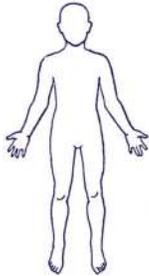


INSIDE

HACKING TRANS- GENDER HEALTH CARE 4

Going to the doctor is stressful, but as a transgender person it can be downright terrifying.



BEYOND THE BINARY 6

People who exist outside of the gender binary of male/female make up a growing part of the population.



Personal Perspective: MY TEAM SAVED MY LIFE 8

TRANS YOUTH: AC- CESS AND EQUITY IN HEALTH CARE 10

There is limited information on how to educate younger trans folk on navigating the system.

Personal Perspective: WE FOUGHT FOR THEIR FREEDOM 14

MORE THAN A RISK GROUP 16

HIV in
Transgender Sex
Workers' Lives

TGNC OLDER ADULTS WITH HIV 19

Providers can play a critical role in reducing the barriers TGNC older adults face.



EDITORIAL 23

Achieve is a publication of

ACRIA

GMHC
END AIDS. LIVE LIFE.



Providing Care to Transgender People

by Finn Brigham

One of the most common reasons that Transgender and Gender Non-Binary (TGNB) people do not have access to healthcare is that they simply cannot find a competent provider. TGNB people living outside of large U.S. cities are unlikely to have a TGNB-competent healthcare provider within a four-hour drive, and those who do often find that those providers are too booked to accept new patients.

According to a 2009 Lambda Legal study, 89% of TGNB people reported there were not enough health professionals adequately trained to care for people who are TGNB, 73% reported that they feared medical personnel would treat them differently, and 51% said they feared they would be refused care based on their TGNB status. In addition, 26% of respondents said they had been refused care based on their TGNB status.

A large part of the problem begins with healthcare training. Few medical professionals are offered any kind of LGBT training in medical or nursing school and for those that are, it is usually a short session focused on the HIV risk of gay men. Even well-intentioned providers who want to provide competent care don't know how to get the information they need.

All of this can lead to poorer health outcomes, especially when coupled with other barriers to health. TGNB people are more likely to live in poverty, more likely to experience homelessness, and less likely to be employed and insured than their cisgender (non-transgender) counterparts. They also experience higher rates of tobacco use, substance use, depression, and anxiety. Tragically, suicide rates among TGNB people are substantially higher than among cisgender people (studies have found that 41% of TGNB people have

continued on next page

achieve

EDITOR IN CHIEF

Kelsey Louie

EDITOR

Mark Milano

ASSOCIATE EDITOR

Joseph Luniewicz

PUBLICATIONS MANAGER

Mark Milano

PUBLICATIONS ASSOCIATE

Laura Engle

For information on how to obtain bulk copies of *Achieve*, call 212-367-1077, email achieve@acria.org, or write to:

Achieve

ACRIA @ GMHC

307 W. 38th St.

New York, NY 10018-9502

Copyright © 2018 ACRIA and

GMHC

All rights reserved. Non-commercial reproduction is encouraged provided appropriate credit is given. Subscription lists are kept confidential.

Individuals pictured are models and are used for illustrative purposes only. Photos used in *Achieve* imply nothing about the health status, sexual orientation, or life history of the models.

Every “Personal Perspective” in *Achieve* contains the views and opinions of the attributed author and does not necessarily represent the views and opinions of ACRIA.

ISSN 1948-0687 (print)

ISSN 2165-4883 (online)

Providing Care *cont. from first page*

attempted suicide). These social determinants of health affect everyone, but are made worse by the fact that TGNB people who can access healthcare are rarely able to find a competent provider.

Specific Needs

Most healthcare for TGNB people is exactly the same as care for cisgender people – there is no difference when caring for strep throat or a broken bone, for example. The difference is the barriers that TGNB people face in getting these things treated. But there are some specific healthcare needs for TGNB people that all providers should be aware of.

Hormones: Many TGNB people (but not all) choose to take hormones to better align their physical body with their gender identity. It is important for medical providers to educate their patients about the risks and benefits of hormones so they are clear on the likely effects.

Gender-Affirming Surgeries: There are many different surgeries TGNB people can get to better align their physical bodies with their gender identities. In addition, many states (including New York) now require insurance companies to cover these surgeries, making them more accessible than ever. Providers should be aware of the different types of surgeries that are available, be knowledgeable about diagnosis and the CPT codes used in billing, and have a referral system in place.

Insurance companies will often require patients to obtain letters from their medical and behavioral health providers to obtain these surgeries. Providers should be well versed on how to write these letters. Depending on the insurance company, various information must be included in the letters, such as the length of time the person has been in care, the length of time they have been on hormones, information on contraindications, etc. Health care providers (including behavioral health care providers) should create templates for these letters that can be altered based on each patient and the requirements of their insurance plan.

Sexual Health: When TGNB people seek sexual healthcare, they often do not

fit into the gendered structure of care that they experience. For example, TGNB men seeking GYN care in a female-focused clinic can face extraordinary problems, and finding providers who can provide post-surgical GYN care for transwomen can be like finding a needle in a haystack. Additionally, TGNB women seeking anal or prostate care can cause great distress for both the patient and the provider. It's important to consider that some TGNB people may use alternative language to name or describe their body parts, so it's good practice to ask them what terminology they prefer. For example, using terms like “chest exam” rather than “breast exam” can be helpful for transgender men who have not had top surgery. Any provider working in sexual health needs to be aware of the healthcare issues that TGNB people face and how best to serve them.

Some TGNB people use alternative language to describe their body parts, so it's good practice to ask them what they prefer.

HIV

HIV is another large issue in the TGNB community. Around a quarter of TGNB women are living with HIV, and 56% of black/African American TGNB women have HIV. In addition, TGNB people are 49 times more at risk of HIV than the general population. It's also important to be aware of whom we are talking about when we talk about TGNB people and their higher HIV risk. Oftentimes, transmen and transmasculine people are not considered in the research and media around HIV risk, treatment, and prevention. Due to the reasons discussed earlier, many TGNB people are hesitant to engage in medical care out of fear of discrimination. This can affect their HIV testing, treatment, and adherence.

It is important to understand the unique way transgender people experience HIV risk and infection in order to treat them competently. For example, although HIV among TGNB women is often spread by unprotected sex, that risk factor cannot be lumped in with gay male sex. Most HIV prevention funding is focused on gay men, and the few interventions for transgender women have rarely involved transwomen in their creation or implementation. We cannot use the lens of gay men when trying to stop HIV in TGNB women.

Many TGNB people prioritize their TGNB healthcare over their HIV care. They may be concerned that HIV meds will interfere with their hormones, or that providers will not prescribe hormones if they are HIV positive. There are no confirmed interactions between hormone therapy and first-line HIV meds.

Providing Competent Care

There are many easy steps a healthcare agency can take.

1. **Hire TGNB people!** Having TGNB-identified people on staff, on your board, and on your community advisory board are great ways to ensure that trans issues are being addressed on a day-to-day basis.
2. **Check your antidiscrimination policy** to ensure it includes gender identity and expression. If it doesn't, update it. Post this nondiscrimination policy around your clinic so patients can see it.
3. **Update your intake form** to ensure it includes multiple options for gender (male, female, TGNB, genderqueer, other). It should also include space for chosen name, legal name, and preferred pronoun. All of this information should be recorded in your electronic medical record, and staff should know to check this information before seeing a patient.
4. **Have gender-neutral bathrooms.** Bathrooms can make trans people feel safe or unsafe, in any environment. Simply change the bathroom signs to "bathroom", especially if they are single stall rooms.
5. **Have staff use their pronouns** when introducing themselves in a group. We should normalize asking people about their pronouns, regardless of



Most HIV prevention funding is focused on gay men, and the few interventions for transgender women have rarely involved transwomen in their creation or implementation.

- whether they are perceived as trans.
6. **Get educated.** There are many TGNB health conferences that take place around the country and the globe. Send staff members to gain new information. Have an LGBT-focused health center (such as Callen-Lorde or Fenway Health) provide on-site training to your staff. Look up the World Professional Association of TGNB Health (WPATH) guidelines on hormone care.

Conclusion

According to current estimates, there are about 1.4 million transgender people in the U.S. In addition, a 2016 Williams Institute report found that the percentage of trans people in the U.S. was double that of its 2011 report. As younger folks age, they are more likely to identify as transgender or gender nonbinary.

All this means the medical community is going to have to do better when it comes to serving the transgender community. We need more providers who are better trained in this type of care. We need more insurance companies that understand our needs and work with us around our unique care needs. We need more transgender people to be involved in the creation and implementation of programs that are targeted toward us. It is not enough for providers to simply be willing to treat transgender people. We need more research, more funding, more training, and more competent clinics. Our lives literally depend on it. ■

Finn Brigham is the Director of Project Management at Callen-Lorde Community Health Center in New York City.



by Sydney Shackelford

Going to the doctor is stressful enough, but going to the doctor as a transgender person can be downright terrifying. When seeking a new health provider, we worry about how they're going to treat us when we disclose that we're transgender. Even if we've been to the provider before, we worry whether a new staff member will treat us like human beings. It shouldn't be this way and doesn't have to be.

In the 2015 U.S. Transgender Survey, conducted by the National Center for Transgender Equality, nearly a quarter of the 28,000 trans people surveyed reported not seeking healthcare due to fear of discrimination. Of those that tried, a third reported having at least one negative experience. Common fears are certainly justified in light of these statistics. With the recent word that the Trump administration may

allow discrimination in healthcare by legally defining gender through archaic definitions, those fears are probably reaching an all-time high.

Some might suggest being "stealth" (a term used to describe those who don't mention they are transgender), but that puts lives at risk. I can't stress

know. Post-op transgender women with prostate cancer can have symptoms similar to those of urinary tract infections, causing misdiagnosis. It is simply not worth putting one's life at risk.

Every transgender woman I know who has gone to a healthcare

In the 2015 U.S. Transgender Survey, conducted by the National Center for Transgender Equality, nearly a quarter of the 28,000 trans people surveyed reported not seeking healthcare due to fear of discrimination.

how important it is to disclose everything to your healthcare provider. As a post-op transgender woman, I could easily go stealth, but I still have a prostate. Even though it is highly unlikely I would ever have prostate issues, since I have very little testosterone in my body, it's something my doctor should

provider since transitioning dreads the question, "When was your last period?" At that moment, the awkwardness really starts. Then you have the lovely pleasure of disclosing your transgender status, and doing it many times at the same doctor's office because the staff member tak-

ing your vitals didn't read all of your chart. It gets awkward for transgender men who need to visit a gynecologist, or who need a mammogram and have to ask for it. (A cisgender woman is asked about it automatically during checkups.) Finally, for those who are nonbinary, it becomes frustrating from all sides.

It's bad enough that the healthcare system is difficult to navigate for anyone, but being transgender makes things seem overwhelming. You have to be an advocate for your own healthcare. Fortunately, there are some resources out there to help.

Your Social Network

Word of mouth is my first go-to for healthcare recommendations. Ask someone in a transgender support group or a trans friend on Facebook – they've been through it and are a resource you can trust.

The Internet

An excellent online source is a website called RAD Remedy, at radremedy.org. You can search all kinds of healthcare providers by location and find other resources, from legal services to yoga classes that are trans-inclusive. What is unique about this website is the option to submit new resources. The site is especially helpful for post-op transwomen needing a pelvic exam, as finding a gynecologist who has experience with neovaginas is very difficult. Transgender men may need a pap smear, so this site is also an excellent way for them to find a trans-inclusive provider.

Facebook groups are another online source, in addition to your Facebook friends. Searching your city or state and the word "transgender" may bring up regional transgender groups that have resources for your area. Using the Facebook "Ask For Recommendations" feature is a great way to find resources in those groups. Reddit has a subgroup (reddit.com/r/asktransgender) where you can post questions about resources in your area. Finally, check to see if your local LGBT community center has a list of local resources on their website.

Planned Parenthood

More and more Planned Parenthood locations provide LGBT healthcare. These are great for basic healthcare needs, but they can't always replace a primary care physician due to limited resources at some locations. They may not have specialists onsite, but may be able to recommend trans-inclusive providers for the specialty you need.



Your Current Provider

Your current health provider may know about other resources. Healthcare providers network with each other in a range of related fields. And patients often educate their own doctors about other service providers. My electrologist has recommended a lot of resources to me, since over half her clients are transgender women. Like a lot of transwomen, I've spent over 150 hours on her table as she removed hair – a wealth of information is exchanged there.

Be an Online Detective

Many healthcare providers have a website, so searching for them should be relatively easy. Most trans-inclusive providers list "LGBT Services" on their site. Often their policies are listed, and if you see the phrase "gender identity" you are likely safe from discrimination. Many healthcare providers provide online documents

and downloadable intake forms. If you see things like "preferred name" or "assigned sex at birth" along with "gender identity" on the forms, you know they are trans-inclusive.

The Reality

Even with research and recommendations, you will probably end up educating your provider yourself. A few years

ago, my wife and I needed to find a new primary care physician. Someone recommended one who had excellent reviews, but there was no indication online about being trans-inclusive – although she seemed to be LGB friendly.

When we arrived, I found that if I had not changed the name and gender on my ID there would have been a problem: there was no place in their system for a preferred name or pronoun. For ease of billing, providers put you in their computer systems based on your legal name and the gender on your ID and insurance cards. Those systems are very expensive to update, so most don't have a place for this kind of information. It's often put in your chart as a sub-note and ends up being the last thing anyone reads. Thankfully this is starting to change, as doctors are asking for the ability to store preferred names and gender identities with patients' information.

continued on next page 22



by Kaleb Oliver Dornheim (they/them)

Despite the apparent mystery surrounding people who exist outside of the gender binary of male/female, we make up a growing percentage of the population. Unfortunately, while healthcare systems are trying to make themselves more comprehensive and welcoming to the LGBTQ+ community, we are never at the top of the list of changes that are being rolled out. But there are multiple ways that the healthcare industry and medical providers can make their spaces and interactions with our community better.

When we think about including individuals who are outside the binary, folks will often fall back on single-use gender-neutral bathrooms (conveniently, the accessible bathroom required by the ADA). They then wipe their hands and congratulate themselves on solving the problem so quickly, with just the low cost of changing a bathroom sign. Cisgender (non-transgender) women and binary trans women will be able to use the women's bathroom or the gender-neutral single bathroom, and vice versa for cis men and trans men, while anyone outside the binary and anyone needing a single stall for accessibility will use the larger, more private bathroom. However, this creates a weird space in which anyone outside the binary must out themselves as nonbinary if they go into the private bathroom. And if it's in use, they

must either wait outside and risk awkward or triggering questions about why they aren't using the other two multi-person bathrooms, or potentially be triggered and anxious while using a bathroom that does not align with their gender, even risking violence.

Additionally, able-bodied people who use the only wheelchair-accessible restroom force people in wheelchairs to wait. Gender neutrality is often positioned as secondary to the real purpose of the bathroom. We should challenge ourselves to confront our privilege, rather than asking one marginalized group to step over another and prioritize their oppression as the one that most needs to be addressed.

Intake Forms

When we group gender-nonconforming, nonbinary, genderqueer, and agender people into one category, those words start being used interchangeably, which leads to equating different experiences and identities. Someone who is gender nonconforming may be cisgender, and may not experience transphobia or gender dysphoria (unease). Someone who is nonbinary may or may not identify as transgender or experience dysphoria – they may pass as binary and so may not experience the same level of transphobia that other nonbinary individuals do.

When intake forms have a limited number of options, it leaves some folks out and forces us to try to choose which part of our

identity is the most prominent that day – when what the form is really trying to get at is something entirely different: collecting usable data. What may take extra time to enter into a data system could mean the world for a trans person. It's important to be able to clearly indicate what their gender identity is, and what their coercively assigned sex at birth was, if it's relevant to their visits. Clients should never be made to feel that they are the “other” when they are trying to receive care, especially at locations that work for the LGBTQ+ community.

Talking About Sex

In many discussions around HIV prevention, risk is based on what category people fall into: crystal meth users, gay men, trans women, etc. But there is little discussion about folks outside of the gender binary. Medical providers will place us into a binary and decide that our risk is based on an assumed or perceived binary gender, even when that's not how we identify. That doesn't indicate the kind of sex we're having.

One of my doctors at a health center that caters to the LGBTQ+ community always asked if I had heard about PrEP and if I wanted to go on PrEP, and only after I declined would he move on to checking my hormone levels. He constantly did so because I had once mentioned I was dating another trans individual who was on the masculine spectrum (who then identified as genderqueer, later as a binary trans guy).

This doctor placed me into the “MSM” category, but he never asked about the type of sex I was having, what parts were interacting with what other parts, and what protection (if any) we were using.

Fast forward to my doctors later at the same health center. They regularly ask me what’s going on in my sex life, allow me to frame the discussion first, and base their questions on what sex I am having, how I have it, and with whom. At first, the difference was startling and led me to wonder why I suddenly wasn’t being pushed to go onto PrEP. I realized it was because I no longer fell into a “high-risk” category. I was being seen as me, not a mistaken binary identity.

Having a different way of navigating conversations around sex and my body would have completely altered my doctor appointments for years. Because I rarely talked about my sex life with my doctor, outside of answering that I didn’t want to go on PrEP, I lost opportunities to discuss other health concerns, such as sexual risk, questions about my body, or how my partner could practice safer sex. It also kept me from doing preventive reproductive health practices and care for years, due to my unease around language or even asking questions about my body and what I should do.

The Body Map

One thing GMHC has recently developed, specifically to present at the Philadelphia Trans Wellness conference, is the Body Map (above left). This body map has various shapes and sizes on an outline of a body, and allows you to answer: “This part is commonly called _____, but I call it _____”. You can do that for all the body parts you have discomfort with or for which you just use different words than your doctor does. You can add it to the other forms you fill out and have your doctor start a conversation about it, or you can review it and talk about it later, or start the conversation yourself.

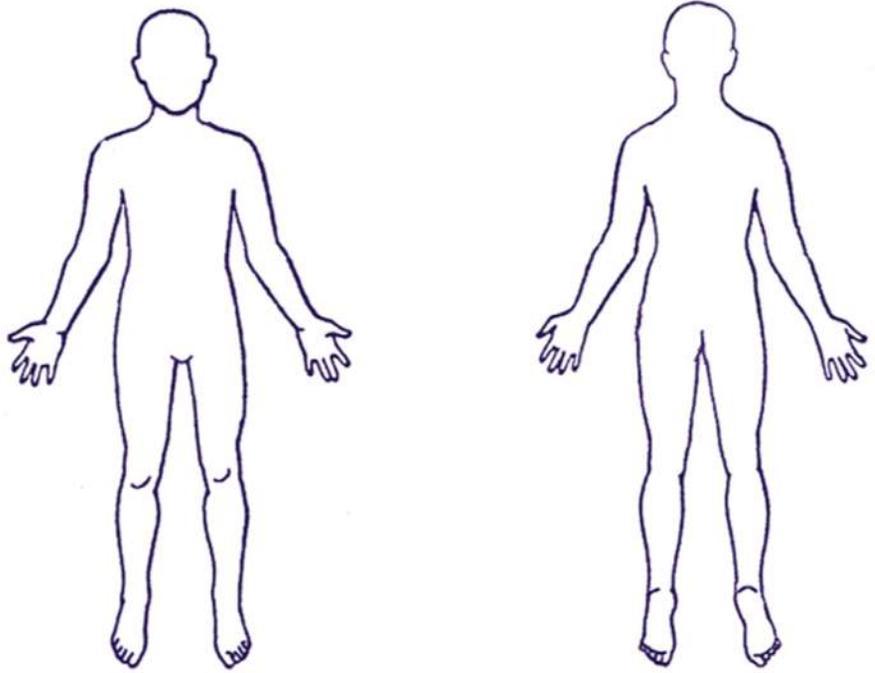
The Body Map also helps providers to discuss sexual risk and HIV prevention, and to talk more easily about sexual health with their clients. When they ask, “What parts of your body interact or touch your partner’s body?” you will clearly understand what parts they mean. It also allows us to move away from always defining the

sex assigned at birth within a binary. It offers the possibility of looking at specific organs and areas of the body as labeled by their inhabitant, rather than having society impose language and terminology that doesn’t fit. You can find the Body Map at our website: gmhc.org.

Conclusion

Treating TGNCNB people with respect in healthcare systems is not complicated – it just takes some time to reprogram ourselves and step away from focusing on treating them as the other, as special cases who appear too complicated to easily understand. If we start looking at everyone with the same intention – to understand what their relationship is to their body, how they refer to their body, and what body parts come in contact with other body parts, we can have more comprehensive exams and portraits of our patients and community members.

TRANS BODY MAP—MY LANGUAGE



Mirroring a person’s own language instead of ascribing gendered and potentially triggering language to their body, creating gender neutral and gender inclusive spaces, and reviewing all documents that ask about risk, gender, sex, pronouns are some steps we can take to create more welcoming and safe health interactions for the TGNCNB community. Take it from a nonbinary person – the more my doctor lets me have agency over my body and allows me to be involved in my appointments, uses my language and doesn’t force society’s ideas about gender, sexual health and practices, and risk onto me, the more I want to come back to my doctor and value my body and health. ■

Kaleb Oliver Dornheim is an Advocacy Specialist at GMHC.

My Team Saved My Life

by Octavia Y. Lewis, MPA

We often tell our stories of survival without mentioning our healthcare providers and their teams who truly go above and beyond. I'm a witness to having one that did just that. When I was diagnosed in April of 2006, I thought my life was over. I planned my suicide, because many of us who identify as women of transgender experience and happen to be of color never get to experience what others take for granted.

However, I was fortunate enough to encounter a wonderful physician by the name of Dr. Nancy Koughan, who worked at the DeKalb County Board of Health in Decatur, Georgia. I was truly amazed and shocked that she not only treated my HIV but provided care for my transitioning process. We went through the pills, patches, and finally decided that hormone shots were better for me because they were given only once every two weeks. This was a game changer for me because I was used to purchasing my hormones on the streets and truly not knowing what the person I purchased them from was giving me.

Dr. Koughan knew that this wasn't legal or safe, and explained to me the importance of never doing that again as long as I had access to hormones through the proper channels. She saw things in me that I did not see in myself, and for that I'll be forever grateful. I wasn't very educated on advocating for myself, and she made that easier for me by explaining that I had options as a consumer and that I should be aware of them. I've never forgotten what it was like to have someone educate me on the value of health literacy and the importance of patient's rights.

Mr. Avery Wyatt, the Health Educator at the time, saved my life, to be honest. Before getting to know him, I was just working, partying, and living my life without a care in the world. That was until my HIV diagnosis stopped me dead in my tracks. I'm not going to say I was the easiest or the best client to work with, but he was determined to ensure that I made something of myself. He told me the importance of having an education and urged me to go back to school to better myself if I wanted to fully embrace my womanhood on my own terms.

I was amazed that my doctor not only treated my HIV but provided care for my transitioning process. This was a game changer for me because I was used to purchasing my hormones on the streets.

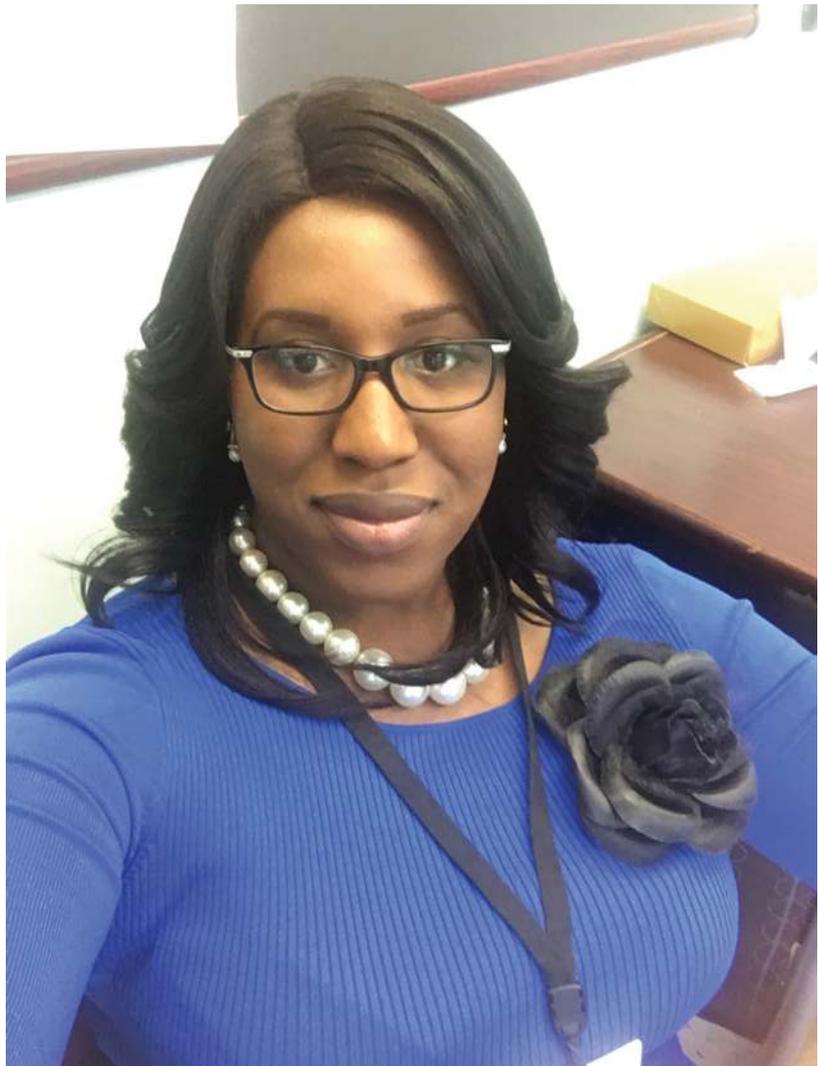
Mr. Wyatt was there for me as I struggled through getting my Associate's degree and while I worked on my Bachelor's degree as well. He also sparked an interest in public service, especially to people living with HIV in my community. I had the opportunity of serving on the Community Advisory Board for the DeKalb County Board of Health and becoming a peer educator as well. Having this part-time position made me feel I was doing something meaningful, and I was getting compensated in the process.

When I graduated and couldn't find employment (not uncommon for recent graduates), I had an

extra layer – my trans identity and lack of experience – that made it extremely difficult to find a job. I had been doing survival sex work while completing my degrees but knew that I wanted and deserved better than that. It was around that time that I researched additional information about HASA (HIV/AIDS Services Administration) after a friend gave me some brief information about the program. Mr. Wyatt and I decided that if I could get into the program it would be the best thing for me.

Our next step was to have a conversation with Dr. Koughan, who had always been supportive of me. But I wasn't sure she would assist me in this process because I was no longer going to be her patient. It shouldn't have come as a surprise that she assisted me with completing the MQ11 and actually wished me well if I got accepted. We submitted the paperwork on a Wednesday afternoon, and you're supposed to wait up to 72 hours to find out if you are accepted. The suspense was killing me, so I broke down and called on that Friday. I was accepted!

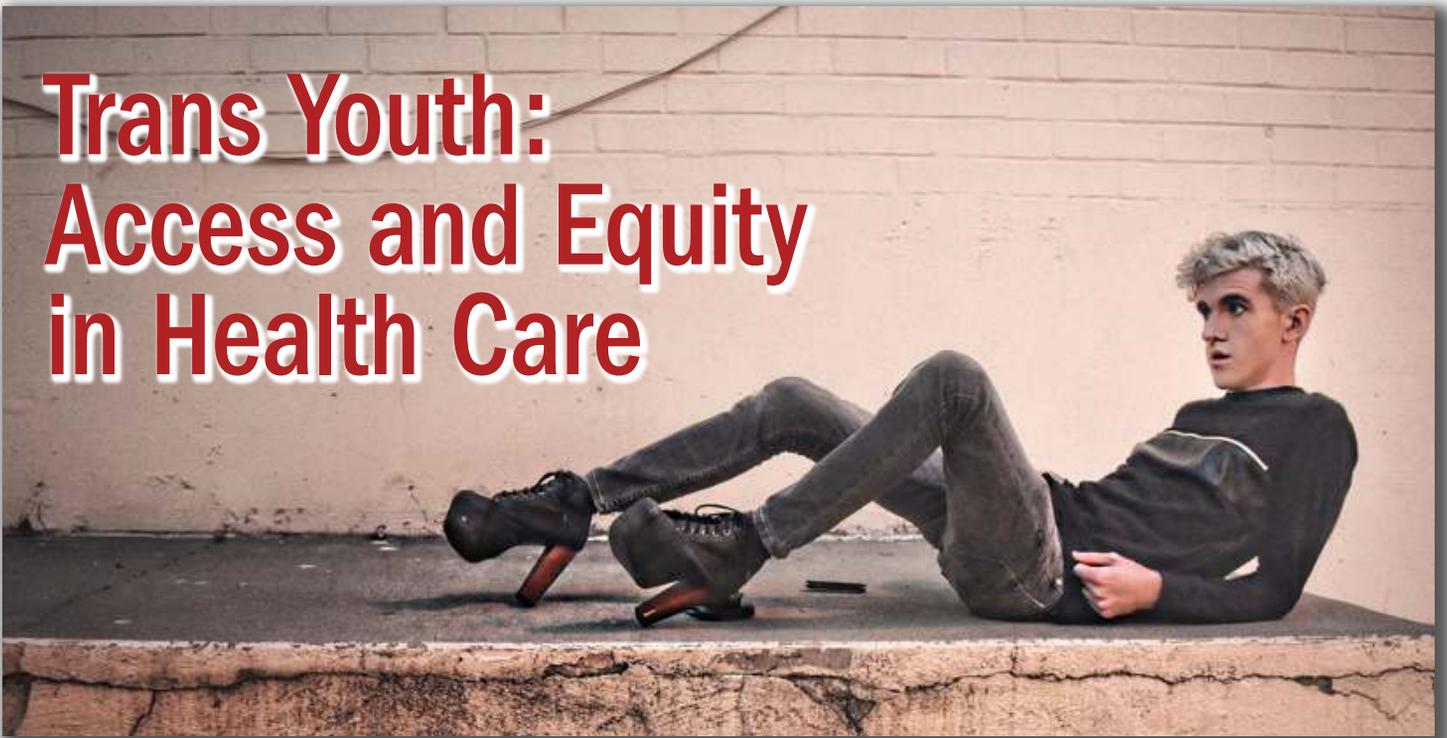
I called both my providers that day, and they were so happy for me! I was so afraid of making Dr. Koughan feel like I had abandoned her and that she would think that I was unappreciative of everything she done for me and taught me under her care. In that moment I realized that while she had been teaching me all along to make better informed health decisions, she didn't feel any sense of entitlement over me and my well-being. She had planted the seed in me from the beginning, and now could see that it was time for me to continue onto the next part of my journey without her.



It has been some time since I've spoken with her, but the knowledge and wisdom she bestowed upon me have become my guiding principles in the work that I do. Mr. Wyatt and I went on to present a workshop at the Michigan State HIV Conference in 2015 and remain in contact with each other to the present day.

I have been beyond Blessed and Fortunate to have healthcare providers who took time out of their busy schedules to ensure I had what I needed to be successful and gave me the skill set I needed to advocate for myself. In the words of my mentor Mr. Wyatt, "People don't care how much you know until they know how much you care." These two providers showed me the true definition of just that, and because of them I continue to assist those impacted by this epidemic. ■

Trans Youth: Access and Equity in Health Care



by Julian Cabezas

I became an HIV organizer as a teenager. My cousin was organizing a team for AIDS Walk Los Angeles in memory of our uncle. She was the only person in my family willing to discuss that he died of AIDS. I was 13 years old, Chicana, and just coming into my baby butch swag.

Where We Are Now

Sex was an off-limits topic. Not only was I not supposed to be having sex because I was 13, I certainly wasn't supposed to be having lesbian sex. I was having lesbian sex, but at least I wasn't having sex with a guy. I felt no need to talk about the sex I was having, since that sex meant I would be safe from all the bad consequences of sex. Having sex with a woman at 13 was be one of the reasons I was asked to leave home.

I knew I wasn't actually a lesbian. I knew I was a guy who liked women. I knew I was straight and wanted to grow up to have a wife, full-time job, two children, and family barbeques at the park. I also knew that I wasn't allowed to tell anyone this. Not even myself. Because there were no words for me when I was a teenager. I knew that LGBT was a term, but I never knew what the "T" meant.

I prayed to God every night I could wake up a boy, but the community I now have was invisible to me. Not until I met friends who had college degrees and attended trans and queer studies classes did I find a language about this part of myself and learn how to navigate the world. Just around this time, I began to see myself as queer man who was having sex with other men. I needed to learn about the medical system: hormones, surgery, syringes, birth control, HIV testing, pregnancy tests, etc. I started searching for answers and a way to survive.

My focus in this article is on the process of finding meaning and understanding the embedded stories about being a trans youth with HIV. I hope to explain how our identities have been shaped by society, how our community has carved out its own identities, and how we can define and live out these narratives.

Working in the Clinics

The trans community as we know it existed before the modern male, straight, cisgender, White, western medical system. (Cisgender refers to people who live with the gender expression/gender identity they were assigned at birth.) I should also define what I mean by White as a race/concept. "White" as a concept has varied throughout history. In the U.S., this has changed over time, as different ethnic groups were welcomed or excluded from the White identity. As a Latino, I have a history that has been explained to me as both European and as indigenous to the Americas. I am of mixed race/mestizo, so I experience light-skinned privilege. Whenever we have conversations around transphobia, we must also think about our own cultural backgrounds and that of those around us.

A community outside of this system has survived in spite of it. The historical context of the trans community is important to point out because the way that language is used often pathologizes marginalized identities and places a moral judgment on behaviors. Additionally, the stigma associated with HIV is enough to keep many people from accessing services. Members of the community who avoid these unwelcoming spaces are often referred to as non-adherent, non-compliant, lost to care, unreachable, or hard-to-reach. Blame is often placed on them, as opposed to a system that has failed to create policies that support

health, encourage conversations around gender and racial equity, expand the notion of what HIV prevention and treatment looks like, or cross boundaries to protect trans youth access to medically necessary services.

When I began working at a NYC DOH Sexual and Behavioral Health Program in Queens, I was told by seasoned case managers and health educators that some of them had never given a preliminary positive HIV test result. I was working in a program with mainly straight Latinx folk, un/underinsured LGBTQ people, and anyone else who needed access to HIV prevention and treatment. I believe one of the strongest aspects of our program was that my co-workers, Lorena Borjas and Liaam Winslet, were amazing community organizers who created ingenious bridges to community support. They were responsive to the needs of clients because their policies were informed by their lived experience. My own direct supervisor Brandon Elgun had a firm grasp on the need for policies that celebrated gender and sexual diversity through a pleasure-based harm-reduction lens.

The objectives in trans health grants showed drastic gaps in cultural humility. Did they really not know that the community needed more than health education around condom negotiation and treatment adherence, and that they were tired of being targeted as “high-risk”?

Within my first two years, I had performed hundreds of HIV tests (each with informed consent that covered the right to health care, PEP and PrEP, HIV treatment, the shame and joy of having relationships outside of heteronormative monogamy, etc.) and gave four preliminary positive HIV test results. Two of them were trans Latinas who were under age 24.

The work didn't get easier. There were real issues for people who needed PrEP but who were still on their parents' insurance. I felt like a gatekeeper when trans youth would come in to get hormone therapy and we had to talk about parental consent and getting hormone therapy outside of their primary care provider's office. They worried about their parents' reactions to their gender identity or the lack of access to mental health professionals who would believe they were the gender they said they were, regardless of their age.

Many clients were immigrants seeking asylum and primary care but who had not been to the doctor in years because of legal documentation issues, transphobic health centers, providers who said “I don't do trans care/I am not trained in trans care”, lack of Spanish-speaking staff, or limited/no health insurance. My official job was health educator, but there was limited information on how to educate younger

trans folk on navigating a system that didn't provide trans-affirming care and often denied medication coverage. This was especially true for trans youth who were not U.S. citizens, white, and middle class. I realized very early on that the objectives stated in trans health grants showed drastic gaps in cultural humility. Did they really not know that the community needed more than health education around condom negotiation and treatment adherence, and that they were tired of being targeted as “high-risk”? I wondered how many trans health care providers were overseeing policies and how we could increase that number.

Navigating the Systems

Around this time, I was also starting to work as a co-facilitator for the Trans Masculine group at the Gender Identity Project of the Manhattan LGBT Center. The trans youth who attended these meetings had distinct needs. Many would discuss issues with their partners, families, coworkers, and strangers. They identified as trans masculine but not as a man, and did not see themselves in positions of power.

The issue of confidentiality when testing and obtaining healthcare also came up. People didn't want to access services because the bills would go to their parents or guardians. They were also exhausted from being denied services by their insurance, dealing with prior authorization, and being asked to take HIV tests. The people in the group were mostly white, middle class, in school, and U.S. citizens. When HIV testing was offered or sex was discussed, there was often avoidance of the topic.

This summer, I attended a panel at the U.S. Conference on AIDS entitled “Deemed Invisible; Transgender Men of Color within HIV Prevention and Care”. It was perhaps one of the first times I had intergenerational discussions with other trans masculine folks about the work that is needed in our communities, the trauma of navigating health care systems as trans men, and the assumptions by health care providers about the sex we have based on our sexual orientations. A call to action by panelists asked how many more of us would have to get HIV before more funding for trans-led HIV health care and social services is available.

It's important to understand that need is based on a person's position in life and that a quintessential “trans youth” does not exist. I recently facilitated a “Trans Youth and Equity” panel for the New York State HIV Advisory Body. Before we started, I encouraged the panelists to “speak truth to power”. As healthcare professionals, we often assume that we understand the issues youth experience, based either on our own experiences or those of our clients. But panelists noted that medically necessary services often look very different to the provider and patient. There was a call for the NYS AIDS Institute to create more employment opportunities for Trans, Gender-Non-Conforming, and Non-Binary (TGNCNB) youth in organizations that have grants to do work in the trans community. One panelist, a woman of color, noted that if everyone at a clinic is white, she

continued on next page

would likely not be hired or have her experiences valued. There was discussion about the need for primary care centers to create systems that address fundamental needs like housing, support groups, and transportation. Adjusting hours and providing walk-in slots for folks who do not have a scheduled week was important. Participants highlighted the ways in which lack of economic opportunities and unstable housing lead many youth into survival sex work.

The juxtaposition of the “Trans Youth and Equity” panel with an earlier panel on youth sexual health that same day was drastic. Addressing sex work in sexual health education for youth was not a conversation piece in the earlier panel. Creating a space to discuss these issues is difficult. Often in advocacy spaces there is more room for detailing trauma than for systemic healing.

And if you discuss sexual health but avoid the topic of sex work, there’s little information on many needed policy changes. This year, El Colectivo Intercultural TRANSgrediendo in Jackson Heights, Queens, hosted “La Marcha de Las Putas 2018”, a march in collaboration with many sex-work-positive organizations. The purpose was not only to bring attention to trans women’s and sex workers’ rights, but also to issues related to society controlling our bodies.

Next Steps

As a healthcare professional, I welcome these issues into the room when meeting with trans youth and policy makers. I don’t see the racism that TGNCNB youth of color experience as separate from their higher rates of depression or increased suicidal thoughts. I validate it. It makes sense. Healing is a process which usually requires that someone discuss their pain, where it started, how it affects them, and how they would like to be treated. Without this type of environment, we will continue to see a lack of engagement in HIV prevention and treatment.

Especially as we work on the NYS Ending the Epidemic campaign, the interventions must be genuine and effective enough to heal the stigma of HIV and transphobia for youth. This means accepting their autonomy, providing sexual health education that moves beyond heterosexual conceptions of sex/gender/genitals, and supporting the fundamental human rights of young adults.

We are moving towards a health care model in New York that will require more from providers than merely putting up a trans flag or asking about someone’s personal pronouns if we are to be seen as a leader in trans care. We need more providers who are competent in HIV treatment and prevention, who provide a gender-affirming environment for TGNCNB folks, and who see advocating for the rights of youth as a necessary aspect of public health.

Policies

The current medical system is seen as normal until you find yourself on the other side of it. Some communities experience this earlier than others. Imagine a young adult being told that their behavior has moved outside appropriate boundaries and whose guardians insist that the next step is a doctor to “correct” them. Protections for trans folks within NYC are drastically dif-



ferent from those upstate. As of October 2018, NYS Senate Bill S263, sponsored by Brad Hoylman, was passed by the Senate and the Assembly, but is still awaiting Governor Cuomo’s signature. I pray that Gender Expression Non-Discrimination Act (GENDA) will be passed by the time this article is published.

One of the organizations working to achieve this end is The New York Transgender Advocacy Group (NYTAG), which hosted a TGNC Policy Day last October. S263 was discussed with congressional representatives, and the governor’s office was made aware of the needs of people he was elected to protect. NYTAG is a grassroots non-profit that is trans-led and is intent on creating new opportunities for the trans community through partnerships and innovative initiatives. (Anyone interested in being part of further organizing should reach out to Executive Director Kiara St. James at nytag.org.)

During a teach-in about homelessness and the AIDS crisis by Vocal-NY’s Queerocracy group, presenters discussed the lack of housing options for LGBTQ youth in NYS and the stigma, discrimination, and criminalization that cause it. (Both the NYS Young Adult Advisory Group and the Transgender and

Gender Non-Conforming Advisory group highlight the need for housing as a way to end the epidemic.) Queerocracy's young (under 30) activists are dedicated community organizers. Their website states:

While our primary focus is to win quality housing for low-income people impacted by the war on drugs, mass incarceration and HIV/AIDS, we are dedicated to the belief that safe, affordable and stable housing is a human right for all. Our accomplishments include:

- Secured a commitment from Mayor de Blasio to develop 15,000 units of supportive housing over the next 15 years. Along with coalition allies, we won this unprecedented, multi-billion dollar commitment to provide housing, along with onsite services for people with physical, mental or behavioral health needs.
- Founded the Homes For Everyone New Yorker coalition, dedicated to ending homelessness in New York through a series of policy changes.
- Implementation of the "30% rent cap" to ensure people living with HIV/AIDS pay no more than 30% of their income towards their rent.

Access and Equity to Healthcare

Given the lack of awareness about the lives of trans people, the majority of the interventions used today enforce a subtle belief in the "gender binary" fairy tale. It goes like this:

There are two universal genders: male and female. These genders have always been the only two genders. Each of these genders is the opposite of the other. They are so far apart that someone would need to "transition" to get to the other side. Any deviation from this system is seen as abnormal.

The two genders are supposed to love each other and want to have sex with one another. Men have penises and women have vaginas. The sex that they have should involve their penis and vagina in a penetrative manner. Men get sex and women give sex. Men gain power as they have sex with more people and women lose power as they have sex with more people.

There should only be two people in a relationship. Any more is viewed as unnecessary and immoral. The extra person would jeopardize stability.

You should never engage in sex work.

HIV only happens to men and women who do not follow this story.

Not surprisingly, the majority of literature, policies, and laws are written by people who grew up being told this fairy tale. Those who can adhere to it are encouraged to repeat it, while those who choose another adventure are threatened. Those whose stories can destroy the privileges of powerful men are silenced and seen as false – particularly if the story is being told by anyone other than a cisgender man. Cisgender folks often feel unease when they are awoken from the gender binary fairy tale.

There is a process that is experienced by those who fear losing their privileges. If this process produces behaviors like emotionally unbalanced behavior, repeatedly misgendering people,

physical/emotional/sexual/financial/spiritual threats, or denial of evidence-based gender-affirming care, it's important to contact a trained gender-affirming consultant, medical provider, legal counsel, or social worker. Depending on the area where these issues are occurring (individuals, partners, family, community, organizations, businesses), the interventions will vary.

For businesses, non-profits, and grassroots organizations, inform the consultant about the policies your organization has in place, including standard operating procedures, diversity initiatives, and how you hope to create a gender-affirming and trauma-informed space. Keep a list of any issues and questions

Those whose stories can destroy the privileges of powerful men are silenced and seen as false – particularly if the story is being told by anyone other than a cisgender man. Cisgender folks often feel unease when they are awoken from the gender binary fairy tale.

to review with a professional. Remember, even the most caring of people can create trauma for trans youth based on ingrained bias, which is why we need well-designed interventions based on both theory and practice.

Conclusion

As I wrote this article, I noticed how much needs to be discussed and realized that would take hundreds of articles. Those who have stories know this is impacting them on a daily basis. Those for whom this is not theory or simply a status on social media must get organized and start building community. We are at a point where there is no alternative but to demand the rights we need and deserve.

Gender-affirming environments are not enough if afterwards you are deported because you're an immigrant. They will not be enough until Black and Brown folks are given access and equity in our world – until we also talk about how we are occupying stolen land. The trauma of the system is large. Healing it will require all of us to believe and work toward it – from feeling better about it to actually making it better. I believe it can be better for all of us. ■

Julian Cabezas is Manager of Outreach Programs at Amida Care in NYC. A gender and sex therapist, he has served as a consultant on issues related to trans and LGB New Yorkers for the NYC and NYS Departments of Health.

We Fought for Their Freedom

by Chanelle Sessooms

I am a woman of color living in a world unfriendly to the transgender community. I am a Native Philadelphian, and a True Legend in eras of greatness that will blow the minds of generations to come, speechless at our beauty.

But I come from a dysfunctional family full of secrets and shame. My mother could not understand what I was going through when I realized as a child that I was transgender. When I was nine years old, my mother had a house party and invited one of her co-workers, who wound up dressing in drag throughout the night. That opened the door to me that I could be a woman. My dream came true, but it meant I had to leave home at age 12, beginning my transition while still in grade school.

I moved in with my auntie, who didn't mind how I dressed as long I was happy. And I was happy, even though transitioning at such a young age was very uncommon in the 1960s. In the eighth grade I had the second highest SAT score in Pennsylvania, so they gave me a scholarship to La Salle College High School. It was rare to get into this school, but it was so above my expectations that I couldn't visualize my future. I wound up dropping out and began doing sex work.

This gave me more time to explore my new life as a trans woman. I started to work on my appearance, from nose jobs, silicone injections, breast implants, and finally sexual reassignment surgery. I eventually stopped working the corner, working for call girl services and doing club dancing instead.

Once when I was hitchhiking, I got a ride from a well-dressed man. And, girl, this guy was fine! I mean fine – I was hypnotized. But then he kidnapped me at gunpoint, taking me all the way from Philadelphia to the Bronx. Fighting him did no good, and running to the cops didn't either. I said, "I know one thing: you're not going to have sex with me!" That lasted for only three weeks.

So I was running tricks for \$5, but I was smart at that game. I thought, "Five dollars? Ha, I'll charge \$30 and keep the rest in my pocket." I saved the extra cash.

One day, I noticed my kidnapper had gone out. I jumped up and ran toward the door, but the other girls started to attack me. I fought them off and escaped. Thank god I had that extra money! So I thought to myself, "I'll go back home and get my GED." I got in touch with my school, and they told me I was a fortunate young person because I had enough credits, and could get my high school diploma.

I told myself I didn't need to use protection because I was just up there partying. All was well, but a month later I got a call from one of the girls. "You know Peter died." I asked "How, girl?" She said, "Did you use a condom? He had the monster!"

Then one weekend in the '80s some girls from NYC invited me to come and party up in NYC to celebrate my success. I took them up on the offer and, long story short, they introduced me to this guy. I told myself I didn't need to use protection because I was just up there partying.

All was well, but a month later I got a call from one of the girls. "You know Peter died." I asked "How, girl?" She said, "Did you use a condom? He had the monster!" That's what they called AIDS back in those days. My life was shattered, and I felt like I was going to die. How could I not have used protection?? I was HIV positive now, hiding it from myself and others. Now I see that I was in denial – I was too scared to start treatment because everybody was dying from AZT. I was finally diagnosed in 1996 and started treatment.

Because of the shame and guilt I felt, being an icon in the community, I just could not face my family, friends, and loved ones. I moved to Queens so that no one would see me die.

I started smoking crack to numb the pain. But stupidly, I ended up in an upstate prison. I was released after three years to a work-release program. I didn't have family in New York, so I went to a women's shelter. I was praying to God – I needed spiritual healing from my crack addiction. I don't want to go back out there and smoke again.

Luckily, a minister came and preached God's word, and I decided I would give my life to Christ. I stayed upstate for five years and began working for the church, inside the jail system. I got certified in Comprehensive Alcohol and Substance Abuse Treatment (CASAT), was ordained as a Pastor, and worked at the NYC Dept. of Correction for 12 years.

You had to be a strong woman to deal with people from all walks of life. But I didn't care what people thought about me being a trans woman of color. I had my CASAT training, and I learned to confront my fear of addiction so I could stay in recovery. It was a tool I could use to conquer every decision that came my way. I was working with people I used to hang out with, but now they were going to receive the knowledge I had, even if they gave me strange looks. And as I spoke with clarity and encouraging words, they received what I said openly.

Years of education, from CASAT to Peer Navigator at the Alliance for Position Change, gave me such power. In 2017, I was introduced to the Translatina Network, where I joined the TGNC Leadership Space. I was a pioneer in this new career development group and learned about many topics in the sexual health/career group. My favorite discussions were about emotional positivity and perseverance. I graduated as the unofficial "mom" of the group.

Soon after this training, I began working at GMHC for a great boss, advocating for the Policy Department and for Sexual and Reproductive Justice (SRJ). I am so grateful that as a trans women of color, I am somebody important – making a mark on a new generation, even if they don't know how we struggled and fought for their freedom. We must all work to understand the values, principles, and morals of the transgender com-



munity of color. We must deal with issues of race, HIV stigma, and widespread unease with trans people.

Being trans back in the day was very much different from being trans today, living with HIV. We lived in a world of secrets, especially girls of color. Having HIV made it even more difficult – I was scared because I was seeing my friends dying left and right. How could we act like everything was all right, with smiles on our faces, hiding in the world of heterosexuals so no one would know we were trans?

Today's trans population? I am still trying to understand them. There is so much hate in the new generation of TGNC, Non-binary, Queer, and Intersex communities. It seems like the outside discrimination isn't enough – we have to deal with discrimination among ourselves. We need to keep the focus on loving one other and respecting each other's opinions, and not get offended when someone makes a statement we don't like. We must instead learn how to listen to what is said. The younger generation doesn't want to listen to us older trans women, but they must – so they don't repeat our mistakes. ■



Staff at St. James Infirmiry, a peer-based clinic for current and former sex workers.

More Than A Risk Group: HIV in Transgender Sex Workers' Lives

by Cyd Nova

Almost every workshop followed a pattern: people would slowly trickle into the room, sit far apart or in tight clusters of friends, or open the door and back away as if having made a mistake (returning minutes later). The conversation would be hesitant at first: myself and my co-presenter sharing, even oversharing, to encourage others to feel powerful enough to be vulnerable. The conversation would often spill overtime, so we would continue outside, chatting as we unlocked bikes or smoked cigarettes.

I facilitated these workshops, called “Taking Care of Ourselves”, for five years. They were a place for transgender sex workers to talk about how we handled internal and external harm: police, self-hate, domestic violence, HIV. They took place at a variety of different organizations, including the one I worked at, St. James Infirmiry. They were held at HIV and harm reduction conferences or at private spaces outside of the nonprofit world. With time, as transgender people and sex worker issues became more widely known, it seemed as though people’s stories came out more easily, perhaps better rehearsed. The thoughts shared, however, always felt unique – insights that many health care providers, or even HIV activists, might not think of when imagining the lives of “transgender prostitutes”.

When I talk about transgender people, I mean people whose gender identity is different from the sex they were assigned at birth. I include trans people who identify as women or men, but also people who identify outside those roles, as gender-nonconforming or something else. When I talk about sex work I am primarily talking about prostitution – including indoor escorting, street-based work, and massage parlors, but also stripping, BDSM work, webcamming, and porn acting.

Sex work can seem like an inevitable future for young trans women, since they are so intensely sexually fetishized in our culture and are often presumed to be working whether they are or not.

While transgender people are an incredibly diverse group – from how we look and experience life to our economic situations, our social circles, the way we speak, and our living situations – there are some similarities. In a 2014 article in the *Lancet*: “HIV Risk and Preventative Interventions in Transgender Women Sex Workers”, the authors cited a 27.5% HIV prevalence rate among sex workers and estimated that between 24 and 75% of transgender women sell sex.

(Transgender men, particularly sex workers, are largely unstudied with regard to HIV.)

This article will explore some of the particular life experiences and social factors behind these statistics. These are perspectives I've cultivated from my own history in the industry and the thoughts shared by hundreds of trans people I met over the past decade. As such, it is U.S.-focused.

Why Do Transgender People Get into Sex Work?

Sex work can be the ideal career for some – flexible hours, high hourly pay, and interesting work – but often it is a job of last resort. According to the 2015 report “Meaningful Work: Transgender Experiences in the Sex Trade”, 76% of sex workers surveyed reported being harassed in grade school and 69% reported experiencing adverse job outcomes as a result of their gender identity or expression. For many trans people, sex work can feel like the only available employment, due to employment discrimination. This can be compounded by a lower education level, as many trans kids drop out of school due to bullying. Lack of access to documents that match their gender identity is also a barrier to employment.

For many, sex work might be a temporary strategy to survive a period when outside employment is especially difficult, such as early in transition. Alternatively, some transgender people use sex work as a way to save up for costly surgeries (which are rarely covered by health insurance), such as facial feminization surgery, breast enhancement, and genital surgeries. Sometimes sex workers plan to work for only a short time, but if they are arrested, prostitution charges on their record make it difficult to move into other employment, effectively keeping them in the trade.

Many trans people are attracted to the sex industry because it provides them with a connection to a wider community. In her book *Redefining Realness*, Janet Mock describes trans sex workers as people from whom she could learn about herself. Engaging in sex work can also seem like an inevitable future for young trans women, since they are so intensely sexually fetishized in our culture and are often presumed to be working whether they are or not.

Sex work can also provide a source of gender validation. In my own experience as a young trans man who identified as gay, I was rejected by the wider culture because of my body, but gay men would pay to have sex with me privately. Some of these relationships provided the nurturing and guidance I craved around becoming a man. Transgender people receive a lot of messages that we are ugly and inferior to cisgender (non-transgender) people, and there is a real emotional validation to being considered attractive enough to hire.

The Risks We Face

One of the reasons for the high rates of HIV among transgender women is their limited group of sexual partners. Since many trans women share the same sexual partners, HIV can be transmitted many times within the group.



Additional risk comes from the added complications transgender people face when negotiating safer sex. Some straight men think that condom use or even talking about HIV is something that only gay people do. Many trans women talked to me about this being a factor in discouraging safer sex. On the other hand, many women had the idea that if they were having sex with a heterosexual man, HIV wasn't a high risk for them even if they were bottoming without condoms. For trans women who were topping, hormones often affected their ability to stay hard and that affected their use of condoms.

For trans men who have receptive vaginal sex, their gay or bi cisgender partners often assign less risk to that kind of sex than to anal sex, and change their behaviors accordingly. Trans men who are new to navigating gay worlds often feel too disempowered to insist on safer sex practices. We may internalize the idea that cis men are in control and their desires are more important than our own. Although high HIV rates have not yet been seen in trans male communities, there is the same pattern of frequent sexual partner overlap which could create an epidemic in the future.

The stigma that transgender sex workers with HIV face is an emotional, physical and financial burden in many ways. Having HIV increases legal risks and decreases financial opportunities for sex workers. As a result, many people I knew struggled with maintaining housing. Without secure housing, other aspects of their lives – taking medication, eating healthy, taking care of their mental health, reducing substance use – suffered.

Medical access of all kinds is an issue for transgender people. On a basic level, transgender sex workers are likely to be un/under-

continued on next page

insured, and avoid medical care for that reason. Even when cost is not an issue, access to medical care is restricted because of a lack of trans-competent healthcare. Many HIV services have programs that are limited to cisgender clients, and providers may not know how to, or may not want to, give services to anyone else. In the past decade the CDC and the NIH have increased funding for the creation of programs and research to address the high rates of HIV in trans communities. There is still, however, a dire need for expansion of these services, especially outside of large cities.

No Bad Whores, Just Bad Laws

“Walking while trans” refers to a common experience many trans women face: being assumed to be prostitutes just by being recognizably transgender. This can cause simple annoyance to violence from wishful johns, but it also includes being targeted by police. In the January 2018 issue of *The Cut* magazine, Emma Whitford interviews several women who were arrested by vice police who accused them of soliciting, even when they turned undercover police down.

“Condoms as evidence” refers to the practice of police and prosecutors using the presence of condoms as evidence that a person is engaging in prostitution. Many trans women, whether or not they are actively working, take into consideration the likelihood of being stopped by police and the risk of being sent to jail when deciding whether or not to carry condoms. While activists have been able to challenge this practice in several cities, it is still common policy across much of the U.S.

In early 2018, Donald Trump signed SESTA/FOSTA into law. These laws, the Stop Enabling Child Sex Traffickers Act and Fight Online Sex Traffickers Act make it possible for websites to be penalized for prostitution ads posted on their platforms. While the bill has yet to go into effect, several widely used sites have already shut down, including Backpage, which was seized by the FBI in April.

While these laws were proposed to deny sex traffickers the ability to advertise, critics say that they only force the coercive sex trade further underground, beyond the ability of law enforcement to track. The impact, however, on consensual sex workers has been definite. Across the country, thousands of escorts that previously advertised online have lost that source of income, and large numbers have moved into working on the street. There they are subject to harassment, arrests and violence. SESTA/FOSTA is an HIV issue because online advertising gives workers the opportunity to set and discuss sex practices and HIV status before meeting. Street-based workers don't have the same opportunities to negotiate those and other boundaries.

One group of transgender sex workers is also dealing with extra legal burdens. The current administration's witch hunt for “illegals” creates a dangerous bind for transgender immigrants, many of whom traveled to the U.S. to leave behind dangerous social, political, or interpersonal environments. As access to asy-

HIV prevention and care are a continuation of work creating opportunities and support networks. These organizations provide affirming, peer-driven services to transgender sex workers:

St. James Infirmary: Peer-based clinic by and for sex workers in San Francisco.

El/La Para Trans Latinas: Community building, leadership development, and health promotion peer organization in San Francisco.

Transgender, Gender Variant, and Intersex Justice Project: Peer-driven program fighting incarceration, supporting trans people inside prison, and building leadership among formerly incarcerated people.

Organización Latina de Trans en Texas: Community-building, legal support, and emergency housing organization for trans people in Texas.

Sylvia Rivera Law Project: NYC organization providing free legal services to transgender and intersex people who are low income or people of color.

lum becomes more restricted, applying for citizenship riskier, and fewer job options available, many immigrants are pushed into the sex trade as a way to stay off the radar and survive. Campaigns against human trafficking encourage the public to call ICE to report those who fit the stereotype of immigrant laborers or sex workers. While some survivors of trafficking may be eligible for visas if they agree to testify in court, new guidelines under the Trump administration require anyone who does not meet the criteria for a T-visa (which allows victims of human trafficking to remain in the U.S.) to go into deportation proceedings.

Taking Care of Ourselves

From Janet Mock to Marsha P. Johnson, stories of powerful transgender people who did sex work are becoming more and more prevalent. The television series “Pose” and the film “Tangerine” brought depictions of our lives to the screen as complete human beings instead of as objects of humor or pity. While there are constantly new laws that deny us our rights, and news of sisters who have been murdered because of their gender, race, and sex worker status, a powerful movement is steadily growing.

Transgender activists are at the forefront of human rights movements – people like undocumented activist Jennicet Gutiérrez, prison abolitionist Ms. Major, LGBT refugee supporter Ceyenne Doroshow, and HIV organizer Cecilia Gentili. These women see the decriminalization of prostitution as intrinsic to their work, and push for the rights of sex workers to be included within larger conversations of racial and LGBT justice. ■

Cyd Nova is a hooker, writer, and harm reduction devotee who worked at St. James Infirmary until 2016. He is pursuing a Master's Degree in International Affairs.



by Kristen E. Porter, PhD and
Mark Brennan-Ing, PhD

Along with the American Psychological Association's guidelines (search apa.org for transgender guidelines) when working with transgender and gender nonconforming (TGNC) people, we published an article in the June 2016 issue of *Clinical Gerontologist* titled "Providing competent and affirming services for transgender and gender nonconforming older adults". Although not focused on HIV, the article does offer suggestions on how providers working with older transgender adults can be more welcoming and affirming.

For TGNC people, the gender they were assigned at birth does not match their gender identity. (Cisgender people are those whose gender identity matches that assigned at birth.) In addition, some people identify as non-binary: neither male nor female. Gender identity is a separate issue from sexual orientation, and TGNC people report a range of same-sex and opposite-sex attractions.

Very little is known about older TGNC adults, and even less is known about those living with HIV. It is estimated that there are around 1.4 million TGNC people in the U.S. (about 0.5% of people over 65). In a book chapter we wrote titled, "The intersection of

Ultimately, older TGNC adults with HIV experience the triple jeopardy of HIV stigma, TGNC stigma, and ageism. This contributes to high rates of depression, loneliness, and social isolation. They also have high rates of living alone and not having a partner or spouse.

transgender identities, HIV, and aging," we found that these adults are overly affected by HIV. The CDC reports that from 2009 to 2014, over 2,350 transgender people were diagnosed with HIV. Of those, 84% were transgender women, 15% transgender men, and less than 1% had another gender identity. Around a quarter of transgender women have HIV, including 56% of African American transgender women. About 2% of people with HIV over 50 are transgender

The CDC says these high rates cannot be explained simply by behavior. Instead, economic, social, health, and cultural factors also play a role. One contributor to the high rates of HIV is transactional or survival sex (sex in exchange for money, housing, protection, or drugs), which may be needed due to the inability to find a job. About 25% of TGNC people have lost jobs, and 75% experience discrimination at their

job. Other factors include unprotected receptive anal sex, lack of access to PrEP, and sex within small networks of partners who have high rates of HIV. Time in prison, drug and alcohol use, mental health issues, violence (including intimate partner violence), stigma, and limited healthcare access or discriminatory healthcare experiences also contribute to high rates of HIV and other health inequalities.

When compared to gay and bisexual men, the New York City Department of Health and Mental Hygiene found that transwomen have similar CD4 counts when diagnosed with HIV, but after a year are less likely to have an undetectable viral load. This may be because transwomen are unable to take their HIV medications correctly due to unstable housing, being unable to get HIV

medications because of cost, or other reasons.

TGNC adults have double the rate of violence and abuse that non-TGNC adults have, and these rates may be even higher for TGNC people with HIV. Older transgender adults experience almost double the amount of violence that older lesbian, gay, or bisexual (LGB) adults do. Most transgender people have experienced discrimination at work, so many hide the fact that they are TGNC and wait before starting hormone therapy or having gender affirmation surgery.

HIV stigma makes it difficult for TGNC people to get tested for HIV, so many do not know their status. Once they do know they have HIV, both HIV and stigma based upon gender identity can be barriers to medical care, HIV medication, and taking medication correctly. When TGNC people with HIV are also racial or ethnic minorities, dis-

continued on next page

crimination and stigma are even worse, due to experiences of racism.

Ultimately, older TGNC adults with HIV experience the triple jeopardy of HIV stigma, TGNC stigma, and ageism. This contributes to high rates of depression, loneliness, and social isolation. They also have high rates of living alone and not having a partner/spouse. Although not specific to TGNC adults, ACRIA's ROAH study of older adults with HIV in NYC found that 70% lived alone and 84% did not have a spouse/partner. In addition, the majority of TGNC adults have been rejected by family and many feel like outsiders even within the sexual and gender minority communities. So, depression and suicidal thoughts are high: 41% of TGNC adults have attempted suicide, compared with only 1.4% of non-TGNC adults.

How Providers Can Help

TGNC older adults face numerous barriers to obtaining services, but providers can play a critical role in reducing these barriers and promoting changes that create safe and inclusive spaces. For example, HIV providers are already experts in maintaining confidentiality about HIV status, while all providers understand HIPAA privacy regulations. This expertise should be extended to their clients' gender identity. Providers should only ask questions that are relevant to care – not just out of curiosity. They should also be especially sensitive when clinical care requires touching, since many TGNC people have been victims of physical and sexual violence.

Providers are encouraged to ensure that their agency or clinic offers all-gender bathrooms, and that their intake forms are inclusive of TGNC gender iden-

ties. All staff must follow clients' lead in how they describe themselves, including names and pronouns. Providers who approach TGNC clients with an attitude of cultural humility and an accepting, nonjudgmental stance will be better able to develop good rapport and trust.

ress has been made on some fronts. The Veterans Health Administration (VHA) piloted a provider education program on transgender health, and 40% of program participants reported they felt more confident to treat TGNC veterans after taking the course.



Recent policies have increased access to healthcare for TGNC people, but access to transgender-competent healthcare remains a problem. Not having access to such healthcare is a serious concern for TGNC people who are aging with HIV, as they are more likely to experience a variety of chronic conditions. Half of TGNC people say they have had to teach healthcare providers how to best care for them. This is no surprise, as one U.S. survey found that a third of medical schools do not require education on sexual and gender minority health as part of their training. Among the schools that do, only 60 minutes are spent on the topic. This survey also found that only 30% of medical schools have course work on gender transition, and only 35% include gender-affirming surgery in their curriculum. But prog-

Guidelines

Although TGNC older adults are a diverse population, some specific guidelines for working with them include:

Intake: When conducting an intake session with a TGNC older adult, providers should ensure that time is taken to assess each client's needs completely and to avoid making assumptions based on gender identity. Providers should also pay close attention to any previous experiences an older TGNC client has had with the healthcare system, particularly around transitioning. Providers should know that transitioning is not uniform and there is considerable variability in the extent to which TGNC people transition. Transgender adults who transitioned before the 1990s were encouraged to conform to binary gender identities, and were

sometimes urged to begin new lives. Because of this cultural hostility, many older transgender adults hid their identities for decades and postponed transitioning until they were much older. Because of this, according to current research, it's important to screen for depression, loneliness, and suicidal risk in older TGNC clients.

Veterans: The experiences of older TGNC adults with HIV differ from those who are younger, as their generation came of age during a different time that included the civil rights movement, the sexual revolution, and the Vietnam War. In fact, the VHA reports that TGNC veterans are six times more likely to have HIV than non-transgender veterans and have

identity to medical providers, which can in turn result in poor care. It's hard enough to find medical providers who take one's health insurance and who have HIV experience, but finding ones who are also sensitive to TGNC issues and have expertise in treating older patients can be a true challenge. Combining HIV meds with hormone treatment, along with meds for conditions common in older adults (such as arthritis or diabetes) is complicated, and requires close monitoring for drug interactions.

Providers can help TGNC clients by having a strong referral list of transgender-welcoming providers who also have HIV and aging experience. HIV medical providers can institute practices

Long-term care facilities typically place residents in shared bedrooms based on gender. But there are few policies on how to determine a resident's gender, and private rooms are not covered by Medicare or Medicaid. Due to these risks, some TGNC older adults chose to "re-closet" or "detransition" by presenting as the gender they were assigned at birth or by stopping hormones. Some may even consider suicide to avoid entering a long-term care facility.

End-of-Life Concerns: Many older adults think about end-of-life issues like a living will, healthcare proxy, and power of attorney, especially people with HIV. But TGNC older adults are less likely than cisgender sexual minority older adults to complete these documents. HIV providers can help by explaining these documents and helping complete them. TGNC older adults may fear how their gender will be represented on death certificates or in obituaries. Putting these wishes into an advance directive is helpful, but only California has a law requiring that death certificates reflect a person's gender identity.

Lack of safe, sensitive, and competent care for TGNC people with HIV in nursing homes, adult day care, assisted living, and hospices is a real problem. Concerns include neglect, physical or psychological abuse, bullying, being "outed" as transgender or having HIV, and not being allowed to dress in line with their gender identity.

depression rates four times higher. They are also more likely to have mental health issues like post-traumatic stress disorder, suicidal thoughts or attempts, and homelessness, and to have experienced sexual violence while in the military.

Identity Documents: An important safety measure for older TGNC adults is to have documents that match their gender identity. Agencies and case managers can support this process by providing letters of support, testifying in court on behalf of clients, and helping them file paperwork. Some clients might need financial help, as there are costs involved with these changes. Every state has its own process – for details, visit: transequality.org/documents.

Access to Care: Due to past discrimination, older TGNC adults with HIV may not disclose their gender

that are TGNC-affirming, like asking people which pronouns they use, using their name of choice if different from their legal name, and expanding patient intake forms beyond simple check-off boxes for male or female (to download a guide, visit lgbthealtheducation.org and search for: Ready, Set, Go!).

Long-Term Care: Lack of safe, sensitive, and competent care for TGNC people with HIV in nursing homes, adult day care, assisted living, and hospices is a real problem. Concerns include neglect, physical or psychological abuse, bullying, being "outed" as transgender or having HIV, and not being allowed to dress in line with their gender identity. These risks are increased for those who need assistance with showering, dressing, and going to the toilet, since this can result in unintended disclosure of their transgender identity.

Conclusion

TGNC older adults with HIV are highly stigmatized, making them especially vulnerable, and many have experienced trauma, discrimination, and violence. Despite these challenges, in a changing environment of acceptance, TGNC older adults show great resilience that should be celebrated and supported by providers. Creating a safe welcoming space, ensuring ongoing training on trans-sensitive services, ensuring that all-gender bathrooms are available, and being mindful to using the correct name and pronouns are all steps providers can take to be supportive. ■

Kristen E. Porter is a gerontologist from Boston whose research focuses on older adults with HIV and older sexual and gender minority adults.

Mark Brennan-Ing is a Senior Research Scientist at the Brookdale Center for Healthy Aging at Hunter College, CUNY.

Hacking Transgender Healthcare

continued from page 5

But when all the paperwork was done and a copy of my chart from my previous provider was forwarded, the staff of my new provider didn't realize my transgender status until I was asked the standard question about my last period. I quickly learned I was my new Primary Care Provider's first transgender patient. Fortunately, she was totally accepting and willing to learn, as she wanted to be trans-inclusive. That was a good sign and acceptable to me. After that, the only awkward moment came when she was having difficulty asking whether I had bottom surgery or not (at the time I had not). She didn't want to offend me – it's important to note that it can be awkward for providers, too.

My follow-up visit made me realize she was sincere about wanting to be trans-inclusive. She told me my lab tests revealed an elevated white blood cell count. I knew why, as it's a common side effect of hormone therapy in transwomen, but I wanted to see if she knew the answer. She told me she looked it up and that it was common for transwomen on hormones. That's when I knew she was a keeper, because she cared enough to do the research. This is another example of why it's important to disclose your transgender status, as that test result could have sent an unknowing doctor on a wild goose chase.

Nobody Is Perfect

Don't assume that every staff member at a trans-inclusive provider is going to get it right. Mistakes can happen even in the best places. The hospital where I had my vaginoplasty prides itself on being trans-inclusive. It even has an LGBT liaison to make sure the proper names and pronouns are used for those who have not been able to legally change them. But even though my patient information listed my correct name and gender, a minor mis-gendering occurred. A staff mem-



Sydney Shackelford

ber who had not yet seen me referred to me as male when asking my wife about my food preferences. He had quickly glanced at my chart and saw the word penile in “Penile Inversion Vaginoplasty” – the procedure I had had. It was an honest mistake that could have happened to anyone.

Have A Support System

There is strength in numbers, and one thing that helps more than anything is to have someone you trust (a family member or friend) with you during your visit. This is especially true for your first visit and for trips to the emergency room. Having that additional advocate helps – not only does it reduce the chance of discrimination, it also helps you feel safer knowing someone you trust is looking out for you.

In the past few years, I have noticed that more insurance companies are starting to cover life-saving transgender procedures and that healthcare providers are becoming more trans-inclusive. It's wonderful to see that progress is being made despite the current political climate. But there is more to be done, including protecting the gains we've already made. By advocating for ourselves and being there for our trans friends, we can further progress in transgender healthcare. ■

Sydney Shackelford is a geeky LGBTQ advocate on the Community Advisory Boards of Callen-Lorde Community Health Center in NYC and RWJ Barnabas

Trans Women: Facing All The Challenges

When it comes to ending the HIV epidemic, one of the most important issues we must consider is how to reach out to and uplift trans women. The 2015 U.S. Transgender Survey found that 1.4% of respondents were living with HIV, a staggering rate five times that of the general population. For black transgender women, the rate was a horrifying 19%. Despite this, little headway has been made to address the particular challenges trans women face with regards to HIV.

Last year GMHC, working with a number of organizations such as Make the Road, the Anti-Violence Project, the Sylvia Rivera Law Project, Translatina Network, Destination Tomorrow, and the New York LGBT Center, conducted forums throughout the city, focusing on the concerns of each borough.

We were able to collect information on the issues that the trans, gender non-conforming, and non-binary communities face in their daily lives. Using input from these forums, we drafted a policy paper stating the needs that were expressed and proposing solutions, including policy approaches and funding recommendations.

Unexpectedly, the areas of highest interest were not related to HIV. Instead, participants were most concerned about the fact that they live in extreme poverty – their most important issues were related to education, employment, policing, immigration, healthcare, and housing

Interventions like PEP, PrEP, and viral suppression are considered to be the “holy grail” of HIV prevention, but the realities of trans women’s lives make administering these interventions very different than it is for other populations.

When we think specifically about how trans women are affected by HIV it is important to consider the environmental factors contributing to their unique problems. Research shows that trans and non-binary folk face an unemployment rate four times that of the general population. Factoring in this sort of discrepancy is crucial to delivering effective care. A holistic, well-rounded approach is needed

– one that understands the “how”s and “why”s of trans women getting infected.

As Andrea Horne, the TransLife program coordinator for the San Francisco AIDS Foundation said: “Many trans women, because nobody will hire them, turn to survival sex work... this ultimately leads to violence, losing your possessions. You might turn to drugs or get HIV. You get arrested. You go

to jail, and when you get out, you don’t have any money. Still, nobody will hire you. So you start the same thing over again. Some women never get out of that cycle .”

The cycle Horne is describing, in which economic opportunities are limited and trans women find themselves turning in desperation to high-risk behaviors, is critical to understanding their struggles with HIV, and when creating prevention and treatment programs.

How can you ask a trans woman to take her PrEP pill if she hasn’t eaten breakfast that morning? Or if she slept under a bridge that night? How can she be expected to prioritize that? These are important considerations, since trans people are twice as likely as the general U.S. population to be living in poverty.



What are we doing when we fail to consider these factors for trans women? It is not terribly difficult to consider how to accommodate their issues. We must focus on creating programs that feed trans people, develop job training targeted toward their needs, and ensure that housing options are both available and gender-affirming. We can do this if we have the vision and imagination to understand that these are crucial aspects of HIV policy, and that ending the epidemic simply cannot happen without approaching the problem from all angles.

Adjusting our programs to match the social factors that affect a population is crucial when trying to deliver the best possible HIV treatment and prevention strategies. We must consider the challenges trans women face, overcome them, and come through for a group that is all too often left in the lurch.

achieve

ACRIA @ -GMHC
307 W. 38th Street
New York, NY 10018
Change Service Requested

Achieve is sponsored by
an unrestricted educational grant
from:

Broadway Cares/
Equity Fights AIDS

NON-PROFIT ORG.
US POSTAGE
PAID
NEW YORK, NY
PERMIT NO. 4732

ACRIA and GMHC present

Take Charge of Your Health

A Workshop for People with HIV

When it comes to HIV, knowledge is power!

GMHC, 307 West 38th St., NYC



Comments from participants:

- "The information was ON POINT – amazing!"
- "I didn't expect much, but actually found it very informative."
- "Very empowering – a wealth of accessible knowledge."
- "I came in not knowing much and am leaving confident!"
- "I learned *why* we should do what is recommended, not just *what*."

Key Takeaways

- Be a partner with your doctor – not just a patient
- Better understand the medical information you need
- Ask your medical provider the right questions
- Make informed decisions about your health

Discussion Topics

- New and improved HIV meds
- What happens when you miss a dose
- What do your lab results mean?
- How to handle intimacy and sex
- Healthy aging

Space is limited \$25 gift cards and lunch will be provided.

RSVP required. To RSVP or for more information, contact Mark Milano at 212-367-1077 or markm@gmhc.org, or register online: bit.ly/takecharge129

I'm Still Here

A Research Study on Aging with HIV Survivorship

**If you're HIV positive, at least 50 years of age,
and were diagnosed before 1996, you may be
eligible to participate in a research study
on Aging with HIV.**

Upon completing the entire study protocol,
you will receive \$130 worth of gift cards
and MetroCards for time and travel.

If you're interested in participating in this or
future studies, please contact Gregg Bruckno, at
GMHC's Terry Brenneis Hub for Long-Term Survivors:

(212) 367-1063

GMHC

END AIDS. LIVE LIFE.

f @ gmhc.org

The
Terry Brenneis
hub
for Long-Term
Survivors
a program of GMHC

**ACRIA Center
for HIV and Aging**

at GMHC