and the other social factors described above, many transgender people experience problems with anxiety, and depression, and other mental health concerns, and many use substances as a means of coping with distress. All of these problems are associated with behaviors that can transmit HIV.

Rates of reported substance use and abuse in transgender communities are often high. In the 2008 meta-analysis by Herbst cited above, almost 40 percent of participants reported sex while drunk or high, and about 12 percent reported injecting street drugs including drugs like heroin and crack.

Substance use can be related to HIV risk in a variety of ways—because people may exchange sex for drugs or money to buy drugs; because sex under the influence sometimes makes negotiating safer sex more difficult; because people are more likely to have unprotected anal sex; and because of needle sharing. Herbst, et. al’s meta-analysis found that although 25 percent to 27 percent of participants reported injecting hormones or silicone, and 12 percent reported injecting street drugs, only 2 percent reported sharing needles when injecting street drugs, and only 6 percent when injecting hormones or silicone.

In one study of transgender adults in the United States, more than one-third of respondents reported anxiety, and 44 percent reported depression, with transgender women reporting significantly higher levels (49 percent) of depression than transgender men (37 percent). High rates of loneliness, social isolation, and emotional distress have also been reported, as well as suicidality. In Herbst’s 2008 meta-analysis cited above, 31 percent of transgender participants had attempted suicide, and 54 percent reported having suicidal thoughts.

Clearly, mental health care that addresses these issues, is affirming of transgender identity, and that fosters the resilience necessary to overcome the challenges of social stigma and discrimination is critically important. Historically, however, the transgender community has had a complicated relationship with the psychotherapeutic field.

One of the myths that transgender people must often confront is the idea that simply being transgender means that they are mentally ill or disordered in some way. Many believe that this notion is bolstered by the inclusion of Gender Identity Disorder (GID) in the current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). At the same time, a diagnosis of GID is often required for people to receive access to transgender-specific care. Further, mental health evaluation is often a requirement for transgender individuals to obtain hormone therapy and gender-confirmation surgery. Supportive mental health
treatment can offer great benefit, including the potential to reduce risk for HIV, as long as providers are culturally competent, and treat the problem that is causing distress, rather than treating transgender identity as the problem.

**Relationship Challenges and HIV Risk**

We know that for transgender women, HIV-related sexual risk often occurs within the context of a relationship with a primary male partner—which is also true for non-transgender heterosexual women, and for non-transgendered gay men. Intimacy, trust, and love are key reasons that many people of all gender identities choose to engage in unprotected sex. In addition, though, the social marginalization of transgender people can work against an individual’s ability to find partners and engage in healthy relationships. For example, if a transgender woman believes that the number of men willing to be in a relationship with her is quite limited, she may have difficulty negotiating condom use if her partner is at all resistant, out of a fear of rejection.

These fears may be even more acute if the transgender woman has experienced the loss of other relationships, such as friends and family, and now relies primarily on her male partner for emotional support or financial support. Also, being recognized as a woman sexually and having a male partner may each be affirming of a transgender woman’s feminine identity—affirmation that may be difficult to come by in other contexts. Rosser (1998) found that some transgender people were reluctant to talk openly with partners about sex because they did not want to draw their partners’ attention to their genitals, and some did not set limits with sex partners out of a desire for identity validation as a member of their self-identified gender.

All of this means that the mandate to talk about safer sex isn’t as easy as it sounds, especially for many transgendered people. Researcher Kami Kosenko of North Carolina State University states that when researchers talk about sexual communication and HIV prevention, they focus primarily on asking partners about sexual history and trying to persuade partners to use a condom. As a result, there has been an emphasis on the importance of communication around HIV without an understanding of how complex that can be, or explanation of what effective and satisfying “safer sex talk” really means to the people involved.

In a small study of 41 transgender people, Kosenko found that participants held multiple, often competing goals in safer sex conversations. These goals often include things like the desire to avoid embarrassment, the desire for intimacy or wish to avoid rejection, and the desire to protect one’s own health (for example, by using a condom or in some other way). The fact that these goals may be in conflict results in “communicative dilemmas.”

Participants talked about maintaining their own sexual safety in many different ways—preserving sexual health; preserving physical safety (like not getting beaten up by a partner); and preserving emotional health. Often these three safety goals were in conflict, so participants might focus on only one at a time, or avoid the topic of sex altogether. When they thought about “disclosure” to partners, many participants had much more concern about sharing their transgender identity than with comparing their HIV status with that of their partner.

** Syndemic Theory: Putting It All Together**

Many HIV risk factors have been identified among transgender women, including sex work participation, sex while using alcohol or drugs, needle sharing when injecting recreational drugs, hormones or silicone, and unprotected anal sex. At the same time, each of these “risk factors” occurs within a societal context that is shaped in part by discrimination and marginalization. Sex work participation is often the result of reduced educational and employment options. The use of alcohol or drugs before or during sex is sometimes related to the need to escape, or cope with, societal stigma, potential rejection, or the stress of doing sex work. Shared needles to inject hormones and silicone are usually an attempt to modify the body in
the desired way when the transgender person does not have access to appropriate, medically safe transition services. Unprotected anal sex can be related to pleasure, love, or trust with a partner, the desire to affirm one’s gender identity, or difficulty in negotiating safer sex boundaries.

Not only does societal stigma toward transgender people (as well as racism and poverty) relate to each of these factors individually, each risk factor is often intertwined with the others. For example, substance use can be a response to stigma, unemployment, and to mental health concerns. It can also reinforce these problems.

Together, the many threats to transgender health combine to create what researchers call a “syndemic”: a set of problems that occur together and amplify each other’s effects. Researchers Don Operario and Tooru Nemoto have argued that the combination of all of these co-occurring public health problems that transgender people experience inform the complexity of the HIV epidemic in transgender communities. They state that the violence and victimization that many transgender people experience from a young age can lead to HIV risk in both direct and indirect ways. For example, forced sex can lead to HIV and other STD exposure, and many forms of violence contribute to mental health problems and substance abuse, which are related to sexual risk behavior. In the 2011 survey of 6,450 transgender Americans cited above, 41 percent of respondents reported having attempted suicide, as compared with 1.6 percent of Americans as a whole. Rates were much higher, however, for those who had lost a job due to bias, who had been harassed or bullied in school, who were poor, or who had been the victim of physical or sexual assault.

Because the factors that contribute to high rates of HIV infection among transgender people (especially transgender women of color) are related to societal and interpersonal factors as well as individual behavior, it is important to attack these underlying problems on multiple levels. This requires advocacy to end the stigma and discrimination that discourage transgender people from obtaining education, employment and access to health care. Research programs that acknowledge and study the needs of transgender people are also needed, as are agency service environments that welcome and support transgender health. The rest of this article discusses ways that researchers, agencies, and HIV test counselors can make a difference in promoting the health and wellness of transgender people.

Telling people that they have to talk about safer sex can make communicating with partners sound easier than it really is. Sometimes people find that their goals for emotional, physical, and sexual safety are in conflict.

What Interventions Are Needed?

A variety of interventions at different levels are needed to nurture transgender health and to prevent HIV transmission in transgender communities.

More Transgender-Specific Intervention Research. Currently, there are no Evidence-Based Interventions supported by the Centers for Disease Control and Prevention (CDC) were developed specifically with transgender people in mind. The CDC reports “several behavioral HIV prevention interventions developed for transgender people.” Although “most have shown at least modest reductions in HIV risk behaviors, such as fewer sex partners and/or reducing unprotected anal sex acts,” the studies have been small and composed entirely or primarily of only transgender women, and none has included a control group. Culturally appropriate, transgender-specific interventions are needed and must be researched and created. Most have shown at least modest reductions in HIV risk behaviors, such as fewer sex partners and/or reducing unprotected anal sex acts, although none have involved a control group.

Appropriate Adaptations of Existing Research. Some existing interventions that were designed for use with other populations, however, have been or are being adapted for work in preventing HIV with transgender people.

For example, SISTA (Sisters Informing Sisters About Topics on AIDS) is an Evidence-Based Intervention designed to reduce behaviors that could result in HIV infection among straight, African American, non-trans women. It can be adapted for HIV prevention work with trans-
women of color (T-SISTA). Both the SISTA and T-SISTA interventions help support participants to experience a sense of community and pride as women of color, to increase confidence in their ability to have safer sex, and to build verbal and nonverbal communication skills. These goals are accomplished through group sessions and discussions, homework exercises, and sharing of HIV risk-reduction information. The Center of Excellence for Transgender Health has created a guide for agencies that want to create their own adaptations—their own T-SISTA interventions. You can read the resource guide at http://transhealth.ucsf.edu/pdf/TSISTAResourceGuide.pdf.

Some of the keys to adapting an intervention not specifically designed for transwomen include making sure that your agency is culturally competent and connected enough to serve the transgender community in your area; understanding that transgender women may share needles for hormone and silicone injection; understanding the pressure that transwomen face to validate their gender identity through sexual behavior; and understanding the ways that stigma, transphobia, and other societal factors increase transgender women’s risk for HIV.

Couples-Focused Interventions. Because we know that transgender women, like non-transgender women, are often exposed to HIV through unprotected sex with primary male partners, some researchers have argued that more effort should be put into developing appropriate couples-focused interventions with transgender women and these partners. These interventions can include testing for HIV as a couple, and couples behavioral counseling. Such interventions can only be effective if they acknowledge that sexual partnerships may exist outside the relationship, and explore what agreements about safer sex within and outside the relationship can be made. Counseling can address important communication issues, such as how to disclose concurrent sex partnerships, HIV status, and how to negotiate safer sex within and outside the relationship. All of these concerns demand a special sensitivity to these couples’ relationship concerns.

Structural Interventions. These are interventions that facilitate HIV prevention by making changes to the environment or context in

---

which HIV risk behavior happens. For example, for the reasons stated above, employment discrimination against transgender people can lead to economic hardship, lack of access to health care, and sometimes sex work. This means that when advances are made in transgender people's employment rights, their access to health care is improved, their economic status is improved, and their options for a variety of occupations that do not potentially expose them to HIV risk is increased. In addition, economic independence can lead to enhanced self-confidence and sense of power in relationships, perhaps making it easier to negotiate sexual safety and to believe that one is worthy of such safety. Further, having fewer survival concerns means that people have more energy to devote to long-term health care concerns such as avoiding HIV. Less social marginalization also means that people are less likely to use drugs and alcohol as a means of coping with isolation and rejection. Because most of the problems that transgender people face around HIV disease are related to society’s non-acceptance of them, the interventions that will best alleviate these problems are also societal in nature.

A Focus on Resilience. Much of the research that has been done on transgender communities focuses on the prevalence of diseases such as HIV, problems such as addiction or mental health concerns, or other challenges and vulnerabilities that transgender people face as a result of transphobia. Although these are important areas of study, it is also important to continue to develop and publicize models of transgender health and resilience. This means identifying factors such as family acceptance, mentoring, pride in transgender identity, and other forms of community building that help transgender people survive and succeed despite adversity. For example, a 2011 survey of 6,450 transgender participants found that family acceptance had a protective effect in human sexuality. These researchers believe that “when people become more comfortable talking about sex, more aware of their culture and identity, more positive about themselves (for example, their body and sexuality), their self-care is enhanced, and they are better able to practice safer

It is important to continue to develop and publicize models of transgender health and resilience—identifying the factors that help transgender people survive and succeed despite adversity.
care, healthy physical and psychological development, and non-HIV-related sexual health concerns.

**What Counselors and Agencies Can Do to Welcome Transgender Clients**

There are many ways that HIV service providers can create an environment that is welcoming, safe, and healthy for transgender clients. Below are a few ways to begin to offer transgender people a respectful service environment.

1. **Be honest with yourself first.** Notice your own biases, expectations, and assumptions related to gender, and to transgender people. Part of maintaining your neutral stance as a test counselor is making sure that any “baggage” you carry around doesn’t become your client’s problem. Your role is to respectfully support people who come in for testing in a client-centered way.

2. **Use materials that are welcoming and inclusive.** As mentioned above, intake forms that use the two-step method to ask about gender identity are a helpful start. Feature images of transgender people on your agency’s materials, advertisements, and in your agency setting.

3. **Offer gender-neutral bathrooms.**

4. **Employ transgender service providers.**

5. **Address people the way they want to be addressed.** Refer to people by the name (as long as they are not testing anonymously!), pronoun, and gender with which they identify. Ask if you are unsure.

6. **Don’t call people “pre-op” or “post-op” or ask if they are “pre-op” or “post-op.”** Not everybody wants surgery to change their bodies. Instead, if it is important for your discussion of potential HIV exposure, ask questions like “What kind of sex do you have?” “What parts go where when you have sex?” You might ask a transman who has sex with men, “What about ‘front sex?’” or ask a transgender woman “Are you ever the insertive partner in anal sex?”

7. **Remember that gender is a many-splendored thing.** Rather than assuming that there are only two genders (male and female), and two kinds of transgender people (male-to-female and female-to-male), understand that people can identify with or transition from any point on the gender spectrum to any other point on the gender spectrum. And for some people, gender identities may change over time.

8. **Remember that transgender people are as diverse as everyone else.** Don’t assume that gender identity is related to sexual orientation or sexual behavior. How you identify your gender, who you are attracted to, and who you have sex with are all individual matters. Similarly, while it is important to understand that there are several social factors that place many transgender people at increased risk for HIV, remember that not all transgender people are.

9. **Staff should receive training related to transgender health.**

---

**References for This Issue**


continued on the next page
to transgender concerns. It’s important that everyone, from the people staffing your hotline, to the receptionist greeting clients at the door, to the counselors conducting the session, to the security officers in your building, is able to create a welcoming, helpful, and respectful environment for transgender clients.

10. Ask the questions that you need to ask in a straightforward, respectful way, and don’t ask anything you don’t need to know in order to assist the client. Many times, transgender people, like other minority groups, find themselves in the position of being interrogated about their lives, bodies, or experience as the result of inappropriate curiosity. Don’t be shy about asking about sex, drugs, hormones, gender, or body parts as they relate to the client’s potential exposure to HIV, but at the same time, don’t expect the client to educate you about the trans experience.

11. Make sure referrals fit. Referrals are a key part of HIV service provision, especially HIV counseling and testing, where the counselor may only have 20 to 60 minutes to spend with the client in a single session. When making referrals for transgender clients, take care that the resources you are referring them to are transgender-friendly. For example, if a transgender woman shares that she is living with intimate partner violence, don’t refer her to a shelter for battered women without first knowing if she will be accepted there without intrusive, offensive questions about her body parts, or whether she might be asked to hide her transgender identity, or turned away altogether.

12. Understand that many transgender people have had negative or even traumatic experiences with the health and mental health care systems. This is not true for everyone, but many clients may have experienced inappropriate curiosity or questions, provider ignorance of their concerns, pathologizing or stigmatizing comments or behaviors.

13. Be open to feedback. Always try to use the same language your client uses to describe body parts and activities, and let your clients know that if they want to use different words to describe a body part or activity, you are open to that. If you make a mistake, apologize. As always, the client’s concerns are guiding the session, so encourage the client to let you know how you can be most helpful during the short time you are spending together.

You and your agency can help create a respectful, safe environment for transgender clients by making your services welcoming and inclusive.


What About Transgender Men?

Although transgender communities are undercounted and understudied in general, we know even less about HIV among transgender men than we do about HIV among transgender women. As mentioned above, most studies related to HIV among transgender people have focused on women. This is in part because HIV rates have been assumed to be quite low among transgender men. Some small studies that have published self-reported rates of HIV infection have found a zero to 3 percent prevalence among transgender men in Philadelphia, Washington, D.C., San Francisco, and Ontario, Canada. 6,28,29,30

In 2011, researchers in San Francisco published a small study of transgender men who tested for HIV in publicly funded counseling and testing for the year 2009 (the last year for which data were available). 31 Fifty-nine men who identified as transgender were included in the study, and although no new cases of HIV were found, several potential HIV risk factors were identified, including unprotected receptive vaginal or anal sex in the last year (63 percent), unprotected anal sex since last HIV test (32 percent), and vaginal or anal sex with a known HIV-positive partner (10 percent).

The majority of transmen in this study (61 percent) reported having male partners in the past year. 31 Because the HIV prevalence among men who have sex with men (MSM) in San Francisco is high, there is a concern that many transmen could be exposed to HIV through sexual partners. Yet few HIV interventions are targeted toward transgender MSM, and service providers who serve MSM communities may not be aware of the specific HIV prevention needs of transmen. 32 For trans MSM, as for straight transgender women, sex with a male partner can be a strong affirmation of their gender identity and sexuality, and the desire for this may prevent some transmen from requiring partners to use condoms. 30

Transmen are diverse. Besides their sexual orientations, which can include attraction to transgender and non-transgender men and women, transgender men (like transgender women) have diverse body parts. Some transmen choose to use masculinizing hormones, and some choose to have gender confirmation surgeries such as chest reconstruction (sometimes referred to as “top” surgery) or phalloplasty (penis construction). Many transgender men do not undergo phalloplasty, and some may refer to their genitals as a “front hole” rather than a “vagina.” For men who do choose to use testosterone, sex drive is often increased, and frontal (or vaginal) dryness may result—possibly increasing exposure to HIV during receptive frontal sex.

The Gay/Bi/Queer Trans Men’s Working Group of the Ontario Gay Men’s Sexual Health Alliance has created a useful guide for transgender MSM called Primed: The Back Pocket Guide for Transmen and the Men Who Dig Them. This sexual health resource explores topics like passing vs. disclosure of gender identity, negotiating safer sex, maintaining sexual health, dealing with fear of rejection, and navigating meeting sexual partners online, and in bars, parks, bathhouses, and other venues. You can download the guide at http://queer-transmen.org.
Test Yourself

Review Questions
1. The term “transgender” describes a) only people who are taking hormones to achieve desired gender characteristics; b) people whose gender identity and gender expression do not match social expectations for the sex that they were assigned at birth; c) people who define gender roles rigidly and strive to live within these norms; d) people whose gender identity matches with the sex they were assigned at birth.

2. True or false: Researchers believe that HIV infection is much more common among transgender men than it is among transgender women.

3. What is “the two-step method” discussed in the lead article? a) a form of data collection on gender that includes two choices—male and female; b) the process of reviewing data first at the local level and then at the state level; c) a way of asking people about their gender expression by asking about current gender identity and about sex assigned at birth; d) both b and c.

4. According to testing data collected by the CDC for the year 2009, the highest percentage of new infections are among a) non-transgender male testers; b) transgender black testers; c) Latino testers; d) transgender white testers.

5. According to data from a 2011 survey, what percentage of transgender people postponed medical care because of discrimination or fear of discrimination from health care providers? a) 48%; b) 75%; c) less than 10%; d) 28%.

6. True or false: For transgender women, HIV-related sexual risk often occurs within the context of a primary male partner.

7. What are structural interventions? a) existing interventions that have been adapted for use with other populations; b) interventions that are supported by the Centers for Disease Control and Prevention; c) interventions that facilitate HIV prevention by making changes to the environmental or context in which HIV risk behavior happens; d) interventions that focus on the relationship between couples.

Discussion Questions
1. What are the greatest HIV prevention challenges you experience when working with transgender clients? How do other social factors, like unemployment, discrimination, mental health concerns, and relationship challenges, have an effect on HIV risk behaviors?

2. How do you think HIV test counselors can best support their transgender clients? What kinds of things can test counselors do to ensure that transgender clients feel welcomed, safe, and respected at the testing site? What steps has your agency taken to make testing more welcoming to clients of all genders?

3. As HIV test counselors, how will you approach topics that you are unsure about? What kinds of questions are appropriate and useful to ask transgender clients? On the other hand, what kinds of questions should counselors not ask?

Answers to Review Questions
1. b. 2. False. 3. c. 4. b. 5. d. 6. True. 7. c.