

Trans-Care: HIV Conversations *Is anyone listening?**

*Working title: HIV and AIDS Prevention, Care, and Treatment Services for Transgender Populations

The Gender Identity Project (GIP) works to foster the healthy development of transgender and gender non-conforming people, partners, family and community. Through the delivery of a range of transgender-driven supportive services, advocacy, outreach, education and capacity-building, the GIP creates a safe and productive atmosphere for community-building, wellness and self-care, and leadership development

Citation and contact information

- Citation

- Davis, C (2009, June). *Trans-Care: HIV conversations - is anyone listening?*. Workshop presented at the HIV Health & Human Services Planning Council of New York, New York.

- Previous versions of this talk have been presented at

- New York State AIDS Advisory Council (2003): *Listening to Hidden Voices: Identity and Barriers to HIV Prevention for Lesbians and Transgender-Identified Women*
- HIV Scholars Saint Vincent's Seminar (2006): *Sexual and Gender Identity and HIV Risk: Is prevention failing?*

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 - Also former coordinator of the Gender Identity Project (GIP) and Center CARE's Group Services
 - Offering counseling and groups for trans-identified youth and adults, trans-partners and those who are gender-different or gender questioning
- A community organizer, advocate and trainer, addressing LGBT identity, legal, health care and social concerns
- In addition
 - Adjunct Lecturer at the Hunter College School of Social Work
 - Project Director for the Transgender Scholarship & Education Legacy Fund (TSELF)
 - Member of the board of advisors for the All Gender Health Online Research Project, UCSF Transitions Project Community, LGBT Health Aware Project (HAP)
 - Has served on the boards of the Sylvia Rivera Law Project (SRLP) collective the International Foundation for Gender Education (IFGE), New York Association for Gender Rights Advocacy (NYAGRA), GenderPAC

The Lesbian, Gay, Bisexual & Transgender Community Center

- Founded in 1983
- 6,000 visitors each week
- More than 300 groups call the Center home today
- Produces many health-related, civic, and cultural programs
- Mission
 - *The Lesbian, Gay, Bisexual & Transgender Center provides a home for the birth, nurture and celebration of our organizations, institutions and culture; cares for our individuals and groups in need; educates the public and our community; and empowers our individuals and groups to achieve their fullest potential*



Trans + HIV and AIDS

A subjugating narrative

*I can't say who I am
unless you agree I'm real*

Imamu Amiri Baraka

- Are trans-people real?
- “We don’t know enough about them yet”
- The MSM model
- Differing healthcare priorities
- HIV as a solution to social problems
- Inclusion of trans-amorous people
- Transition as a period of increased risk
- Role of sex-work within the trans-communities
- Women-centric models of HIV prevention
- Reconsidering trans-men
- Ethical research practices
- Community and capacity-building
- Providers as allies

Are trans-people real?

- Fundamental *disbelief* in trans-identities
 - Trans-women are *really*
 - Biological men who *think* they are women
 - *Rather than women who were misassigned as male at birth*
 - Trans-men are *really*
 - Biological women who *think* they are men
 - *Rather than men who were misassigned as female at birth*
- Assumes
 - Gender is simple and is a binary
 - Synonymous with sex
 - Sex is immutable
 - Pathologizes any conflict with gender identity

Trans-people are seen as a challenge *to dominant cultural and gender orders*

- Trans-individuals may be seen to challenge dominant notions of gender normalcy
 - Biological, legal and religious methods to quantify the sexes and maintain patriarchal structure
- Discourse concerning trans-people is often translated into difference
 - Trans-people are “different women” and “different men”
 - Trans-people have “different histories”
 - Trans-people have “different oppressions”
- Difference is predicated on the assumption that all non-trans women and all non-trans men share universal gender histories and experiences of oppression
- Enforced by restricting trans-people’s connections to other people and having trans-people to seek
 - Different places to congregate
 - Different services and providers

Trans-people are held responsible *for making non-trans-people uncomfortable*

- This authorizes
 - Discrimination, harassment and violence directed toward trans-people
- Subverts the understandings trans-people have of themselves
 - Defining them as *gender transgressors* and *aggressors*
 - Subjecting them to *ostracism, hatred, physical and sexual assaults, self-hatred, suppression of their true selves, and even murder and erasure*
 - Providers sometimes play a role in misconfiguring trans-identities

A culture of innocence

Providers play a role in this process

- The construction of transgender as a form of deviance, abnormality or *pseudo-pathology*
 - Creates a culture of innocence
 - Those who actually act out and perpetuate oppression, as well as violence, directed against trans-people do so without knowing their actual place in a larger, cultural subjugation
 - Shielded from realizing the actual damage they do – both to those they subjugate and to themselves
 - HIV-services are entangled in this structure
- A process where disconnection itself becomes the pathology
 - From the self
 - HIV intervention usually focuses on this aspect
 - From the culture

Language, realness and double-standards

- “FTM” or “MTF”
 - Simply vectors of transition (from A to B) --> not identities
 - People are not acronyms
 - Are lesbian women and gay men identified as STL (Straight-to-Lesbian) and STG (Straight-to-Gay) or merely as lesbian and gay?
 - If a Christian becomes a Buddhist is that person a CTB (Christian to Buddhist) or merely a Buddhist?
 - As if trans-men were not “really men” and trans-women are not “really women”
- “Real” women or men, “Genetic” and/or “Bio(logical)” man or woman
 - Conflict
 - With the knowledge trans-people have about their own lives
 - With the science of gender - biological or anatomic components are actually assigned gendered meaning in a social context
 - Create a double standard applied to trans-people
 - Everyone is real, genetic and biological
 - Enforce existing cultural hierarchy which structures and subjugates trans-people as less real and less natural than non-trans-people
 - Alternative terms
 - Non-trans: to distinguish between an individual with a trans-history and an individual without a trans-history (or cisgender)
 - Assigned sex: To refer to the sex an individual was assigned at birth

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How common?

- No one knows
 - Identity is always difficult to quantify
 - Like other identities, there are no concrete boundaries or agreement to what constitutes a transgender-identity
 - Because of stigma and fear
 - It is not safe to be seen as trans
- Common estimates vary wildly
 - Some use a medical model
 - Estimating numbers using pathological understandings of trans
 - “Gender Identity Disorders” or “Transsexuality”
 - An involuntary process
 - Focuses on most the visible trans-people
 - Those in need and seeking services
 - Ignores hidden trans-populations
- Identity-based solutions
 - Require a census
 - Community participation



12,500

One possible number

- Some data indicates approximately 12,500 adults in NYC may have undergone some form of gender transition
 - 1 in 500 of the general adult population
 - 6,283,000 of 8,300,000 total estimated adult NYCs
 - Estimated adults ages 18 - and up (represent 75.7% of NYC population - 2008 estimate based on 2000 US Census)
 - Actual trans-population could be much larger in NYC due to benefits of proximity
 - 1 in 40 of the LGBT adult population
 - 500,000: estimated size of LGBT segment in NYC of adults
 - All LGBTQ, approx. 8% of adult population
 - Estimate is impacted by multiple factors and could be as low as 250,000 and as high as 630,000

Olyslager, F. & Conway, L., *On the Calculation of the Prevalence of Transsexualism*, presented at the WPATH 20th International Symposium, Chicago, Illinois, September 6, 2007.
<http://ai.eecs.umich.edu/people/conway/TS/Prevalence/Reports/Prevalence%20of%20Transsexualism.pdf>

Testing and self-report

HIV prevalence and trans-people

- Meta analysis of 29 studies focusing on transgender women
 - Five of these studies also reported data on transgender men
- Differences between self report and testing
 - 27.7% of trans-women tested positive for HIV infection (four studies)
 - 11.8% of trans-women self-reported being HIV-seropositive (18 studies)
- Racial/ethnic differences associated with over 2x higher HIV infection rates were found among African-American trans-women
 - 56.3% test result
 - 30.8% self-report
- What about trans-men?
 - Prevalence rates of HIV and risk behaviors were low among FTMs
 - Limited amount of data

Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. Herbst JH, Jacobs ED, Finlayson TJ, McKleroy VS, Neumann MS, Crepaz N; HIV/AIDS Prevention Research Synthesis Team. *AIDS Behav.* 2008 Jan;12(1):1-17. Epub 2007 Aug 13.

DPM Prioritization

NYC PPG's proposed Dynamic Prioritization Model

- A replacement for the Risk Targeting Model (RTM)
- HIV and population factors
 - Population size (weight: 4)
 - HIV diagnosis rate/1000 persons (weight: 4)
 - % change in HIV diagnosis from 2004-06 (weight 1)
 - HIV/AIDS prevalence in 2006 (weight: 1)
- Cofactors
 - Poverty rate (weight: 2)
 - Homelessness rate (weight: 2)
 - STI rate per 100,000 (weight: 2)
 - Mental distress rate (weight: 2)

“Unknown”

The newest HIV risk factor

- Transgender people are one of the 10-DPM target populations
- Unknown
 - Most data fields necessary for DPM prioritization are listed as “unknown” for transgender people
 - Despite the existence of “29 studies focusing on transgender women” and HIV, and thousands of studies, articles, and sources of information written about the trans-communities, most of it collected over last sixty years

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Using the MSM model

A flawed foundation for most trans-related HIV prevention

- Inaccurately assumes all trans-people (seen as trans-women) are “biologically” male
 - Ignores trans-men
 - Misidentifies and erases many if not most trans-people
- Generates insensitive and incongruent outreach and programs
 - Resulting interventions and educational material is often irrelevant for trans-needs
 - Appropriates funding that could better focus on trans-needs
 - Ignores largely unrecognized trans-specific risks
 - Underground market hormones and silicone use
 - Tucking and binding
 - Social and cultural structural barriers
 - Ignores largely unrecognized trans-specific protective factors
 - Connection to other women - trans and non-trans

A barrier to services for trans-women

- Identity reconfiguration and erasure of identity are experienced as a form of harassment
 - Trans-people and partners may be cautious in approaching providers due to past experiences related to gender harassment
 - These individuals may fear revictimization through transphobia, degradation, hostility or accusations from providers
- Trans-women may be segregated from other, non-trans women when seeking services
 - Trans-women may be served in male or gay-oriented facilities
 - Many choose to not receive services rather than endure this double standard
- Service providers who specifically outreach to trans-people and partners may be limited
 - Trans-women may fear losing their privacy or not being able to maintain anonymity within care settings
 - Even in larger cities such as New York

Disentangling *trans issues from gay & lesbian issues*

- Both sexual orientation and gender identity are
 - Unrelated to genital configuration and/or access to gender-confirming surgeries
 - A trans-identity is not dependent on access to gender-confirming care
- Gender difference is often only seen in gay context
 - Masculine females and feminine males are assumed to be gay
 - “Anti-gay” discrimination and violence often targets gender expression, not sexuality
- Homophobia is different than transphobia
- Trans-people are often outcast within a “gay” context
 - Providers of services for gay and lesbian people
 - May **NOT** be safe for trans-people
 - May **reconfigure** or **erase** trans-people as confused gay men or lesbian women
- Trans-people need to be able to access services through their trans identities rather than in spite of them

Trans-identity erasure

- Trans-people are made invisible through reporting methodology
 - Alienating intake procedures, insensitive forms
 - Inaccurate and inconsistent data collection
 - Trans-men become (non-trans) women (often heterosexual)
 - Or, in rare cases, non-trans men
 - Trans-women become (non-trans) men (often homosexual)
 - Or, in rare cases, non-trans women
 - Ignores other risks
 - Trans-people who are infected via other vectors of transmission
 - Negatively impacts funding and prevention

Messy data for trans-people

The MSM model erases trans-people

- Don't know how many trans-women are being seen
- Excludes trans-men and other gender non-conforming people from the data
- No data = No evidence = No services
- If needed, providers need to develop in-house data collection tools to keep track of trans service utilization

Singer, B. (14 June 2007) *Sex/Gender Categorization in Trans Surveys 1996 - 2007: A Brief Overview*

Data flows through the CDC

- *Negative:* Dr. Irene Hall, chief of the HIV Incidence and Case Surveillance Branch within the CDC's Division of HIV/AIDS Prevention
 - *For the time being (June 2008) the CDC has no plans to change its surveillance collection efforts to separate out transwomen from the MSM risk category*
 - *...If a male-to-female transgender individual has not had gender reassignment surgery and retains male sexual organs and engages in sexual activity with a male that can transmit HIV, categorizing her as having male-to-male sexual contact is currently CDC's best method of identifying the most likely mode of transmission*
- *Positive:* CDC has made changes to its HIV surveillance program to provide more information about transgender people who test positive
 - CDC's eHARS (Evaluation HIV/AIDS Reporting System) - for states to transmit HIV surveillance data to the CDC
 - CDC's Program Evaluation Monitoring System (PEMS) database - for states to transmit data about people seeking HIV counseling and testing services
 - Allows states to **optionally** identify people by gender as either male, female, or transgender
 - Those states using the transgender **option** can further identify trans-people as either "MTF" or "FTM"

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HIV and trans-women

Conventional wisdom

- Associates HIV with
 - Higher risk behaviors
 - Multiple partners
 - Unprotected anal and vaginal sex
 - Injection drug, silicone, and hormone use
 - High incidence of sex-work
 - Lower levels of AIDS knowledge than other non-transgender groups
 - Significant rates of substance abuse within transgender communities
 - As well as engaging in sex under the influence of drugs and/or alcohol
 - Acknowledges social and cultural risk factors
 - But does not adequately focus interventions and funding on these structural concerns
- Adapts interventions
 - From those created for and evaluated with non-trans men
 - Sometimes non-trans women

Risk and cofactors

- “Risky behavior” is the typical focus of most research
 - 27 - 48% of trans-women reported engaging in “risky behaviors”
 - Higher risk behaviors such as
 - Unprotected receptive anal intercourse
 - Multiple casual partners
 - Sex work
- Cofactors are often downplayed
 - Contextual factors potentially related to increased HIV risk include
 - Mental health concerns
 - Physical abuse
 - Social isolation
 - Economic marginalization
 - Unmet transgender-specific healthcare needs

Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. Herbst JH, Jacobs ED, Finlayson TJ, McKleroy VS, Neumann MS, Crepaz N; HIV/AIDS Prevention Research Synthesis Team. *AIDS Behav.* 2008 Jan;12(1):1-17. Epub 2007 Aug 13.

Cofactors galore

Transgender & gender non-conforming people were

- **Income**
 - Almost twice as likely as non-transgender people to be very low income (20.7% as opposed to 11.1%, for household income under \$10,000 per year).
- **Healthcare**
 - More than three times as likely as non-transgender people to worry doctors would refuse them care
 - 73.4%, or twice as many as non-transgender people, said that lack of well-trained providers was a problem for them in accessing healthcare
 - Twice as many (56.3%) as non-transgender people said that fear of being treated badly kept them from accessing healthcare
 - 60.2% said that community stigma or fear of LGBT people was a problem in attempting to access services.
 - Nearly twice as likely as non-transgender people to indicate that housing was a problem for them in accessing healthcare
- **Housing**
 - Three times as likely as non-transgender people to indicate that they were currently (3.7%) or formerly (29.6%) homeless as were non-transgender people
- **Violence**
 - Much more likely to be victims of hate violence than non-transgender people who conform to gender norms
 - 28.4% of had experienced a serious physical or sexual assault motivated by homophobia or transphobia.

Frazer, M. S. (2009) LGBT Health and Human Services Needs in New York State. Empire State Pride Agenda Foundation: Albany, NY.

Not a great fit

Are traditional prevention models relevant to the trans-communities?

- Many trans-people aren't interested in prevention and associated messages
 - HIV is not a very compelling issue for many trans-people
 - Prevention is not a prioritized concern of the trans-communities
 - Dealing with other issues
 - Isolation, oppression, coming out, medical and so forth
 - Desire opportunities for social interactions with each other
 - NYC has few social settings for trans-people
- Most prevention models
 - Are not trans-affirmative
 - Ignore large portions of the trans-communities
 - Focus on limited areas within trans-space
 - Ignore diversity within the trans-communities

Differing trans-health priorities

Access to and quality of care - not HIV

- Research typically posits HIV and AIDS as the most prominent trans-health concern
 - Most trans-related funding follows this vector
- When asked, trans-people instead focus on access to and quality of care, not HIV
 - Lack of Health Insurance and Underinsurance
 - Lack of Health Insurance Coverage for Trans Health Services
 - Lack of FDA approval for Transgender Hormonal Therapy
 - The Continuing Misclassification of Sex Reassignment Surgery as "experimental"
 - Lack of Training in U.S. Medical Schools for Trans Health Service Delivery and Working with Transgender Patients
 - Medical, Mental Health and Substance Abuse Treatment Provider Insensitivity and Hostility to transgender people
 - Gender Identity Disorder (GID) as the Principal Diagnostic Means Determining Access to Trans Health Services

Based on discussions held in the Trans-Health Initiative of New York (THINY), a joint project of the Gender Identity Project (GIP), the Transgender Legal Defense and Education Fund (TLDEF) and the New York Association for Gender Rights Advocacy (NYAGRA)

Risk vs. identity

- Dr. Irene Hall, chief of the HIV Incidence and Case Surveillance Branch within the CDC's Division of HIV/AIDS Prevention
 - Transgender identity may be relevant in discussing the demographics of people infected with HIV, but it is not as relevant in examining the risk factors for infection
 - *...If a male-to-female transgender individual has not had gender reassignment surgery and retains male sexual organs and engages in sexual activity with a male that can transmit HIV, categorizing her as having male-to-male sexual contact is currently CDC's best method of identifying the most likely mode of transmission*

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HIV as a pathway to survival

- Impact of social and cultural HIV risk cofactors are significant
- Particularly evident when HIV is seen by some trans-women as a pathway to meet basic survival needs
 - Housing
 - Health care
 - Monthly income
 - Social connection

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Comprehensive and affirming services for trans-families

- Typical definition of transgender omits critical elements of community
- An inclusive and supportive vision includes
 - Partners of trans-identified people
 - Family of trans-identified people
- Includes the needs of others who may be affected by
 - The stigma and oppression associated with trans-identities
- Inclusion helps to normalize the trans-self concept and addresses
 - Isolation
 - Developmental concerns
 - Reduce HIV risk



Photo from the 1999 NYC Pride March

Innovative trans-family frameworks

- In contrast to traditional models
 - That pathologize trans-people and families
- Normalize trans-family structures
- Recognize complexity and diversity of family models
 - Prioritize the creation of inventive, durable, complex & rich trans-families
 - Trans-family couples, the House & Ball Communities, communal living systems, polyamorous families, families with dissimilar sexual orientations, group homes, on the street
 - Adjustment of traditional families to a life cycle including gender transition of one of its members
 - Gender identity and transition as one of many life changes and transitions that a family might go through
 - Frame the choice relationally
 - Redefine of some of the major components of the relationship, the gender of its members and sometimes the sexual identity - private and social

Trans-partners

- Very little attention has been focused on the partners, lovers, spouses and intimate friends of trans-people
 - The needs and problems of trans-partners often become overshadowed by the issues of transgender-identified participants
- Partners
 - Those who seek trans-people - *trans-amourous*
 - Attraction to one's partner's trans-history
 - Identity
 - Body
 - Gender non-conformity
 - Partners who discover their partner has a trans-history
 - Partners whose partners come out as trans, sometimes seeking to actualize that identity
 - Those who discover their partner has a trans-history
 - Those whose partners come out as trans
 - May or may not seek to actualize that identity

Concerns of trans-partners

- Recognition - trans-partners are critically important in trans-lives
 - Have their own, unique concerns
 - Are deserving of time and consideration
- Identity and/or community shift or loss
 - Isolated and loss of community support and affiliation
 - Getting social needs met
 - Many trans-partners are straight-identified and find little support in a “Gay Center”
 - This leaves out an essential component of the trans-communities
 - Enhanced HIV risk
- Stigma affecting individuals associating/associated with trans-people
 - Financial and economic barriers
 - Barriers to medical care
 - Internalized transphobia
 - Erect barriers to intimacy
- Stigma associated with attraction to trans-people
 - Perception of attraction to trans-people as a fetish
 - Affected by same cultural stigma as trans-people

Identity diversity

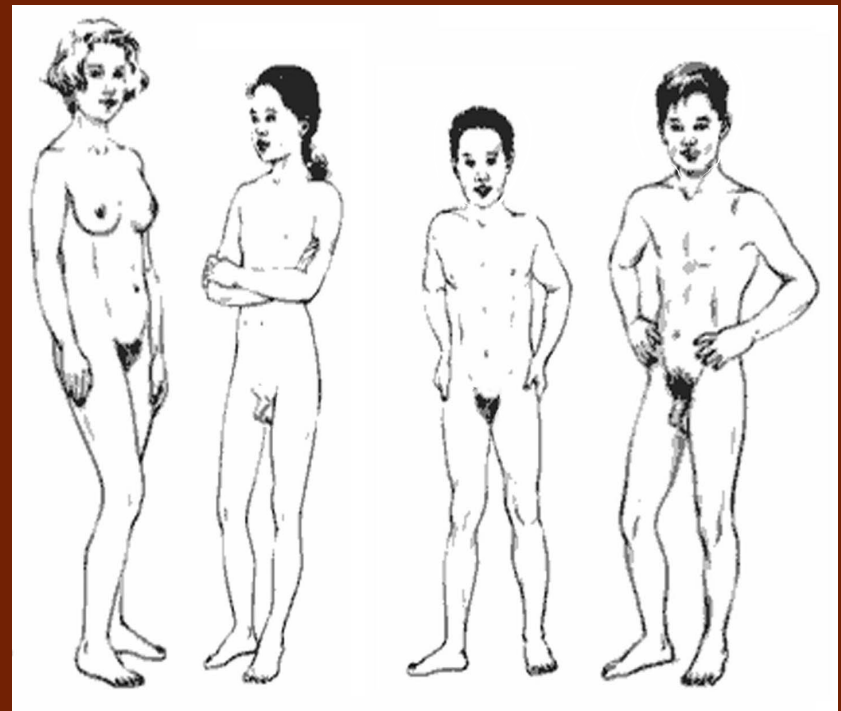
- *A measure of congruence*
 - Straight-identified non-trans men who date straight-identified trans-women (often coming from gay communities)
 - Gay-identified non-trans men who date gay-identified trans-men (who may come from either straight or lesbian communities)
- *A measure of conflict*
 - Lesbian-identified non-trans women who date straight-identified trans-men (often coming from lesbian communities)
 - Straight-identified non-trans women who date lesbian-identified trans-women (often coming from straight communities)
- **Naming trans-relationships – words to name one's reality**
 - Few affirming terms for individuals who prefer and are attracted to trans-people
 - SOFFA, trannie-chaser, admirer, trans-am/trans-amorous, transsensual femme, trans-partner

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Transition or gender transition

A trans-adolescence or trans-puberty

- The process or vector
 - From living and being perceived as identified/assigned at birth (*either M or F*)
 - To living and being perceived as the trans-individual sees & understands themselves
- A developmental opportunity
 - Development of a less conflicted sense of identity
 - Enter into satisfying peer and interpersonal relationships
 - Continue in professions or school
- A physical opportunity
 - To reverse or moderate the effects of the client's initial puberty
 - Exogenous, gender-confirming hormones, and gender confirming surgery engender physical changes associated with a second puberty



Trans-adolescence is typically delayed

- Rarely occurs at an age-appropriate period
 - Non-trans adolescence usually commences between ages 9 - 14
- Typically takes place in
 - Late-adolescence
 - Adulthood (average age - mid-30's)
- A period of identity exploration that may create concerns about age-congruent
 - Behavior
 - Dress
 - Mannerisms
- Consequences include
 - HIV risk, isolation, job loss, physical and sexual violence and abuse
- Intervention: reframe such behavior as “adolescent”
 - Encourage exploration
 - Openly address risk factors

Transition and risk

- Some risks are similar to non-trans adolescents
- Personal risk assessment
 - Gender-appropriate assessment mechanisms are under-developed
 - Magical thinking regarding risk
- HIV and physical risk
 - Increased sexual activity
 - Gender “euphoria” associated with coming out
 - Unfamiliar partners
 - Isolation - disconnection from protective structures
 - Family, religion, education, profession, ethnicity
 - Mental health
 - Low-self esteem, depression, anxiety, sexual abuse, trauma
 - Increased risk of physical and sexual assault
 - Needle sharing associated with hormone and silicone use
 - Economic factors
 - Transition-related unemployment/under-employment
 - Trans-women - association with sex industry

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HIV, sex-work and trans-women

- Meta analysis of 25 studies among 6405 participants recruited from 14 countries to compared HIV prevalence among transgender women sex workers with prevalence among transgender women who do not engage in sex work, male sex workers, and non-transgender women sex workers
- Overall crude HIV prevalence
 - 27.3% in transgender women sex workers
 - 14.7% in transgender women not engaging in sex work
 - 15.1% in male sex workers
 - 4.5% in non-transgender women sex workers
- Conclusions
 - Transgender women sex workers could benefit from targeted HIV prevention interventions, HIV testing, and interventions to help reduce the risk of contracting or transmitting HIV
 - Structural interventions to reduce reliance on sex work among transgender women may be warranted

Sex work and HIV status among transgender women: systematic review and meta-analysis. Operario D, Soma T, Underhill K. J Acquir Immune Defic Syndr. 2008 May 1;48(1):97-103.

Sex work is “bad”

- Sex is bad
 - Concerns about sex-work are sometimes derived from a sex-negative culture
 - Frightened by sexuality
 - Represses both straight and queer desire
- Prostitution is illegal in most jurisdictions
- Sex -work may be exploitative
 - Traumatic
 - Patriarchal
 - Dangerous

Sex work is “all we have”

- Sex-work and its derivations - exhibition and entertainment
 - The only historical employment opportunity permissible for many trans-women, particularly
 - Trans-youth and trans-immigrants
- Seeing trans-people as a form of deviance or as pathology
 - Restricts employment opportunities, especially for non-passing or visibly trans women
 - Is utilized to deprive trans-people of legally sanctioned employment
 - Engenders economic dependence on sex-work
 - Includes work as prostitutes and escorts, strippers, lap dancers and showgirls, telephone sex-workers, performers, and as models or actresses for masturbatory oriented print, film and video materials

Sex work is “good”

- Work
 - Sex-work is one of the few ways many trans-women are able to earn enough money
 - To survive - food, housing, clothing
 - To pay for trans-specific health care
- Affirmation
 - Sex-work may be gender affirming for some trans-women
- Community
 - The street and/or sex-work community is often the only visible and vibrant trans-community
 - Community has a powerful protective function in connecting trans-women to each other and in HIV prevention

Dual role of sex work

- Research indicates sex work serves a dual role for many transgender female youth sex workers
 - “Helping to achieve an otherwise elusive economic viability”
 - “Validating a much-desired female gender identity”

Garofalo, R., Deleon, J., Osmer, E., Doll, M., & Harper, G. W. (2006). Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *The Journal of Adolescent Health*, 38, 230–236. doi:10.1016/j.jadohealth.2005.03.023.

High HIV testing rate

A prevention opportunity

- Cofactors associated with sex work for trans-youth
 - Lower education status
 - Homelessness
 - Use of street drugs
 - Perceived lack of social support
- HIV prevention efforts for this population need to include broad-based approaches that take into account
 - Individual, social, and community-level factors relevant to the lives of transgender female youth
- Findings indicate that transgender female youth are aware of their risks for HIV as indicated by HIV testing rates
 - Few other communities have been shown to have such high HIV testing rates
 - Indicates a willingness to participate in risk reduction behaviors

Wilson, E., Garofalo, R., Harris, R.D., Herrick, A., MartinezJaimeMartinez, Marvin Belzer, the Transgender Advisory Committee and the Adolescent MedicineTrials Network for HIV/AIDS Interventions. (2009). Male-to-female transgender youth and sex work: HIV risk and a comparison of life factors related to engagement in sex work. *AIDS and Behavior*

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If trans-women are women *then why not use trans-affirmative and women-centered, prevention models?*

- Q: Why are most trans services & models of HIV prevention MSM-driven?
 - ❑ A: Gender theory is just academic -- the **real world** is based on the gender binary and no one (including providers) really believes trans-women are women
 - ❑ A: Gender is not binary -- some trans-feminine persons may identify (or fit better) in some ways as male
 - ❑ A: MSM-based funding is reliable and we don't want to mess this up
- Why are trans-women re-categorized as "male" in most final statistics?
 - ❑ A: Many trans-women come from gay male backgrounds or community
 - ❑ A: That's the way it has always been
 - ❑ A: It is not the responsibility of providers to challenge trans-oppressive systems
- Why is trans-specific health care such as gender-confirming hormone therapy typically unavailable or uncovered by Medicaid?
 - ❑ A: I really don't know but get over it - it is not the responsibility of providers to challenge trans-oppressive systems
- Why are trans-women denied access to women's services and groups?
 - ❑ A: It is what our funders require and funding is already difficult enough to obtain
 - ❑ A: Stop it! It is not the responsibility of providers to challenge trans-oppressive systems
 - ❑ A: Trans-women make non-trans women (and us) uncomfortable
 - ❑ A: That's the way it has always been
- Why are most providers and allies silent on these issues?
 - ❑ A: We didn't know any better - sorry

Women, trans-women and HIV risk

Gender inequality and violence put [trans] women at risk

- *Traditional sex roles, in which [trans] women are passive and men lead*
 - *Keep [trans] women from voicing their sexual needs and limit their ability to prevent HIV infection*
 - *A [trans] woman's hesitation to discuss safer sex with a male partner [may be] based on her understanding of power and lower perception of control*
- *Male dominance and power ... plays a critical role in increasing the risk of HIV infection to [trans] women*
 - *The threat of violence deters many [trans] women from negotiating safer sex*
 - *Or resisting unprotected sex with a high-risk partner*
 - *If a [trans] woman brings up condom use, she may be concerned that her male partner will*
 - *Accuse her of being unfaithful*
 - *Ignore her request and force unprotected intercourse*
 - *Physically abuse in the belief that she is a carrier of HIV or other sexually transmitted diseases*

From Women in Peril, HIV/AIDS - The Rising Toll on Women of Color (2005) for New York State's AIDS Institute

Women, trans-women and HIV risk

Cultural norms & stigma increase the risk to [trans] women

- Patriarchal cultural structures of male dominance impact trans-women
 - *[Trans] women are typically considered subservient to men*
 - *Some [trans] women are totally dependent on men*
 - *Emotionally*
 - *Socially*
 - *Financially*
- *A partner's masculinity [may be] associated with having multiple sexual partners*
 - *[Trans] women are expected to accept or at least not to question, the lifestyles of male partners*
 - *Secrecy and denial surround risk activities*
 - *Discussion of sexual matters is often taboo*
 - *[Trans] women often fear that seeking HIV testing or care will lead to social stigma and blame for infecting their partners*
- *May also limit access to health care for many [trans] women*
 - *Immigrant [trans] women frequently face language and literacy barriers and may be suspicious of treatments that are different from their own cultural beliefs and practices*
 - *Undocumented immigrant [trans] women or those who have violated the law may avoid contact with the health care system out of fear of arrest or deportation*

From *Women in Peril, HIV/AIDS - The Rising Toll on Women of Color* (2005) for New York State's AIDS Institute

Women, trans-women and HIV risk

HIV status and risk

- *[Trans] women may also face violence as a result of being HIV positive*
 - *[Trans] women who are diagnosed with HIV are often afraid to tell their male partners or to encourage their sexual partners to be tested for HIV*
 - *Abusive partners may use the [trans] woman's HIV status as an excuse for physical and psychological abuse*
 - *May threaten to reveal the [trans] woman's HIV and/or trans status to children, family, friends and employers*
- *HIV-infected [trans] women in poverty are at particular risk*
 - *They may be reluctant to leave abusive partners because they are dependent on their partners for*
 - *Housing*
 - *Food*
 - *Money (to pay for costly medications and treatment)*

From *Women in Peril, HIV/AIDS - The Rising Toll on Women of Color* (2005) for New York State's AIDS Institute
- **Negative consequences associated with multiple, intersecting oppressions**
 - **Trans-identity + HIV-status + racial/ethnic identity + socio-economic status**

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What about trans-men and HIV?

- Less research has been conducted with trans-men
 - Myth that trans-men partner exclusively with women
 - Miscategorization of trans-men as “female”
 - Erases trans-masculine identities
 - CDC reporting methodology largely overlooks female-to-female sexual contact as a vector for transmission
 - Actual risk remains unknown
- Anecdotal observations indicate many, if not most, trans-men explore their sexual orientation during transition
 - Many trans-men may possibly identify as gay, queer or bisexual men
- May be at higher risk for HIV infection due to
 - Lack of access of intramuscular needles
 - Low self esteem
 - Immunity belief - a community belief that they are not at risk
 - Engaging in unprotected sex

T(MSM)

Trans Men Who Have Sex With Men

- Bockting's research indicates 18% of trans-men have sex with men
 - Conflicts with myth that trans-men partner exclusively with women
- Engage in very high levels of risk behavior, especially during the coming out period
 - Unprotected vaginal and anal intercourse
 - Adopt norms that exist in the MSM community, including multiple partner and sex as a way of celebrating sexual freedom, and they want to measure up
 - Concerns include doubt about being desirable and lovable
 - *Will men really want to be with me if I don't have a penis?*

Walter Bockting, Ph.D. directs the University of Minnesota Transgender Health Services

Barriers to participation for trans-men

- Barriers

- Research focus on trans-women
- Hidden or hard to reach
- Trans-men don't perceive themselves at risk
- Suspicious of studies

- Recommendations

- Study trans-masculine risk separately

Singer, B. (14 June 2007) *Sex/Gender Categorization in Trans Surveys 1996 - 2007: A Brief Overview*

Vectors for HIV transmission

- In 1997 the San Francisco Dept. of Public Health surveyed 123 trans-men
 - 31% had a prior STD diagnosis
 - 15% did not have stable housing or were homeless
 - 57% used gender-confirming hormones and 54% injected gender-confirming hormones
 - 18% used injection drug use and 91% of those shared syringes
 - 27 median lifetime sexual partners
 - 31% engaged sex work/survival sex
 - 59% reported raped/forced sex
 - 28% engaged unprotected receptive anal intercourse
 - 64% engaged unprotected receptive vaginal intercourse

Source: *The Transgender Community Health Project* (San Francisco Department of Public Health 1999)
available online at <http://hivinsite.ucsf.edu/InSite.jsp?doc=2098.461e#mtf>

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“...neither addressed to us nor recycled within our communities...”

- *Academics, shrinks, and feminist theorists have traveled through our lives and problems like tourists on a junket. Picnicking on our identities like flies at a free lunch, they have selected the tastiest tidbits with which to illustrate a theory or push a book. The fact that we are a community under fire, a people at risk, is irrelevant to them. They pursue Science and Theory, and what they produce by mining our lives is neither addressed to us nor recycled within our community*

Wilchins, R. A. (1997). Read my lips: sexual subversion and the end of gender. Ithaca, NY: Firebrand Books

A strained relationship

- At least 29 trans-specific needs assessments have been prepared since the early 1990's
 - Most, if not all, have focused on the needs of funders -- especially HIV-specific funding
 - Rather than the needs trans-people themselves prioritize
- *Most studies have a clinical bias, viewing the transgendered individual in a specialized and highly artificial situation. Researchers ... have been for the most part blind to the way their own needs and prejudices influence the treatment setting and have been quick to place the blame on their transgendered clientele*

From Dallas Denny's (1994) Gender dysphoria: a guide to research

Others have examined this conflict

- *Intellectual poaching license[s]*
 - Geertz (2000) describing anthropology and the social sciences
- *Texts ... ultimately meant to serve the intellectual curiosities of the author and his or her "home" society, ... ultimately empowered the academy, and by extension, the dominant societies in which the academy was situated*
 - Lassiter (2000) describing anthropology and ethnography
- *Hegemonic self-perception promulgated by biomedicine*
 - Kleinman (1995) describing medicine

What should trans-specific research seek to accomplish?

- Trans and gender non-conforming people
 - Are at risk
 - Are underserved
 - Confront a critical and dangerous lack of
 - Ethical practitioners
 - Practice knowledge
 - Confront a scarcity of resources
 - For research
 - For services
- Because money, human resources, and time are limited all research must confer a benefit to trans-people
 - Be useful and of value

Responsible research *must not*...

- Commandeer already limited resources
- Seek to enlarge the growing body of theory about transgender peoples
- Participate in the further pathologization or colonization trans-identities
- Exploit trans-identities as phenomena
- Generalize beyond the boundaries of the actual study

Ethical research *must* ...

- *Listen* to trans-people
 - Endeavor to affect the realities that trans-people encounter
 - Ask trans-people what they need and prioritize
 - Formulate research around those needs
- *Include* trans-people in this process
 - Be authored by trans-allies and trans-people
 - Located within trans-spaces
- *Acknowledge* the complexity and diversity of trans-identities
 - Recognize multiple identities and oppressions
 - Look beyond the most visible trans-communities
 - Challenge existing paradigms and biases about need and risk
- *Seek permission*
 - Conceive research endeavors as a purposeful and knowing transaction within the bounds of participatory action research
 - Validate results with those that participate in the collection of the data
 - Be subject to review and correction by the subjects prior to publication
- *Examine social location*
 - Scrutinize the role and influence of the researcher/investigator and the research design
 - Identity, class, culture, ethnicity, privilege, oppression, and the dynamics of power

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The systemic oppression of trans-people

- Patterns of relational disconnection
 - Economic barriers
 - Unequal economic opportunity
 - Higher risks
 - Unequal exposure to risk and risk-related behavior
 - Structural barriers
 - Cultural concerns that manifest in various social systems
- These are interrelated
 - Synergistically impacted by multiple and intersecting oppressions

Community-interventions

- Focus on enhancing the participants' understanding of their transgender identities as normative
 - Effectively address cultural aspects of isolation, development and HIV prevention
- Peers are recruited in community settings to
 - Conduct outreach
 - Share their role model stories (life experiences and stories) with
 - Other peer-community members
 - Providers of services
 - Allies to the transgender communities
 - This enhances community involvement and resilience
 - Educates the public and allies

Capacity-building assistance

- For individual practitioners, organizations and government agencies
 - To improve the delivery and effectiveness of HIV prevention services
 - To address other critical needs and services required by the transgender communities
- May take the form of
 - Advocacy, technical assistance & planning
 - In partnership with providers or government agencies
 - Trainings and forums
 - Directed to providers
 - Hybrid-clinical events
 - To bring providers and members of the transgender communities together to share clinical best practices
 - Hybrid community-focused forums and celebrations
 - Where members of the transgender communities share their experiences and life stories with peer-community members, providers and allies

Good prevention practices

acknowledge social practices and context

- Envisions culturally appropriate intervention strategies
 - Is research-based, rather than adapted from other communities and identities
- Acknowledges social context
 - Recognizes multiple behaviors and complex identities
 - Is associated with trans-space
 - Bars, clubs, coffee shops, parties, community forums and events, medical or mental health clinics, religious venues and so forth
 - Recognizes cultural/ethnic influences
 - Recognizes role of stigma and oppression
 - Racism, sexism, classism, bigenderism and so forth

Profound sense of difference

- Many [trans] people characterize their childhood and early adolescence by a profound sense of difference

Adapted from Nealy, E. (2007) From the Margins to the Center: A Study in Queer Community Building Practice, CUNY Graduate Center, Hunter College Doctoral Program in Social Welfare, Qualifying Examination

Disconnection

Surrounded by culture that is not our own

- Disconnection
 - Trans-people often find themselves surrounded by a non-transgender and gender-conforming history and culture that is not their own
 - Rituals (courtship, engagement, bachelor parties, wedding showers, marriage)
 - Relationships (heterosexual male/female), the language (boyfriend/girlfriend, husband/wife)
 - Often know and expect or fear their lives and choices (children, careers, partners, religion) will play out differently than the paths of those around them
- Unlike ethnic immigrants, even their own families are different
 - This dynamic that creates an even more profound sense of being a stranger in a foreign land

Adapted from Nealy, E. (2007) From the Margins to the Center: A Study in Queer Community Building Practice, CUNY Graduate Center, Hunter College Doctoral Program in Social Welfare, Qualifying Examination

Lack of visible community

- For many generations LGBT-people have had no visible community
- When they do, LGBT-people are typically been relegated to the margins – to “gay ghettos” or sex-work “strolls”
 - The Castro in San Francisco and/or the Piers and Greenwich Village in New York City
 - Or gay and trans bars and clubs that are typically hidden from mainstream heterosexual society
- Disconnected and isolated (Garnets & D’Augelli, 1994)
 - From their own culture
 - From mainstream society and culture
 - From their families of origin because of their differences
 - From mentors and role models with whom they can relate
 - From peers and friends who resemble themselves and their emerging identities

Adapted from Nealy, E. (2007) From the Margins to the Center: A Study in Queer Community Building Practice, CUNY Graduate Center, Hunter College Doctoral Program in Social Welfare, Qualifying Examination

Traditional vs. community models

- Traditional models

- Focus on the individual's personal experience as the locus of concern
- Do not typically confront the societal structures and systems that perpetuate the parallel addiction/mental illness/oppression cycle

- Community building models

- May offer the greatest hope for work with oppressed groups
- *An effort to organize and strengthen social connections and build common values that promote collective goals Briggs (2003)*

Adapted from Nealy, E. (2007) From the Margins to the Center: A Study in Queer Community Building Practice, CUNY Graduate Center, Hunter College Doctoral Program in Social Welfare, Qualifying Examination

The strength of community-based interventions

- Offer LGBT-identified clients an opportunity to recover
 - From the intersecting dynamics of addiction/mental health concerns, oppression, and alienation (Garnets & D'Augelli, 1994; Gutierrez, Oh, & Gillmore, 2000; Huebner, Rebchook, & Kegeles, 2004)
 - Particularly against the backdrop of societal harassment, discrimination, and violence
- Significance of community connections
 - Social environments free of stigma
 - Minority group affiliations enable oppressed individuals to experience social environments free of stigma (Jones et al.-as cited in Meyer, 2003)
 - Community cohesiveness
 - Members of stigmatized groups who have a strong sense of “community cohesiveness” are better able to reappraise societal stigma and reclaim a positive sense of identity
 - Group-level resources
 - Essential in this process - even very resourceful individuals may experience deficient coping skills when they are absent (Meyer, 2003)

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Power

The relationship between providers and trans-people is not innocent

- *Doctor Myth*

- Hormonal therapy is contraindicated for transgender women. The patient needs antiretroviral therapy and the co-administration of antiretroviral therapy and gender reassignment hormonal therapy is contraindicated.

- *Doctor Reality*

- Although some potential drug interactions do exist with antiretroviral medications and estrogen compounds, a safe antiretroviral regimen can be constructed for transgender patients receiving hormonal reassignment therapy. In addition, providing hormonal therapy may provide an incentive for HIV-infected transgender women to regularly attend medical clinic visits and engage in care for their HIV disease.

- How will a trans-person know which provider you are?

Are you an ally or a trans-institution?

- You may be a transgender organization/agency/project/business/corporation if...
 - Your services or products are directed to and focused on transgender people, partners, family and transgender community...
and
 - Your senior executive(s) (Executive Director, President and so forth) is a trans-person and/or partner or family member of a trans-person...
and
 - Your board of directors (if you have one) includes trans-people and/or partners or family members of trans-people...
and
 - Your staff includes trans-people and/or partners or family members of trans-people.
- If your institution doesn't comfortably fit these guidelines
 - You are probably **not** a trans-organization, though you may be an ally
 - That's wonderful because the trans-communities need allies!

An allied or inclusive group or organization

- Wants/has trans-participants
- Wants/has trans-employees and staff
- Has an inclusive name
- Has a trans-inclusive mission and services
- Has trans-inclusive advertising
 - Promotional material
 - Does outreach to trans-people and in trans-places

Orientation and training

- Don't just add a "T" (to the L and G)
 - Without doing the critical work necessary to make your organization trans-inclusive and responsive
 - Make an organizational commitment towards trans-inclusion and the provision of trans-services
 - If you advertise services or events for LGBT people, make certain you recognize the difference between those groups
- Train ALL of your staff
 - From frontline to senior administration about trans-concerns, needs and issues
- Examine your institutional assumptions about trans-identities
 - Insist staff respect the confidentiality, choices and fluidity of identity of your trans-staff and the trans-people you serve
 - Remember to challenge transphobia when you hear or see it
- Respect the ways trans-people refer to themselves
 - Transgender is a privileged term and many people feel
 - It does not accurately reflect their identity
 - May not be aware of it
 - Feel comfortable using it

Creating trans-services

- Enlist the expertise and voices of trans-people when creating services and groups for trans-people
 - Trans-people are the experts about our needs, bodies and lives
- Transgender encompasses a broad spectrum of identities
 - Don't assume transgender refers solely to trans-women or trans-men
 - Different trans-communities have different needs
 - If you only serve one segment of the trans-communities, say so
- Trans-services include more than HIV prevention
 - Seek funding for other trans-specific concerns such as access to healthcare, housing, employment, and so forth

Offering trans-services

- Take responsibility to modify any forms, paperwork or software you use
 - So trans-identities, names and bodies can be accommodated and accurately represented
- Don't subject trans-people to additional hoops and hurdles to obtain the same necessary care and services offered to non-trans-people
 - GID (Gender Identity Disorders) and the HBIDGA Standards of Care are widely discredited within the trans-communities and should not be the basis for services
 - Be careful not to create "Genital Standards"

Hiring and providing services

- Employ trans-identified staff
 - In addition, it is vital to employ trans-identified staff in positions with *institutional authority*
 - Be careful not to fill a “trans-quota” with part-time, outreach, temporary or low-wage positions
 - Be aware of the tendency to tokenize trans-staff
- If you have a board of directors
 - Make certain to include trans-people in it

Resources and benefits

- Create trans-inclusive restrooms
 - Don't police public restrooms
 - Recognize that gender different people may not match the little symbols on the restroom door - or your expectations!
 - Include all-gender or gender-neutral restrooms
 - Encourage businesses and agencies to have unisex bathrooms, and, if necessary, offer to accompany a trans-person to the bathroom so they are less vulnerable
- Include trans-health care, or a reasonable substitute, in your employee benefits packages
- Accommodate the unique needs of employees who transition on the job
- Celebrate trans-identities and support trans-causes

Funding

- Trans-organizations often have
 - Less history
 - Fewer resources
 - Rarely can compete for funding and grants against larger, more developed institutions
- Take care not to appropriate funding
 - Offer technical and capacity-building assistance
 - Assist trans-organizations whenever possible to obtain appropriate funding

Research

- Doing research with the trans-communities
 - Is a privilege and an opportunity to assist a community under fire
- Don't do research with the lesbian and gay communities and add the "T" as an afterthought
- Funding opportunities are severely limited
 - Before you undertake research projects ask the trans-communities
 - What our priorities are
 - What we think is needed
 - Who should be included
 - How to best accomplish these goals

Check gender assumptions

- Sexual orientation and gender identity
 - Don't make assumptions about a trans person's sexual orientation - gender identity is different than sexual orientation
- Pronouns and names
 - You really do not know what pronoun or name someone uses until you ask
 - Use pronouns and names of choice and encourage others to do so also
- Confidentiality, disclosure and "outing"
 - Don't assume someone's trans-history is known to others
 - Knowing a trans person's status is personal information and up to them to share with others
 - Do not casually share this information, or "gossip" about a person you know or think is trans
- Many ways to be trans
 - Don't assume what path a trans-person is on regarding surgery or hormones
 - Affirm the many ways all of us transcend gender boundaries, including the choices some make to use medical technology to change our bodies
 - Some trans people wish to be recognized as their gender of choice without surgery or hormones

Listen, be open, take action

- *Listen...*
 - To trans voices
 - The best way to be an ally may be to listen to trans people themselves - they are the experts on their own lives!
 - Check out trans websites and books
 - Make trans friends and talk to trans folks in your community
- *Be open...*
 - To criticism
 - Try to view criticism as an opportunity, not a failure
 - To change
 - New ideas and ways of doing things
- *Take action...*
 - Volunteer for, or make donations to, trans activist groups and providers
 - Talk to your coworkers, friends and family members about the trans-communities
 - Get your organization, community, church or school group together and show documentary films about trans-people
 - Invite trans-people to train and present



Resources

Moving from silence into speech is for the oppressed, the colonized, the exploited, and those who stand and struggle side by side a gesture of defiance that heals, that makes new life and growth possible

bell hooks

The Gender Identity Project's prevention goals

- To perceive trans-identity as normative
 - And work with participants to develop a healthy and un-conflicted transgender self concept
- To emphasize positive role models
 - Where participants adopt the behaviors of those who are similar and respected
- To focus on reducing isolation
- To recognize the oppression trans-people experience is structured within the dominant culture rather than the individual
 - Developing multi-layered interventions - individual, group, community, advocacy and capacity-building
- To develop community-level interventions that enhance trans-identified spaces
 - To reduce or prevent substance abuse and the risk of HIV infection among the transgender communities
- To engage and appeal to an inclusive trans-community
 - Including gender non-conforming people, partners and trans-amorous people, family, allies and hidden transgender populations, such as youth, men, and the elderly
- To utilize a harm reduction approach
 - Emphasizing a “stages of change” methodology

Center CARE Wellness and Y.E.S.

Counseling, Advocacy, Education & Recovery
(212) 620-7310, www.gaycenter.org/health

- Center CARE Wellness
 - Short-term, integrated substance abuse and mental health counseling to the lesbian, gay, bisexual and transgender communities
 - Groups and workshops around loss and grief, harm reduction, living in recovery from alcohol and other drugs, smoking cessation, sexuality, coming out issues, services for people living with and/or affected by HIV and AIDS, and services for transgender, gender-different and gender questioning individuals, their partners and families
 - GIP (Gender Identity Project) - part of Center CARE
 - Information and referrals, as well as support groups for transgender, gender-different, gender-questioning people, their partners and families
 - Professional education, sensitivity training, forums and community education
- Y.E.S. (Youth Enrichment Services)
 - HIV prevention for lesbian, gay, bisexual, transgender and questioning youth
 - Activities-bases support, counseling and discussion groups for young people ages 13-21
 - Dances, socials and workshops in creative writing, video performance and computer training

Center CARE Recovery

(212) 620-7310, www.gaycenter.org/health/recovery

- A new medically supervised outpatient chemical dependence treatment program that uses an abstinence model and incorporates a wide range of holistic services
 - Individual, group, and family counseling
 - Alcohol and substance abuse education
 - HIV prevention, education, and referral services
 - Vocational preparation activities and skills development
 - Tobacco education and smoking cessation programs
 - Psychiatric, medical, and other health and wellness services
 - And services to significant others
- Center CARE Recovery accepts Medicaid and private insurance and also offers sliding scale payment options
- Clients are able to connect with the greater, organized LGBT communities
 - Fosters a sense of empowerment
 - An opportunity for proactive involvement in community activities
 - Access to the Center's myriad resources

Other Trans-Care trainings

A clinical training standard, typically configured in multiple 1½- to 3-hour segments

- **Trans-Care: Basics**
 - An overview of transgender identity and community, terminology and engagement concerns
- **Trans-Care: Practice (Mental Health)**
- **Trans-Care: Medical**
- **Trans-Care: Allies**
 - How to be a trans-ally
- **Trans-Care: Employers**
 - How to strengthen your business' or organization's capacity to hire and work with transgender employees
- **Trans-Care: Families**
- **Trans-Care: Hidden Populations**
- **Trans-Care: Inclusion**
 - How to make your group or organization more trans-inclusive
- **Trans-Care: New York City Human Rights Law**
 - What a provider needs to know about working with the recent changes to the NYC Human Rights Law
- **Trans-Care: Research**
 - A review of ethical research practices with the trans-communities
- **Trans-Care: Substance Abuse**
- **Trans-Care: Survivors of Sexual Abuse**
 - How to offer trans-specific services and interventions for transgender survivors of sexual abuse
- **Trans-Care: Youth**

Silicone risks

- Risks include
 - Respiratory distress
 - An immune response, which causes the lungs to fill with fluid
 - A pulmonary embolism
 - Neuropathy
 - Severe autoimmune and connective tissue disease
 - Toxic shock syndrome
 - Granuloma and scleroderma
 - Infection
 - Transmission of HIV
 - Hepatitis B and C
- Reactions can be immediate or delayed for years or even decades
- Silicone often moves around in the body, especially larger quantities
 - Especially dangerous when introduced into the breast
 - May become hard and lumpy
 - May develop infections, form cysts or open sores, become hyperpigmented, cancer
 - In rare circumstances, develop gangrene



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Thank you

This training has attempted to offer insight and examine the intersection of gender and transgender-based oppression, identity, development and health.

It is therefore vital to offer thanks to those that have come before us and who influence our work. In that spirit, this workshop is indebted to feminist, post-colonial and queer theory, orientation and methodology in regard to practice.

We would also like to offer our many thanks to Rosalynne Blumenstein, Barbra Ann Perina, Barbara Warren, Samuel Lurie, Joe Ippolito, Scout, Gal Mayer MD, Anne Lawrence MD, Jean Malpas, Laura Booker, Griffin Hansbury and so many, many others for their contributions to this workshop and the important work they do.

*The Gender Identity Project
The Lesbian, Gay, Bisexual & Transgender Community Center
(212) 620-7310, www.gaycenter.org*