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# FOCUS

## A Guide to AIDS Research and Counseling

## Transgender Identity and HIV: Resilience in the Face of Stigma

Walter O. Bockting, PhD, LP

Transgender people—people whose gender identity or expression differs from their birth sex—have existed throughout history and across cultures. In modern times, however, this natural gender diversity has been reduced to the binary classifications of men (who should be masculine) and women (who should be feminine).

While everyone suffers when gender is reduced to only two confining categories, transgender people experience multiple forms of oppression for transgressing gender norms. This article explores key aspects of this oppression—including invisibility, economic hardship, stigma, and isolation—that make transgender people especially vulnerable to HIV infection and transmission. It also explores the need for HIV prevention and service efforts that address transgender people's HIV risks in the context of their overall health and lives.

### Vulnerability to HIV Infection

One example of transgender people's invisibility is that, until recently, the Centers for Disease Control and Prevention (CDC) did not include "transgender" as a category for the collection of surveillance data. The lack of such data is a serious barrier to assessing the prevalence of HIV in this population.

There is mounting evidence, however, that HIV prevalence is high among certain subgroups, particularly transgender women—as high as 28 percent, according to a recent meta-analysis of studies conducted with mostly inner-city con-

venience samples.<sup>1</sup> This meta-analysis also indicated that HIV infection rates are higher among African American transgender women (56 percent) than among Latina or White transgender women (17 percent and 16 percent, respectively). Common risk behaviors among transgender women included unprotected receptive anal intercourse (44 percent), having multiple sexual partners (32 percent), sex work (42 percent), casual sex (48 percent), and the use of injection drugs (12 percent), hormones (27 percent), and silicone (25 percent).<sup>1</sup>

Few studies have examined HIV risk behavior in transgender men, but the HIV prevalence for this subgroup appears relatively low (2 percent).<sup>1</sup> One exception is the minority of transgender men who have sex with men (17 percent), for whom behaviors that can transmit HIV are prevalent and include unprotected anal and vaginal intercourse (45 percent), substance use immediately before or during sex (27 percent) and multiple partners (71 percent).<sup>2</sup>

### Oppression, Economics, and HIV Risk

Societal oppression of gender nonconformity makes transgender people especially vulnerable to HIV infection and transmission.<sup>1</sup> This oppression reduces transgender people's visibility and creates economic hardship, which can lead to HIV risk.<sup>1</sup>

Many transgender youth flounder academically or drop out of school because they lack role models and support for their developing gender identity.<sup>3</sup> This in turn affects their future job prospects. Outright employment discrimination is common.<sup>1</sup> Thus, many transgender people fear applying for work as openly transgender people, while others are afraid to undertake a gender role transition because it might jeopardize their employment.

# Editorial: It's Not a Silent "T"

Michelle Cataldo, LCSW, Clinical Editor

Recently I attended a conference featuring a compelling, articulate panel that was slated to speak on working with "LGBT" clients. As each panelist began, he or she noted that the talk would cover lesbian and gay issues, and that while bisexual and transgender people face some similar challenges in receiving care, the talk would not address their specific concerns.

I'm not sure if the panelists decided to frame the panel as "LGBT," or if the conference organizers did, but it wasn't the first time that transgender issues have gotten lost in the mix of a nominally inclusive group. I believe that there are many goals toward which lesbian, gay, bisexual, and transgender people (and other sexual minorities) can, and should, work together, and other times when our needs may not overlap. But too often transgender concerns are lost—as if putting the "T" in "LGBT" were enough. We saw this division play out politically when sponsors of the Employment Non-Discrimination Act jettisoned transgender rights because they feared they could not achieve pas-

sage without doing so, and because they felt that protection for gay, lesbian, and bisexual Americans was better than protection for none of the LGBT community.

Transgender invisibility and exclusion also happens during health and mental health service provision, and I'm not always the first to notice the subtle and blatant ways this occurs. Last year our agency, whose direct-service clients are predominantly gay men, created its first gender-neutral bathroom. This simple change helped open my eyes. Now I notice whether the building I'm in offers such facilities.

In this issue, Don Operario discusses the importance of gender-neutral bathrooms, inclusive intake forms, and other measures in making services friendlier to clients who don't fit into our preexisting boxes of gender and sexuality. Of course, it is not only LGBT service providers who must respond better to the needs of transgender consumers. As Walter Bockting notes in his article, in the Centers for Disease Control and Prevention's national HIV surveillance data reports, transgender

people literally do not count. Yet.

As with so much of the journey toward cultural competence, perhaps achieving transgender sensitivity means making both the obvious structural changes that welcome everyone we serve and the more subtle and individual adjustments. It seems to me that Bockting and Operario each emphasize slightly different approaches to facilitating sexual minority health. Bockting underscores the undeniable empowerment that strong identification with the transgender community brings many people. Operario reminds us that we'll miss the boat with many sexual minority clients if we deny the complexity of their identities, or assume that they feel an affiliation with one "category" or another. These views are not mutually exclusive—nor are they relevant only to work with sexual minority clients. Affiliations can be empowering—and if forced on clients, stifling.

But transgender people are not only clients. As more transgender researchers and service providers come to the forefront, all kinds of services will become more inclusive and appropriate. When those designing and delivering services understand both group needs and individual concerns, our services become far more client-centered.

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2. *Bockting WO. Gender identity and HIV risk: Report from an Internet-based study of the U.S. transgender population. Presentation at the University Consortium for Sexuality Research and Training Inaugural Conference, Bloomington, Ind., April 2007.*

As a result, many transgender people struggle to make a living. Some, after having been very successful in their careers, lose their jobs after coming out. Unemployment of transgender people is estimated at 23 percent.<sup>1</sup> A scarcity of employment options increases the likelihood that some transgender people will engage in sex work. Sex work and lack of employment are both associated with HIV infection among transgender people.<sup>1,4</sup>

## Developmental Issues

Stigma and invisibility can negatively influence psychosexual development and mental health, lead to loneliness and isolation, and prompt transgender people to validate their gender identities through risky

sexual behavior. Each of these factors can influence HIV risk.

Transgender children and youth whose outward appearance, mannerisms, and interests conflict with traditional gender roles experience overt stigma from an early age. Other people recognize this difference even before the children are old enough to understand what their transgender identities mean. These children are often subject to ridicule, and as a result, many develop psychological resilience at an early age. Nevertheless, they often internalize the stigma and develop feelings of shame.

Transgender young people whose outward appearance, mannerisms, and interests conform more closely to traditional gender roles are able to "pass" as belonging to

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the gender they were assigned at birth and often keep their transgender feelings secret to avoid social stigma. Because these children do not visibly challenge societal gender expectations, they typically do not come out as transgender until much later in life, often midlife or later. Yet the secret is isolating, and gender-conforming children do not escape internalized stigma.

While gender-nonconforming children are targets of overt stigma, they also benefit from the consistency between their internal and social identities. They receive accurate social mirroring, while the gender-conforming child does not. For gender-conforming children, the mirroring of the “false self” can result in an identity split. These two different developmental paths affect not only the management of transgender feelings and identity, but also personality development, attachment style, and overall mental health.<sup>5</sup>

### The Quest to Affirm Gender Identity

Developing a sense of attractiveness and sexual competence is a key aspect of sexual development. For many transgender individuals, discomfort with gender roles or with their primary and secondary sex characteristics complicates this task.<sup>5</sup> This discomfort causes some to delay sexual experimentation, while others attempt to affirm their gender identity through sexual activity. For example, for a transgender woman, attention from a male partner may serve as a strong validation of her femininity.<sup>6</sup> This desire for validation may either undermine sexual negotiation or result in compulsive sexual behavior, or both. Together with economic hardship, it can increase the likelihood that some transgender people will engage in sex work, which often leads to substance abuse. Moreover, “the stroll” itself has long been one of the few places where transgender people, particularly transgender women of color, could find validation through a sense of community with others like themselves. Fortunately, a surge in transgender community organizing facilitated by the internet has resulted in a growing number of alternative ways to affirm identity and obtain peer support without resorting to sex work.

The quest to affirm gender identity leads some individuals to use hormones or silicone to feminize or masculinize their bodies, often without adequate medical supervision. In addition to the risks associated with sharing needles, erratic hormone use

results in mood swings that can lead to risky sexual behaviors. Some transgender women who are the insertive partners during sex may not use condoms because feminizing hormones already make maintaining an erection difficult. Illicit silicone injections at “pump parties” achieve quick results, yet often lead to serious medical consequences and sometimes death.<sup>7</sup> In contrast, when qualified medical providers administer treatment, hormones and surgery are safe and highly effective.<sup>8</sup> Unfortunately, with notable exceptions in Minnesota and California, most health insurance policies in the United States exclude transgender-specific medical care from coverage.

### Isolation and Loneliness

The social stigma associated with gender nonconformity leaves many transgender individuals isolated and lonely. Isolation can occur before a person comes out as transgender, or after gender-role transition—when a person tries to “pass” and limits association with other transgender people or when he or she experiences overt stigma.

Shame associated with gender nonconformity can lead some people to feel unlovable or to feel insecure about their abilities to establish and maintain intimate relationships. Many men involved sexually or romantically with transgender women are hesitant to publicly acknowledge these relationships or introduce these partners to their families. Living as “a man without a penis” may cause some transgender men to feel insecure about dating and relationships.

Many people struggle with how and when to disclose their transgender identity and anatomy to potential partners. Fear of rejection and a perceived shortage of accepting partners impede sexual negotiation. Some people may not want to risk rejection twice, first by revealing a transgender identity and then by insisting on safer sex. Often, early in the coming-out process, transgender individuals may use alcohol and drugs to cope with isolation and loneliness, thus lowering inhibitions and increasing risk. However, support from peers, community, and family can help transgender individuals conquer these challenges and find love and acceptance.<sup>5</sup>

### Supporting Transgender Mental Health

Many transgender people are vulnerable to anxiety, depression, and substance

abuse, all of which are associated with HIV risk behavior.<sup>1</sup> In an online study of transgender adults in the United States, 35 percent of participants reported anxiety and 44 percent reported depression.<sup>9</sup> Transgender women, who may suffer greater levels of overt stigma than do transgender men, reported significantly higher levels of depression (37 percent for transgender men versus 49 percent for transgender women). Prevalence of anxiety did not differ by gender. Participants who were resilient—that is, who reported good mental health despite experiencing high levels of stigma—reported more support from family and peers and greater pride in transgender identity than did participants who were not as resilient.<sup>10</sup>

Psychotherapy can facilitate transgender mental health and HIV risk reduction, but the transgender community has a complex relationship with the field of psychotherapy. Transgender people must undergo evaluation by a mental health professional in order to gain access to feminizing or masculinizing hormone therapy and transgender surgery. This requirement can set up an adversarial dynamic between client and provider. Some argue that the mental health diagnosis of Gender Identity Disorder perpetuates stigma, yet this diagnosis is often a prerequisite for access to transgender-specific care. In fact, treatment of anxiety, depression, and other mental health concerns in the context of a transgender-affirmative therapeutic relationship allows for successful resolution of developmental tasks, acceptance of transgender identity, and a different personal relationship to sex and HIV risk.<sup>4</sup>

### Lessons for HIV Prevention

For many years, the invisibility of transgender people translated into an invisibility of the extent to which HIV and AIDS has affected them.<sup>6</sup> Transgender people with HIV disappeared into other epidemiological categories of risk. For example, transgender women who had sex with men were categorized as men who have sex with men. Yet the same people were excluded from services for men who have sex with men—and no other appropriate services were available. Similarly, the unique risks of transgender men who have sex with men (such as the possibility of vaginal intercourse) were not addressed by prevention messages.

In response to this invisibility, some ser-

vice providers have developed sex-positive and transgender-affirmative approaches to HIV prevention, such as the All Gender Health Seminars of the University of Minnesota.<sup>11</sup> This intervention combines education with entertainment, confronts internalized transphobia, and promotes sexual self-efficacy, dating, and relationship skills—thus emphasizing the full humanity of participants and their relationship to their partners and community, and not just their individual HIV risk behavior.

The diversity of the transgender population makes creating relevant and effective interventions a continuing challenge to HIV service providers. Gender identity (transgender woman versus transgender man), sexual orientation, stage of coming out, economic status, and substance use behaviors all shape the context of risk. Yet prevention services must bring this diverse population together to affirm transgender identity, build community, and foster empowerment.

The key to promoting transgender HIV prevention and sexual health is a greater understanding of transgender sexuality as distinct from male and female sexuality—as well as homosexual or heterosexual sexual scripts. Transgender sexuality must be explored and valued in its own right in order to assist transgender people and their sexual partners in reducing risk and experiencing sexuality as a positive force in their lives.

### Conclusion

Greater visibility and affirmation of transgender identity are critical to promoting transgender health and HIV prevention. Over the past 15 years, transgender people have come out, challenged gender norms, created community, and established coalitions with the gay, lesbian, and bisexual communities. Many mental health and HIV service providers have responded to these changes, creating environments that are increasingly responsive to transgender individuals' unique identities, needs, and strengths.

But individual change is not enough. Many of the factors that create HIV risk for transgender individuals are societal. In order for transgender people to become less vulnerable to HIV, structural barriers must be addressed through public awareness, improved access to competent health care, and equal education and employment opportunities. ■

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### Authors

Walter O. Bockting, PhD, LP, is Associate Professor in the Department of Family Medicine and Community Health at the University of Minnesota Medical School. He coordinates the Program in Human Sexuality's Transgender Health Services there. He is the president-elect of the World Professional Association for Transgender Health, [www.wpath.org](http://www.wpath.org). To contact him, e-mail [bockt001@umn.edu](mailto:bockt001@umn.edu).

# Outside the Box: HIV Prevention with Hard-to-Categorize People

Don Operario, PhD

Conducting HIV risk assessment is often a matter of ticking off boxes. Participants complete surveys describing their sexual practices, demographic characteristics, and identities—usually by selecting one option from a pre-specified list. Identifying “high-risk” individuals allows for use of group-based counseling protocols and for efficient targeting of public health resources.<sup>1</sup> But providing HIV prevention services to people whose behaviors or identities cannot easily be categorized remains a challenge. This article explores some of the issues HIV prevention services must consider in order to serve these hard-to-categorize individuals adequately.

## Hard-to-Categorize People

Many people at risk for HIV undermine the conventional social categories of female/male and heterosexual/bisexual/homosexual. Transgender women and their male partners, as well as non-gay-identified men who have sex with men (MSM) offer three clear examples of hard-to-categorize people. HIV prevention interventions rarely serve these groups adequately. These individuals reveal some of the limitations and fallacies of group-based approaches to HIV risk identification and intervention. Whereas group-based research is essential for clarifying the characteristics of people who are similarly situated (based on their gender presentation or sexual behavior, for example), findings from these studies do not often yield client-centered guidelines to help these people avoid HIV.

*Transgender Women.* No simple profile of

transgender women exists. Individual transgender women may or may not, for example, wish to undergo sex reassignment surgery, show overtly feminine characteristics, or be sexually attracted to men. Amidst this diversity, an unfortunate commonality is social discrimination and victimization that can lead to HIV risk.<sup>2</sup>

Transgender women are under-researched relative to their potential for HIV infection. Often, HIV prevention programs do not address transgender individuals at all. No known randomized controlled trials have tested the efficacy of health promotion interventions for transgender women. Prevention services must therefore be informed by guidelines developed for other groups, such as gay men or non-transgender women, which are often inappropriate given the unique societal experiences shared by many transgender women.

Transgender people who do receive services often experience environmental and interpersonal barriers to quality care.<sup>3</sup> From intake forms to bathrooms, the environment of a service agency either diminishes or promotes transgender comfort. Service providers' adherence to an inflexible notion of gender also contributes to sub-standard service delivery. For example, providers might assume transgender women are sexually attracted to men or desire sex reassignment surgery, beliefs that reflect the providers' confusion of gender identity, sexual orientation, and anatomy. When counseling transgender women, a more fluid approach is preferable.

*Male Partners of Transgender Women.* Men who have sex with transgender women also defy easy categorization and pose intriguing questions about sexuality, sexual behavior, and gendered attractions. Little research has been done with this population, so HIV prevalence in this group is unknown. However, these men engage

*Transgender clients often experience environmental and interpersonal barriers to care. Everything from an agency's intake forms to its bathrooms communicates its openness to serving transgender people.*

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in both unprotected insertive and receptive anal intercourse with their transgender women partners and unprotected insertive vaginal intercourse with post-operative transgender women.<sup>4</sup> They also report a range of unprotected sexual behaviors with biological female and male partners. One study of men who have sex with transgender women found that these men's sexual orientation identities did not align with particular sexual behaviors.<sup>5</sup> Another showed that they were equally likely to identify as heterosexual, homosexual, and bisexual and that a notable number chose not to identify with any sexual orientation category.<sup>4</sup> Transgender women indicate that these men use condoms inconsistently, especially if they are non paying partners.<sup>2</sup> Accounts from the men themselves showed different motivations for using condoms with biological females (for example, to prevent pregnancy) versus transgender women and biological men (for example, to prevent HIV with partners of unknown status).<sup>4</sup>

*Non-Gay-Identified Men Who Have Sex with Men*. The "MSM" acronym describing men who have sex with men was adopted by researchers as a more inclusive approach to HIV prevention, because it refers to a specific behavior rather than a subjective identity.<sup>6</sup> But the majority of studies of MSM in the United States include mostly homosexual or gay-identified men; few non-gay-identified MSM are represented in HIV prevention research. Perhaps these men are overlooked by researchers, or perhaps their absence reflects the difficulty in recruiting them to participate.

Consequently, many evidence-based HIV interventions for MSM do not reflect an understanding of how to engage non-gay-identified MSM in services. Interventions are sometimes based on the assumption that participants have a fixed homosexual iden-

tity, and include activities to support their "coming out."

Men who have sex with men who do not embrace a gay identity may be viewed as "in denial," or worse. A few years ago, sensationalized media coverage of African American MSM who have steady female partners and who might be at risk for HIV sparked controversy.<sup>7</sup> Depictions of these men are mostly negative: they are portrayed as vectors of disease transmission, dishonest partners, and closeted homosexuals. Such portrayals influence some service providers and ultimately taint services to clients. For example, heterosexual-identified African American MSM have described poor quality HIV counseling, often delivered by unsympathetic gay-identified men or heterosexual women, that is disparaging of their need to maintain a heterosexual identity.<sup>8</sup> In response, some of these men may opt out of HIV prevention or other health promo-

tion services because of anxiety about being confronted with this discrepancy between their sexual behavior and sexual orientation identities.

## Building Effective Interventions

How do we work with people whose identities and behaviors defy traditional standards of HIV prevention?

*Investigate Needs:* Research on hard-to-

*One study of men who have sex with transgender women found that they were equally likely to identify as heterosexual, homosexual, and bisexual—and many did not identify with any sexual orientation category.*

## Comments and Submissions

We invite readers to send letters responding to articles published in *FOCUS* or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals. Send correspondence to [rob.marks@ucsf.edu](mailto:rob.marks@ucsf.edu) or to Editor, *FOCUS*, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.

categorize individuals must be a priority. Using different methodologies—qualitative interviews, cross-sectional and longitudinal surveys, and randomized controlled intervention trials—is helpful. This diversity of approaches yields clues about how to best reach these individuals and engage them in services, the prevalence and contexts of risk they experience, and the programs that can effectively reduce their HIV transmission. There is a tension between the need for more research about HIV risk and prevention for hard-to-categorize individuals versus the tendency to construct sweeping generalizations about ways of delivering HIV services to these people. Although it may be necessary to first understand individuals according to crude subgroup classifications, findings must ultimately point the way to client-centered approaches that respect individuality and non conformity.

**Structural Interventions:** Structural interventions that acknowledge gender diversity and clients' previous gender history, such as inclusive language on service intake forms and gender-neutral bathrooms, reflect a consideration of and respect for transgender clients. Hiring staff members who mirror client populations can facilitate access and trust. Training staff members to take a holistic perspective on the lives of MSM clients, and transgender women and their partners, is also essential. Service organizations must examine their own staff and programmatic assumptions about the fixed nature of gender and sexuality.

**Acknowledge the Fluidity of Identities:** As noted, intervention practices that assume

fixed and static categories for gender and sexuality might deter individuals who do not adhere to these notions. Group-based workshops might be inappropriate for non-gay-identified MSM, who might not perceive themselves as belonging to a community of men with similar patterns of sexual behavior. HIV prevention counseling with these men may be most effective when counselors focus on specific sexual behaviors (such as insertive or receptive intercourse) men may engage in with any partners and on the context of high-risk sexual episodes (such as sex while intoxicated) rather than on sexual identities themselves.

## Conclusions

By articulating their own identities and expressing sexual behaviors on their own terms, the people discussed in this article destabilize basic assumptions about gender dichotomy and the correspondence between sexual behavior and sexual orientation. They also question the legitimacy of working models of HIV prevention, which often assume neat, bounded categories of sexuality and gender.<sup>9</sup>

This analysis does not call for an end to category-based approaches to HIV risk identification, prevention, and counseling. Risk group categories simplify a complex social world and might be personally meaningful for some individuals. Rather, this analysis of hard-to-categorize individuals reminds us of the often faulty assumptions that social categories are based on, and stresses that when we tick boxes to categorize clients, we should do so lightly and be prepared to erase. ■

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## Authors

Don Operario PhD, is Associate Professor of Medical Sciences at the Alpert Medical School, Brown University. He is also Adjunct Professor in the Department of Social Policy and Social Work at the University of Oxford. To contact him, e-mail don.operario@socres.ox.ac.uk.

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## Related Resources

### Publications

**Garofalo R, Deleon J, Osmer E, et al. Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Journal of Adolescent Health. 2006; 38(3): 230–236.*** Describes the life challenges and HIV-risk behaviors of young transgender women of color using a convenience sample of 51 youth aged 16 to 25 years old. Among other risks, nearly half the subjects reported unprotected receptive anal sex in the past year.

**Melendez RM, Pinto R. 'It's really a hard life': Love, gender and HIV risk among male-to-female transgender persons. *Culture, Health and Sexuality. 2007; 9(3): 233–245.*** Reports on findings from in-depth interviews with 20 transgender women attending a community clinic. Emphasizes that stigma and discrimination create a heightened need for love and acceptance among these transgender women. This in turn leads to HIV risk, because these women are willing to engage in unsafe sexual behaviors with partners who meet these needs. Offers a model illustrating how stigma and discrimination generate HIV risk.

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**Mottet L, Tanis J. *Opening the Door to the Inclusion of Transgender People: The Nine Keys to Making Lesbian, Gay, Bisexual and Transgender Organizations Fully Transgender-Inclusive.* New York: National Gay and Lesbian Task Force Policy Institute and the National Center for Transgender Equality, 2008.** Suggests ways that organizations can integrate transgender-sensitive perspectives. Gives direction on how to create a welcoming environment, deal with prejudices, acknowledge past mistakes, have more transgender-inclusive programming, and use fair employment practices.

**Nemoto T, Sausa LA, Operario D, Keatley J. Need for HIV/AIDS education and intervention for MTF transgenders: Responding to the challenge. *Journal of Homosexuality.* 2006; 51(1): 183–202.** Uses qualitative and quantitative measures to identify HIV-related needs of 48 transgender women focus group participants. Participants reported high levels of HIV-related risk behaviors, inadequate HIV transmission knowledge, a lack of sexuality education and health services, and persistent discrimination against MTFs of color in health services.

**Sausa LA, Keatley J, Operario D. Perceived risks and benefits of sex work among transgender women of color in San Francisco. *Archives of Sexual Behavior.* 2007; 36(6): 768–777.** Seeks to explain the social context and determinants of sex work and related health risks among 48 transgender women of color participants. Examines why and how participants became involved in sex work, risks associated with sex work, and participant motivation to remain in sex work. Advocates for structural and social network-based interventions to minimize the vulnerability of transgender women of color to social and public health harms.

**Web Sites**  
**Center of Excellence for Transgender HIV Prevention: [http://www.ucsf.edu/paetc/about/COE\\_transHIVprev.html](http://www.ucsf.edu/paetc/about/COE_transHIVprev.html).** A collaboration between the Pacific AIDS Education and Training Center (PAETC) and the Center for AIDS Prevention Studies (CAPS), both part of the University

of California, San Francisco (UCSF). Contributions include professional training, capacity building, and research development to improve the access that transgender people in California have to culturally competent HIV prevention services.

**FTM International: <http://www.ftmi.org/>.** Includes links to health information, personal stories, and publications about transgender men as well as community resources for transgender men and their families.

**HIV InSite: HIV Transmission and Prevention in Transgender People: <http://hivinsite.ucsf.edu/InSite?page=kbr-07-04-16>.** University of California, San Francisco web site with links to HIV-specific resources, provider and community education sites, conference web sites, and publications.

**World Professional Association for Transgender Health: <http://www.wpath.org/>.** A professional organization devoted to the understanding and treatment of gender identity disorders and includes medical, legal, mental health, and other professionals. ■

## Next Issue

Before the advent of effective HIV antiviral therapies, cognitive impairments were among the most devastating complications of HIV disease. In our Summer issue, **Tom Marcotte, PhD**, Associate Professor of Psychiatry at the University of California, San Diego, offers an update on the role that cognitive impairment plays in HIV disease today.

Also in the Summer issue of *FOCUS*, **Lawrence McGlynn, MD**, Clinical Assistant Professor of Psychiatry and Behavioral Sciences at the Stanford University School of Medicine, and **Maggie Chartier, MPH, MS**, Director of Research for the Stanford–Santa Clara County Methamphetamine Task Force discuss medical assessment and treatment options for patients with HIV-related cognitive disorders.