
TRANSGENDER WOMEN AND HIV PREVENTION
IN NEW YORK CITY
A Needs Assessment

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Prepared by:

Paul Kobrak

Director of Risk Reduction in Vulnerable Populations
Bureau of HIV/AIDS Prevention and Control
New York City Department of Health and Mental Hygiene

With the assistance of:

Bali White

Research Consultant



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Author's note: This assessment includes graphic language and content in excerpts from interviews with transgender women and their male partners. Such content offers direct evidence of how study participants understand the social, cultural and sexual contexts of HIV risk. It was included to illustrate the challenges facing transgender women and to inform efforts to reduce HIV transmission in this population. Though much colloquial and potentially offensive language has been removed, readers may find some of the remaining material disturbing.

EXECUTIVE SUMMARY

Transgender women – individuals who were assigned a male sex at birth but who prefer a female identity – are at very high risk for HIV and other sexually transmitted infections. To aid in the design of an HIV prevention initiative for transgender women, the New York City Department of Health and Mental Hygiene carried out this needs assessment. The study broadly examines the social, sexual and economic factors that contribute to transgender women's high rate of HIV. It was based on in-depth interviews with 45 transgender women, mainly of Latin American and African descent, supplemented by six interviews with men who partner with transgender women and additional discussions with researchers, advocates and service providers.

Qualitative findings from the interviews suggest that transgender women can be both socially marginalized and sexually desirable. Study participants recounted how they have struggled with community and family rejection, harassment and violence, and how reaction to their unique gender presentation can undermine opportunities for education, employment and stable housing. Widespread stigma against transgender women may contribute to mental health concerns and, for some, problematic substance use, creating additional challenges to transgender women's health and wellness. Undocumented immigrants, a sizeable part of the transgender population in New York City, also confront the fear of deportation and limited access to health insurance and medical care.

Participants faced significant barriers to formal employment, while experience with commercial sex work was widespread. Some described how having sex for money allowed them to survive the challenges of poverty, limited education, lack of familial support and, in certain cases, alcohol or drug dependency. Beyond survival, participants presented sex work as enabling a full, socially-active life as a transgender woman. Sex work can finance gender transition or the enhancement of one's feminine appearance through clothes, accessories, hair products, hormone treatments and surgical and cosmetic procedures, which can help increase both self-esteem and personal safety. Sex work can also be a way to meet men who know you are transgender. Transgender women may be encouraged into sex work by their peers, and by some men's presumption that all transgender women are sexually available for a price. In this study, sex work was common among better-educated transgender women and among those at the early stages of gender transition when the need for money for feminization procedures may be greatest.

High HIV prevalence appears to be related to the centrality of sex, including anal intercourse, to the lives, identities and personal economies of many transgender women. Beyond being a source of income, sex with

men can also be an important means of validating one's gender identity and affirming one's attractiveness as a woman. Transgender women appear to face a set of unique barriers to consistent condom use. Sex workers in the study report that they are frequently offered extra payment for unprotected sex. Some transgender women may embrace a norm of submissiveness as a way to appear more feminine or to attract potential partners. Various participants noted the difficulty of finding a man willing to have a romantic relationship, which may lead some transgender women to engage with high-risk men or make themselves more appealing to men through a willingness to have unprotected sex; likewise, male partners, even those interested in relationships, experience public hostility and face other barriers to developing stable partnerships with transgender women. Young transgender women may be at particular risk if they are both sexually naive and sexually in demand as they navigate the challenges of gender transition. Unsafe injection practices associated with silicone and hormone use, which many transgender women engage in without a doctor's supervision, are an additional potential basis for both HIV and hepatitis C transmission.

Transgender women in this sample appeared well aware of HIV, how to prevent it, and the benefits of getting testing and knowing their status. In interviews, unprotected sex was sometimes associated with not caring about one's body or one's future, but was more commonly understood – particularly in the context of non-commercial partnerships – as a way to pursue intimacy, approval, self-esteem, sexual pleasure, an emotional connection or a reduction in one's social isolation. These motives were often tied to the social stigmatization and sexual objectification that affect many transgender women. Greater access to social support and transgender-sensitive healthcare providers can help transgender women reduce their risk of acquiring and spreading HIV.

Possible interventions to reduce HIV infection among transgender women and their partners include the following ideas, some of which may be more amenable to private rather than public initiatives.

1. Improve transgender HIV and health surveillance. At the local, state and national levels, there is a need to systematically collect data on HIV and other health outcomes among transgender persons. A major improvement would involve instituting a two-step question on birth sex and gender identity in HIV testing forms. Asking separate questions about sex and gender would enable public health authorities to more accurately track health conditions among different sex and gender categories, including HIV incidence and prevalence among transgender women. Improved surveillance would allow health authorities to continually evaluate and inform HIV/AIDS control efforts among transgender populations.

2. Create HIV prevention education materials that appeal to transgender women.

Study interviews found that transgender women embrace a female identity and are unlikely to recognize themselves in campaigns that are targeted to men who have sex with men. Nevertheless, few HIV prevention materials mention or use images of transgender persons or their partners, losing an opportunity to raise awareness of HIV risk in a very vulnerable community. Recognizing transgender as a category, and a category at risk, should not only encourage transgender women, transgender men and their partners to get tested and protect themselves, but could also help to erode ignorance of and stigma towards this population, factors that help keep transgender persons marginalized and engaged in high risk behaviors.

3. Increase on-line HIV prevention resources for transgender persons.

Expanded on-line content can help address the HIV prevention and care needs of New York City transgender populations. Web pages could, for example, include basic information about HIV prevention while addressing specific issues of concern for transgender women – such as the challenges of staying safe during gender transition and the risk of transmission from needle sharing when injecting hormones or silicone. On-line content could also provide links to resources for transgender women and men in New York City, including, but not limited to, assistance with HIV testing and partner notification, finding shelter or a support group, and assistance with legal issues.

4. Establish transgender-specific HIV prevention education involving peer outreach.

Some study participants and service providers cast doubt on whether printed and Internet-based educational materials would be sought out and read by transgender women, particularly those with limited literacy. A peer outreach program that combined the delivery of printed, video-based or on-line materials with one-on-one or small group discussion could get around this barrier. Such an approach could take advantage of the strong social networks that exist among transgender women in New York City. Whatever the format, education efforts should be conducted in multiple languages.

5. Provide capacity-building to medical and other service providers.

Greater provider awareness of transgender-specific health needs and social issues can help reduce barriers to medical and social services. Advocates and service providers frequently cite capacity-building around transgender issues as a priority for improving transgender persons' access to medical services, housing and other forms of social support. Precedents exist for creating such capacity-building curricula for both community-based organizations and local health departments. A guide for medical providers that discusses both physical and

psychological challenges of gender transition could be particularly useful.

- 6. Increase HIV testing among transgender women.** Community advocates suggest that the relative lack of “trans-friendly” health providers and testing clinics discourages transgender persons from knowing their HIV status. One way to reach transgender women who have avoided regular testing is through a social network recruitment strategy. Such network-based testing could include a focus on transgender sex workers or immigrant transgender women.

- 7. Intensify provider outreach to HIV-positive transgender women.** The New York City Department of Health and Mental Hygiene has found that HIV-positive transgender women transgender women have been less likely than men who have sex with men to initiate HIV care within three months of diagnosis and less likely to continue in care. Providers of HIV care and treatment services could be encouraged to intensify outreach to transgender women for initiation and coordination of care. One possibility is to develop a peer navigation program that in which HIV-positive transgender women counsel and support newly diagnosed individuals. An enhanced partner services program could assist transgender women, including those have experienced violence and stigma because of their gender, with the challenges of notifying past and present partners about their infection.

INTRODUCTION

Transgender women – individuals who were assigned a male sex at birth but who prefer a female identity – are at high risk for HIV and other sexually transmitted infections. A recent meta-analysis of research on transgender women in the United States found an HIV seroprevalence of 27.7 percent across four studies that tested subjects for antibodies, and a prevalence of 11.8 percent across 18 studies in which participants self-reported their HIV status (Herbst et al. 2008). The situation appears even more alarming in New York City. The recently-completed New York Transgender Project – a behavioral and biomedical study funded by the National Institutes of Health and administered by National Development and Research Institutes – documented both a profound health crisis and a troubling health disparity among 571 transgender women in the New York City area. In that study, 49.6 percent of transgender women of Latin American origin tested positive for HIV antibodies (n=246), as did 48.1 percent of participants of African descent (n=121), while HIV prevalence was only 3.5 percent for white, non-Hispanic transgender women (n=152) (Nuttbrock et al. 2009a). The study also found high and unequal rates for other sexually transmitted infections: lifetime exposure to syphilis was 21.6 percent among Latinas, 14.7 percent for blacks and 1.4 percent for white study participants (op cit.).

Transgender women appear to face an even greater risk of HIV infection than more recognized risk groups. Compared to men who have sex with men, transgender women in some studies report significantly higher rates of HIV and of risk practices such as engaging in unprotected anal intercourse, injecting drugs, and having high numbers of sexual partners (Nemoto et al. 1999; Herbst et al. 2008; Sánchez et al. 2009). Research has found that transgender women of color have particularly high rates of HIV infection (Herbst et al. 2008). Other transgender sub-groups at heightened risk are those who engage in commercial sex work (Operario et al. 2009; Wilson et al. 2009), have high number of sexual partners (Clements-Nolle et al. 2001a; Nuttbrock et al. 2009a), are homeless (Sevelius et al. 2009), are young or began living as women at a young age (Nuttbrock et al. 2009a) and those who are predominately attracted to men (Nuttbrock et al. 2009a). Though HIV infection among transgender women may principally involve sexual transmission, unsafe practices associated with the injection of hormones and silicone represent an additional risk of viral infection.

This needs assessment considers how the New York City Department of Health and Mental Hygiene can expand and improve its HIV prevention services to transgender women and their partners. Furthermore, it aims to contribute to an emerging body of literature that addresses HIV risk among transgender persons in New York City (McGowan 1999; Grossman and D'Augelli 2006; Melendez and Pinto 2007; Hwahng and Nuttbrock 2007;

Valentine 2007; Mauk 2008; Schulden et al. 2008; N. Sanchez et al. 2009; T. Sanchez et al. 2009; Merchant 2009; Davis 2009; Nuttbrock et al. 2009a; Nuttbrock 2009b).

DEFINING NEW YORK CITY'S TRANSGENDER POPULATION

Transgender persons form an identity-based group which avoids easy definition or measurement. As commonly understood, “transgender” is an umbrella term that describes a spectrum of gender expression and identity that does not conform with one’s birth sex, comprising individuals who have had or desire sex-reassignment surgery; persons who do not want to alter their sex organs but who may engage in other forms of body modification; those whose efforts to achieve a feminine or masculine presentation are limited to “cross-dressing” and the adoption of social characteristics stereotypically associated with the opposite sex; and individuals who do not exclusively identify as either woman nor man and can be described as gender non-conforming or “gender queer.” Transgender is a relatively new term (Valentine 2007). Many people who are ascribed a transgender female identity may prefer to call themselves trans women, transsexuals, transvestites, t-girls, fem queens, women of transgender experience, or by a number of other terms. In addition, “male-to-female transgender” exists as a common analytic term and “transfeminine spectrum” is increasingly used in community and service contexts to capture a range of gender-variant identities. Some persons who adopt a feminine presentation may also identify as gay males (compare Kulick 1998; Valentine 2007) or have lived as gay male youth before their gender transition. Transgender women often enhance their feminine appearance by taking female hormones or testosterone blockers. Many undergo procedures such as electrolysis, cosmetic surgery or the injection of silicone and other oils, frequently in the absence of medical supervision. Not all identify only as women or live as women full-time, due to preference, family or community pressures, or issues of safety.

Though reliable numbers are scarce, New York City may be home to the largest concentration of transgender women in the United States. In addition to transgender persons who grew up in the five boroughs, the metropolis draws migrants from foreign countries and elsewhere in the United States. Carrie Davis of the Lesbian, Gay, Bisexual and Transgender Community Center uses prevalence estimates of “transsexualism” in Belgium and the Netherlands to calculate that at least 12,500 adults in New York City have undergone some form of gender reassignment, and argues that the actual number may be significantly higher as the city attracts many transgender persons from elsewhere (Davis 2009, citing Olyslager and Conway 2007). Similarly, Larry Nuttbrock, principal investigator of the Transgender Project, estimates that there are approximately 5,000 to 6,000 natal males who at times see themselves as female or wish to be treated as female and who are actively

involved in social and medical services in New York City, and believes that the total number of residents fitting this definition of transgender women, in services or not, may be close to 10,000 (personal communication).

As HIV disparities suggest, transgender experience is often shaped by ethno-cultural community and can be highly segregated. The city's distinct transgender scenes include, among others, young transgender women of African and sometimes Latina descent who participate in gender-fluid House Ball communities in Manhattan and Brooklyn; Latina transgender women, often of immigrant background, some of whom are socially active in the gay bars and street-based sex venues of Jackson Heights, Queens; immigrant Asian transgender sex workers; gender-variant natal males of diverse national origin who may not identify exclusively as either female or male; and white transgender women who sometimes experiment with gender variance later in life and typically do so from a much more advantageous socioeconomic position (Hwahng and Nuttbrock 2007).

Transgender women represent a challenge to HIV prevention approaches that assume straightforward categories of gender and thus sexuality (Operario et al. 2008). They are born male, often have their male genitalia intact, and may engage in high-risk sexual behavior, such as anal sexual intercourse with men, but often identify as heterosexual women. Men who have sex with transgender women are an even more elusive population at risk, "an unknown and nameless group" with very little collective identity or sense of community, whose desires and practices do not match recognized categories of attraction or risk, but who nonetheless form a population at elevated risk of HIV and an integral part of transgender-related HIV transmission (Coan et al. 2005; Mauk 2008; Valentine 2008).

THE NEEDS ASSESSMENT

The goal of this needs assessment was to explore the unique HIV risks facing transgender women and how to address them through public health initiatives. The study builds on the findings of an earlier New York City Department of Health needs assessment for transgender populations (McGowan 1999). Research began with a literature review and discussions with transgender advocates, service providers and researchers (see acknowledgements). The next phase involved a set of in-depth interviews with 45 transgender women living in New York City. Instead of focusing on an enumeration of risk behaviors and barriers to care, this study used qualitative methods to attempt to understand the lives of transgender women holistically and to broadly examine social and sexual factors that contribute to this population's high rate of HIV infection. A modified version of the interview was given to six men who have partnered with transgender women; results from these interviews are reported in the section on "Men who Have Sex with Transgender Women."

Study methodology. Interviews were semi-structured and open-ended, designed to collect descriptive data on demographics and sexual risk practices and to engage participants' own understandings of transgender experience and HIV risk. Certain questions elicited language around the negotiation of sexual encounters or transgender identity that could directly guide the creation of HIV prevention materials (i.e. "What do men say to try to convince you to have unprotected sex?"; "When getting tested for HIV, how have you identified your sex or gender?").

All study protocols were approved by the Institutional Review Board of the New York City Department of Health and Mental Hygiene. Interviews were confidential and in person, lasted between 45 minutes and 2 hours, and were conducted between December 2008 and April 2009, either in English or in Spanish (using a translated questionnaire – see appendix). Participants had to be at least 16 years of age and to provide oral consent or assent, and were compensated for their time and travel with a \$25 gift card to a local pharmacy and a \$4 New York City Metrocard. Half the interviews of transgender women were conducted by this report's author, and half by Ms. Bali White, who at the time was the coordinator of the transgender program at Housing Works, Inc., and served as a consultant to the New York City Department of Health on this project. In addition, Ms. White did all six interviews with male partners of transgender women. Each interview was digitally recorded, partially transcribed and then analyzed by the interviewer herself or himself in a detailed fieldnote, which was then further coded and analyzed by the author. Quantifiable responses were entered in a Microsoft Access database.

As with much research on transgender women, participants in this small-scale study were recruited using non-random convenience sampling methods. Through flyers and word-of-mouth, we advertised a study of "transgender women and HIV prevention." There was no requirement that participants identify as transgender or as female. The study's language may have discouraged gender-variant persons who do not view themselves as transgender or strictly as women, but who may nonetheless be at elevated risk of HIV infection. In this study, all participants said they were assigned male sex at birth; and all currently identified primarily as female, except for one young African-American who identified as a "butch queen" and who reported feeling like both a woman and a man at times (compare Hwahng and Nuttbrock 2007, footnote 3).

As our aim was to inform HIV prevention initiatives, we sought out sub-populations at greater risk of infection, including Latina and black transgender women, homeless and street-involved persons, active and former sex workers, and those who have struggled with drug or alcohol dependency or mental health issues. We made efforts to include the experiences of both the emerging generation of transgender women – including those who had recently "transitioned" from a male to female identity – and those in their 30s and 40s who came of age in

an earlier era and could provide historical context on transgender experience in New York City. Recruitment took place in Queens, Manhattan, the Bronx and Brooklyn through transgender support groups, in areas known for street-based prostitution, at homeless shelters for lesbian, gay, bisexual and transgender youth, and through referrals from an endocrinologist with a youthful transgender clientele. Below, all study participants are identified by pseudonyms.

Demographics of the sample. Given our recruiting methods, those interviewed may not be representative of all transgender women in New York City. The data presented here should be interpreted as describing the sample and not the population as a whole. As detailed in Table 1, transgender study participants were diverse in terms of age (range: 18 to 56 years), education, borough of residence, and place of birth. Almost all participants, 43 of 45, identified as being either of African or Latin American descent, including those who reported multiple racial or ethnic identities. Thus the sample underrepresents the city's white and Asian transgender populations. In accord with New York City's immigrant character, 17 of 45 were born outside the 50 United States. Among those who migrated to New York City, half (14 of 28) said their move was related to their gender or sexuality. Although "transitioning" or "coming out" as a woman is often a long process involving stages of disclosure in different contexts (e.g. among friends, in public, daytime versus nighttime), we asked participants when they began living as women: 28 of 45 did so at 18 years of age or younger, and 41 of 45 before they turned 25 years old. Over half the sample never completed high school, and only 3 of 45 were formally employed at the time of the interview. Conversely, commercial sex work was widespread: 41 of 45 participants acknowledged that they had ever had sex as a way to make money, and 22 of 45 had received money for sex in the last year. While categories of sexuality like homosexual or heterosexual are hard to define consistently when an individual's physical sex and gender identity do not correspond, all the women in this study reported that they were predominantly attracted to men. As presented in Table 3, 15 of 44 participants (34 percent) acknowledged being diagnosed with HIV.

Table 1 – Descriptive Statistics

Descriptive Statistics (N = 45)		
	N	%
Borough of Residence		
Bronx	10	22
Brooklyn	12	27
Manhattan	11	24
Queens	12	27
Staten Island	0	0
Place of Birth		
New York City	14	31
Other United States	14	31
Puerto Rico	6	13
Virgin Islands	1	2
Other country*	10	22
Racial and Ethnic Identity		
Latina/Latino/Hispanic	19	42
Black/African American	18	40
White	2	4
Asian or Pacific Islander	0	0
Multiple ethnic identities	6	13
All with Latino identity	22	49
All with black identity	21	47
All with white identity	6	13
All w/ Native American identity	1	2

Source: interviews with 45 transgender women in New York City, December 2008 to April 2009.

*Other countries of birth include Mexico, Honduras, Dominican Republic, Jamaica and Kenya.

Descriptive Statistics (continued) (N = 45)					
Age in years	At interview	33.0		Début as female	
	Median			18.0	
	Range	n	%	n	%
	0 – 13	0	0	6	13
	14 – 18	1	2	22	49
	19 – 24	11	24	13	29
	25 – 29	9	20	3	7
	30 – 39	11	24	1	2
	40 – 49	11	24	0	0
	50 – 56	2	4	0	0
Years Living as a Woman		12.5 years			
	Median				
	Range	N	%		
	0 – 5 years	10	22		
	6 – 10 years	10	22		
	11– 20 years	11	24		
	20– 34 years	14	31		
Education					
	Less than high school diploma	23	51		
	GED	2	4		
	High school diploma	6	13		
	Some college	12	27		
	College degree	2	4		
Access to Medical Insurance					
	Medicaid	30	67		
	Private insurance	2	4		
	New York State Healthfirst	1	2		
	No insurance	12	27		

MOTIVES FOR GENDER TRANSFORMATION

Many transgender women's desire to transform their identities and bodies flows from a strong, persistent identification with their non-natal sex, a crisis of identity often described in popular culture as "a woman trapped in a man's body" (Kammerer et al. 2001a). In this study, many participants said that even in childhood they identified as girls or knew that they were different. Various women said, "I always knew" or "I was born this way." Nevertheless, ethnographic research in different cultural contexts suggests that the initial motive for gender transformation can be varied and is in some cases related to an attraction to members of one's own birth sex (Pettiway 1996; Kulick 1998; Valentine 2007). For example, natal males may pursue a feminine presentation as a means of making themselves more attractive to men, particularly men who do not identify as gay or bisexual. That is, gender identity is not necessarily innate, but may be mutable and evolve in response to social experience or even economic opportunity.

Study participants provided diverse narratives of how they came to identify as women. Rubi, 26, for example, described in an interview how she lived as a gay male in her native Mexico. Two years after migrating to New York City, she began to occasionally dress as a woman to make money as a sex worker on the streets of Jackson Heights, Queens. A year later, she began to take female hormones, not out of any profound disconnect between her body and her gender identity, but "to help me in my work"; that is, to be more attractive to male clients. Since then, she has received breast implants and has had silicone injected into her hips and breasts. Speaking three years after beginning her gender transition, she said,

"To me, it's more or less the same being a gay man or a transgender woman." (Me da un poco igual ser hombre gay o mujer transgénero.)

Others told of becoming aware of the possibility of gender change upon coming in contact with a community of transgender women. For example, Jasmine, 38, ran away to New York City as a 15 year old adolescent. To survive, she began doing street-based sex work and met a number of transgender women.

At that time I didn't know what transgender was, I didn't know what gay was. But I started out as a gay boy, very feminine mannerisms and feelings... I was hanging around trans people. I was prostituting in order to survive, as a boy. They were like, "You'll make much more money as a girl." So I said, "Alright." I had a friend, like what we call a gay mother. She was the one who helped me dress, tell me what makeup to buy, stuff like that. She was trans... She was the one who told me to get dressed.

As with others in the study, exposure to a transgender community helped Jasmine define her gender experience and led her to live and identify as a woman. Twenty-three years later, she still acknowledges uncertainty about her gender:

Sometimes I'm still not sure. For the most part I've always felt just like a woman, or I guess what a woman would feel like – emotionally, physically. Sometimes I wish I wasn't born a man. It would be so much easier if I had been born a woman.

The desire to change gender can also be a response to social pressures, such as the hostility experienced by gay male youth or those of indeterminate gender whose effeminacy challenges gender norms (Sandfort et al. 2007). A service provider pointed out that many New York City neighborhoods can be dangerous for effeminate males, who, if they develop a more “fem” appearance through dress or body modification, can receive more positive attention from local men. For Jamila, a 22 year old African-American, harassment and rejection as an identifiable male with feminine characteristics encouraged her to adopt a more explicitly feminine presentation:

I don't want the world to perceive me as being a gay person, a “[derogatory term],” as what they would call people. It's tiring. Since I've lived my life like this the last couple of years, I've never had that issue. Ain't nothing smart being said because [people] look at me and be like, “Oh that's a man, but that bitch is pretty.” Now if I was to be a boy and pump down the street: “Oh, [derogatory terms].” I can't. No. I just want to live my life as normal, as passable, basically to end that part... This suits me, this is who I am, this is who I grew to be, not who I thought I was, but who I grew to be, and how I feel, and how I want the world to fill that in. Because, see, I was just nothing but a [derogatory term] walking around, switching, looking [feminine], had my hair up in a ponytail with a shirt tied around my head. And I don't want to live like that. I want to be able to be out with my man, and walk around the street, like any normal person, not have to be in the closet. I'm tired of that.

Harassment and stigma. Some participants in this study, like Jamila, changed gender as a way to pursue a more socially acceptable public persona. But transgender women are also subject to a variety of hostile reactions – from cat-calls to physical attacks to getting kicked out of one's home. Those who begin their transition from male to female during adolescence (or even earlier) are at risk of not finishing their secondary education. In this study, 10 of 25 participants who did not receive a high school diploma said they stopped going to school because of reasons related to their sexuality or gender, often because of unwanted or excessive attention or outright sexual harassment from fellow students or teachers. Furthermore, as noted by one service provider, families that struggle with accepting a gay son may have even greater difficulty when that child becomes a transgender daughter. Thus social stigma against gender-variant people – which can be compounded by discrimination based on gender, race and class – may cause transgender women to suffer

social dislocation, homelessness, limited educational attainment, job discrimination, poverty, as well as substance use and mental health challenges (Kammerer et al. 2001b; Keatley 2005; Wilson et al. 2009).

THE PURSUIT OF FEMININITY

Study participants frequently mentioned how stressful and mentally exhausting – and potentially rewarding – it can be to go out in public as a transgender woman. To Coco, 45, “It’s like you’re on stage – you get a great deal of applause, from *some* people.” Tisha, 25, echoed this idea, describing how transgender women are constantly expected to perform, and in a sexual manner:

It’s kind of like, “lights, camera, action.” It’s kind of like being Britney Spears... When they can tell that you’re obviously trans, people get excited. It’s an amusement to people, it’s not just a lifestyle. It’s lights, camera, action. They’re looking to you to perform, or to carry on. So you never get a break. When you step outside your door, it’s always lights, camera, action... When I leave out of my house every day, because of [talk show hosts] Maury [Povich] and Jerry Springer, it’s so exploited for transgender women. It’s always lights, camera, action. People are not educated on what we are, and what is transgendered. All they think about—. People when they think of transgendered, a lot of men think of sex. It’s a lot more to that.

Participants mentioned that the transgender life can be particularly difficult for those who do not easily “pass” as women. Many described going to great lengths to perfect their feminine presentation and enhance their “softness” through time-consuming routines that involve hair care, make-up, procedures to hide their facial and body hair, using accessories to enhance their bosom, and, for some, painfully “tucking” their penis in layers of underwear to make it less noticeable or practicing to make their voice sound more feminine. Tisha noted that men may also obsess about the way transgender women look. She said some in her Manhattan neighborhood wait for her to come out of her apartment, “so they can throw that flaw in my face.”

Study participants often pointed out that a big part of their appeal to men is that they make more of an effort to look and act feminine than do many “real women.” But looking good is not just a means to self-esteem or a matter of sexual competition; it can also be an indispensable part of earning legitimacy as a woman or achieving safety on the streets. To Mercedes, 45, an immigrant from Central America, feminine appeal is a matter of survival in a hostile environment:

A transgender woman, to get respect, has to look good. That’s the reality, wherever you may be – in China, on Mars, everywhere... Like animals in the jungle, when you win a space, you get respect. But, imagine, it’s by fighting tooth and nail, whatever it takes. (*Una transgénero, para que se le respete, tiene que dar una buena imagen. Esta es una realidad, existente, y*

esto es dondequiera – en China, en Marte, donde sea... Como en la selva, como los animales, cuando se gana un espacio, se le respeta. Pero imagínate, tú agarras a uñas, o como sea.)

Body modification, hormones and silicone. Body modification efforts were common among study participants – 42 had ever taken female hormones; 10 had had silicone injected into their bodies; and 7 had had some type of formal surgical procedure to enhance their feminine appearance, including breast enhancement and facial feminization surgeries. Notably, only one woman in the study had undergone sexual reassignment surgery. Though some spoke of wanting to have their penis removed and replaced with a vagina if they could someday afford to, the majority embraced combining a feminine presentation with the maintenance of their male genitalia.

As detailed in Table 2, 32 of 42 participants who had taken hormones reported having done so without the care of a licensed medical provider (compare Clements-Nolle et al. 2001a; Xavier et al. 2005). New York City has a thriving black market for hormones in both pill and injectable form. Many transgender women who receive medically prescribed hormones either sell their prescriptions or share them with friends, while others reported using female hormones smuggled from abroad. Participants also describe a do-it-yourself approach to figuring out dosage or using different hormones concurrently to achieve the desired feminization effects (compare Moore et al. 2003). Among those who have taken hormones, 18 acknowledge ever taking more than the prescribed dose while others said they did not know what the medically-appropriate dose might be. Among those who had taken excessive amounts of hormones, at least four said they did so in the hope that larger doses would speed up their feminization process. Twenty-three of 42 reported irregular hormone use – often because of health concerns or inconsistent availability but sometimes as part of a strategy to maintain or restore testosterone levels and erectile functionality. A similar pattern of hormone use has been observed among Asian immigrant transgender women in New York City (Hwahng and Nuttbrock 2007). Participants also mentioned that hormones can cause emotional instability or irritability.

Though gender transition may create additional psychological stress for transgender women, quite a few participants made a point of saying that the use of female hormones improved their mental health and well-being by making them look and feel more feminine. Though some New York City medical providers have created programs for low-cost access to hormones, particularly for younger transgender persons, in other ways medically-prescribed hormones may be becoming less accessible because of insurance restrictions. One woman told how she received hormones through her Medicaid insurance until 2005 when Medicaid instituted a rule that female hormones would only be available to individuals with a female gender marker on their

identification. Now she buys them from a friend. A hormone regimen can cost, out of pocket, in excess of \$200 a month – either on the black market or through a prescription without insurance – a significant expense which can encourage transgender women pursuing a convincing feminine presentation into high-risk forms of money-making such as sex work (Sevelius et al. 2009).

Table 2 – Body Modification Efforts

Body Modification		
	n	%
Feminization Efforts (N = 45)		
Sexual reassignment surgery	1	2
Ever used testosterone blocker	29	64
Ever used someone else's syringe to inject hormones or silicone	6	13
Ever used hormones	42	93
Ever used silicone	10	22
<i>Silicone use among those with Latino identity (N=22)</i>	7	32
<i>Silicone Use among those without Latino identity (N=23)</i>	3	13
Hormone Access and Use (N = 42 who have used hormones)		
Median age at first hormone use	19.0	---
Ever prescribed hormones by a doctor	32	76
Ever received hormones from a friend	30	71
Ever purchased hormones from a street dealer	15	36
Ever received from a source other than a doctor	32	76
Ever took more than the prescribed dose	18	43
Ever used irregularly	23	55

Source: interviews with 45 transgender women in New York City, December 2008 to April 2009.

Some transgender women inject silicone in the face, breasts, hips or buttocks as a low-cost alternative to achieve a fast feminization, but with significant health risks (Hage et al. 2001). Participants spoke of a number of experienced but unlicensed silicone injectors-for-hire who operate in New York City. While some providers claim to have access to medical-grade, free-flowing silicone, many who offer such “kitchen-table surgeries” use industrial-grade silicone or other oils or may administer injections using non-sterile procedures, running a significant risk of infection or toxic reaction (NYC DOHMH 2009). Despite the risks, 22 percent of participants had received silicone injections. Other interviewees were adamant that they would never inject silicone into their bodies in part because of health dangers, but also because of the cosmetic risks, as silicone tends to settle over time and may appear to sag. Indeed, many women come to regret using silicone, and New York City service providers lament that few doctors are willing to offer corrective procedures to women with botched procedures or unsightly results.

Injection and viral transmission. Though data are scarce, hormone or silicone injection involving non-sterile procedures such as the shared use of syringes may be a basis of transmission of hepatitis C and HIV among transgender women. Hormone injection may be particularly risky, as it tends to be on-going and repeated. In this study, six women acknowledge using a syringe after someone else had used it (compare Xavier et al. 2005; Herbst et al. 2008; N. Sanchez et al. 2009). Perhaps more worrisome, many said that they typically have someone else administer their injections and have little idea if the syringe being used is sterile. In addition, transgender women may purchase a bottle of hormones together and then share its contents. Using non-sterile syringes to draw from a common bottle creates another potential basis of contamination. One service provider noted that transgender women often use a large-gauge needle to draw injectable hormones or silicone from the source container, then switch to a smaller gauge needle to inject, with the possibility of mixing up and thus reusing needles or syringes in social injecting situations. The Transgender Project found that exposure to hepatitis C – a virus associated far more with injection than sexual contact – was 15.7 percent among Latina transgender women, 7.4 percent for blacks and 3.6 percent for whites, including many cases of infection among subjects who reported never injecting psychoactive drugs (Nuttbrock et al. 2009a). Blood-to-blood contact through the injection of drugs, hormones or silicone could potentially lead to HIV infection among transgender women, though sexual transmission appears to be a greater basis of the epidemic.

SEX WORK AND THE TRANSGENDER WOMAN

Many transgender women have difficulty finding employment, due both to limited schooling and mainstream society's discomfort with gender variance. Even if low-wage entry-level jobs were attainable, they may appear inadequate to transgender women in New York City who must deal with the city's high cost of living and the additional expense of enhancing their feminine appearance through clothes, makeup, accessories, hormones, surgeries, hair removal and other cosmetic procedures. At the same time, transgender women are frequently an object of sexual desire and curiosity. This combination of social disenfranchisement and sexual desirability has encouraged a significant number of transgender women to engage in commercial sex work, potentially increasing their risk of HIV infection and their vulnerability to violence and exploitation.

In this study, only 3 of 45 participants (7 percent) were formally employed at the time of the interview, while 41 of 45 (91 percent) had ever engaged in sex work and almost half had done so within the last year (Table 3). While interviewees are not a representative sample of transgender women, their stories suggest that earning a living through exchange sex has become a norm in New York City's transgender community, as elsewhere,

perhaps particularly among transgender women of color (Elifson et al. 1993; Pettitway 1996; Kammerer et al. 2001a; Eyre et al. 2004; Nemoto et al. 2004a; Sausa et al. 2007; Operario et al. 2008a; Wilson et al. 2009).

Study participants described a range of types of sex work. “Dates” may involve oral sex or anal sex, or both, or may not involve any sexual contact or penetration: some mentioned getting paid to accompany a man for a dinner date or other social outing; sometimes men just want to masturbate in the presence of a naked transgender woman; others said that some clients pay to have the company of a transgender woman while consuming drugs (with the sex worker possibly disrobing but not getting penetrated), which also puts sex workers in harm’s way by encouraging substance use. Exchange sex can also occur casually, and may involve requesting some form of payment after a sexual engagement. Participants believed that most of their clients identified as “straight” or heterosexual. As discussed in the section on male partners, although many clients prefer to take the penetrating role in anal sex, some seek out a transgender woman to be anally penetrated by her.

Seventeen participants mentioned making contact with their male clients through street-based venues known for prostitution, while eight mentioned working through bars known as meeting places for transgender women, seven through escort services and three through advertisements posted in the Village Voice or other publications. Internet sites, particularly Craigslist.org, are becoming a common way to advertise erotic services, especially among younger women (six of nine participants who had ever solicited via the Internet were 25 years old or younger).

Initiation into sex work. Study participants also described a diversity of social contexts that led to their involvement in the sex trade. For some transgender women, earnings from sex work allowed them to survive desperate circumstances, often related to growing up in unstable home environments. Notably, one third (11 of 34) of interviewees who grew up in the United States lived in the foster care system at some point during their youth. Ten of these 11 women had engaged in sex work, often from a very young age, echoing findings on foster care and sex work from a recent study on sexual exploitation among socially disenfranchised youth in New York City (Curtis et al. 2008).

One example of this pattern involves Alana, now 21, who was born in Puerto Rico and grew up in the Bronx. A child of drug users, she moved in and out of foster care. When Alana was 13 and already dressing as a girl, she experienced her sexual début when she was anally raped by the son of her foster mother. She immediately fled the foster home. Given her experience, the streets looked inviting:

I didn't trust any kind of establishment that I wasn't in control of. Therefore: going in to sex work. That's when I started on [street name].

Alana was young and inexperienced. At first she would go out on the "stroll" dressed in jeans, but soon learned that to make more money she had to dress up like a "smutbag." She made herself available for anal sex, always as the receptive partner. Though her clients usually used condoms, she said she was willing to forgo protection if no condom were easily accessible. Alana says she was well aware of the risk of HIV infection and that her willingness to have unprotected receptive anal sex had more to do with not caring about herself and with her focus on short-term survival of a very difficult situation.

Honestly there were times that things got that desperate that I didn't care... At the time I was still going through my traumatic experience and I really didn't value myself. I didn't care about my body. I was worried about getting through until the next day.

Alana worked nights on the same stroll for almost three years. She continued to go to high school by day and rented a room of her own. Selling access to her body became a routine way to resolve a crisis. When she did not have money to pay for her room she reports that she had anal sex with the landlord in exchange for the rent. Alana said that her mother's disappointment upon finding out she was involved in prostitution encouraged her to begin efforts to get out of the sex trade. At the time of the interview, Alana was living in a youth shelter and was receiving counseling for post-traumatic stress disorder. She said she has never been diagnosed with HIV or any other sexually transmitted infection. Nevertheless, she regretted her experience on the streets and the pain it has caused her:

I would rather have no money in my pocket than have to result to what I used to do. I think that was the worst decision that I could ever make, about sex work, because it destroyed me, emotionally, because I had no emotions. I didn't like anyone, I didn't care to like anyone.

Sex work and a socially-active life as a transgender woman. While some study participants describe sex work as a way to survive on the streets or to pay for a drug or alcohol dependency, in others' narratives prostitution is presented as a means of money-making that can enable a full, socially-active life as a transgender woman and an occupation that is widely accepted and embedded in transgender culture. Many in the study say they were encouraged into sex work by other transgender women as a way to make money or to meet men (compare Curtis et al. 2008). At least four women said they were introduced to sex work by fellow residents while living in a homeless shelter, while one immigrant transgender woman said she was introduced to prostitution by someone she met at a transgender support group. To Nadine, 35, who began doing sex work soon after coming out as a woman at age 26:

Other, older trans women teach them this is how they should make money. And it just looks, from a naïve point of view, it looks somewhat glamorous, when you're young and naïve. Then you're just coming into that world and you see all these men running after [transgender women], it's like, "Wow, they all love trans women." It's exciting, in the beginning.

Participation in sex work can provide entrée to a community of other transgender women, creating a basis of camaraderie and social support that is often lacking in one's biological family context (Sausa et al. 2007). In this study, some participants describe street-based sex strolls and bars known for prostitution as key spaces of transgender socialization. Lola, 36, contrasted her current attendance at transgender support groups to her choice to engage in sex work as a socially-active new woman in the early 1990s, when few services were available to transgender women in New York City:

I didn't have to do street work. I just wanted to be part of the clique with the girls. And I wanted to show off, wearing a cute outfit and coming out that night and being the money-maker of the night... I wanted to give the girls that I was very feminine, the most feminine transgender in the world. It was kind of the thing to do. There were no trans groups [support groups]. That's where we met... I did it more for like sport, like a hobby.

After years of New York City police crackdowns on prostitution and other "quality of life" crimes, street-based sex work is less common in Manhattan, though it continues in the outer boroughs, as does socializing around prostitution venues. Three Latina immigrants in the study mentioned that they occasionally get dressed up and spend time with their friends on the bustling late-night sex stroll in Jackson Heights even when they are not particularly focused on meeting paying customers.

The personal histories of study participants provide evidence that sex work, beyond paying for basic survival, can enable a socially-active life as a transgender woman. Many participants justified their involvement in the sex trade because it could pay for hormones and other procedures to enhance their femininity and allow them to live both safely and securely as women. We asked participants how much they spent each month on their feminine appearance, including clothes, accessories, makeup, hormones and medical and cosmetic procedures: median expenses were substantially higher for those transgender women who had engaged in sex for money in the past year (\$450 a month) than for those who had not (\$125 a month). Earnings from sex work can enable a glamorous life, one that can be particularly satisfying for individuals with low self-esteem. Four interviewees mentioned using the proceeds from sex work (and in one case, petty theft) to pay for elaborate gowns and finance participation in transgender beauty pageants or "house ball" competitions (Murrill et al. 2008). Marisa, 45, believed that the need for quick cash for surgeries can be driven by competition among transgender women over who has the biggest breasts or the biggest buttocks. Appearance is paramount. Said Chantal, 21, an active

Internet-based escort who reported currently spending \$1000 a month on clothes, hormones and hair removal procedures:

A lot of these people work their asses off for \$500 for two weeks. That's nothing. I demand to look good. I want to look nice... If you don't have the money, in our case, you start to feel that you're not worth anything. I'm just saying that's how we feel at the time.

A number of participants spoke of sex work as a temporary occupation, and described how their savings would eventually be used to enable a less risky lifestyle. Tisha, for example, saw sex work as necessary step towards gaining legal employment as a woman, and said that she planned to use earnings to pay for surgeries, "so I can feel comfortable going to a workplace." However, at least two interviewees who said that they had first gone in to sex work with a plan of using earnings to pay for gender-confirming surgeries noted that they had yet to save any money for such procedures.

Sex work and gender validation. Beyond being a source of income and sexual pleasure, sex with men can also be an important means of validating one's gender identity. Sex work was mentioned as a way to meet men – for both relationships and financial support. As in other studies of transgender women, many participants felt that having men express interest in having sex with them affirmed their attractiveness as women (Melendez and Pinto 2007; Sausa et al. 2007). A particularly common theme in the interviews was the ego boost transgender women said they got from men paying to have sex with them. To Jasmine:

I just loved putting on women's clothes, heels, you know, putting makeup on. Primping, coiffing my hair. Just the attention that I would get. And the fact that the guys were paying me for sex. I was in Jackson Heights, there was a group of us, and when a car pulled up and you were singled out, you felt like the diva of the block.

Mercedes, from Central America, said that although now she only does sex work in moments of financial need, like when her bills come due, previously she sought out clients because she enjoyed the experience:

I liked how the clients treated me, the good life they showed me, taking me to restaurants, to buy me clothes, to go out drinking, to the dance clubs, all of that. I felt comfortable with all of that, I felt satisfied by it. I felt important. I felt like I was worth something because there was someone who was paying to go out with me. I liked all that. A life full of excitement and fantasy, and love. *(Me gustaban los buenos tratos de los clientes, la forma como te tratan. Me daban la buena vida. Que, me invitan a los restaurantes a comer, me invitan inclusive a comprarme ropa, a tomar, a las discotecas, todo eso. Me sentía cómoda con todo eso. Me sentía complacida. Me sentí importante. Me sentía que valía porque había alguien que estaba pagando por mi una cuenta. Había alguien que estaba saliendo conmigo, y todo eso me gustaba. Una vida llena de emoción y de fantasía, y del amor.)*

Another frequent theme in the interviews was that the feeling of validation from paid sex tended to wear off with time and gave way to the drudgery and unpleasantness of having sex with strangers. For example, Keisha, 22, had been doing sex work since she first began living as a woman three years before:

At first I guess it used to validate my sense of being a woman: "All these guys are attracted to me. Oh wow, they want to have sex with me. I must look good, I must be doing something right." But not anymore. Now it's just like, "OK, this is how I pay my bills." It's not very exciting. After dealing with guys for so long, you realize that guys will have sex with anything: men, women, animals, you name it... You realize that with men, it's not anything about how passable or how pretty you are. Men, for whatever reason, they'll [have sex with] anything. It no longer validates me.

To, Iris, 25, men's sexual interest in her can feel both affirming and degrading:

It's like a blessing and curse to be a beautiful woman. Because I know that most guys only want me for sex. But it's also nice to know that guys want me because they think that I'm beautiful, and that I'm a "woman" to them, in quotation marks... I know how much they'll pay to have me – but the fact that they'll pay to have me is kind of like a turn-off.

Some participants mentioned that, although the money is good, sex work carries a psychic cost. Alexis, 25, who had only begun living as a woman and simultaneously engaging in sex work months before the interview, reflected on the fact that she could no longer tell her mother how she made a living:

I don't know, for me it's kind of like lowering myself, lowering my dignity. Like I tried doing the stroll thing – that really felt really bad. I only did it a couple of times, going on the street, working on the street. Then I felt people driving past me. I looked like a prostitute. And Craigslist is escorting – it's not as bad. Like if I can't tell my mom something that I'm doing, then it's bad. That's how I look at it.

The objectification of transgender women. Participants also highlighted how they could be encouraged into sex work – and unprotected sex – by the stereotypical views held by some men that all transgender women are highly sexualized or available for a price: To Marisa:

They think we're all prostitutes. Men look at you not as a person, they think of you as a prostitute.

Sharice, now 20, said that constantly getting solicited by men for sex led her to consider selling access to her body as a 16 year old. Even transgender women with no interest in sex work said that they are frequently approached for sex, or offered money for sex, typically without any pretense of romance. Says Lana, 22:

An individual will approach me and call me, "Sexy, whatcha doin' tonight?" and not try get to know me. It's disgusting.

Says Celia, 25:

Basically, when they see us they see us as a sex toy, as sexual beings.

Men's attitudes, and their approach, may change as soon as they realize the woman whom they are attracted to is transgender. Says Keisha, echoing other participants:

When guys know, you go from being a female and being *someone* who maybe they could start a relationship with, to being *something* that they can [have sex with].

Participants frequently mentioned the difficulty of finding a man who is interested in having a relationship (compare Melendez and Pinto 2007), reflecting a profound disconnect between what transgender women are looking for in men and how interested men may view and treat transgender women. Men may expect transgender women, as women, to conform to patriarchal ideas of the submissive female role, particularly in sexual relationships. To Kelli, 27, "They feel as though we ought to be pleasing them sexually." To Savanna, 34:

I think there's a lack of recognition for us as people. So if you don't have to really think of this person that you're dealing with as a full human being, then you can mistreat them. And I think that has been our status in society and I hope that it's slowly changing.

To Lily, 41, being viewed as a sex object is particularly an issue for those involved in sex work:

If they meet you on the street, the stroll, they think that you're a whore all the time. They don't think about what you want to accomplish in life... No, they're just thinking that you like to have sex all the time for money. They don't have respect for us. I think if you meet him in like a restaurant or a theater, they have more respect for you because you're not selling anything.

Harm reduction approaches to sex work. Study participants described a range of techniques they have used to reduce the harms associated with sex work. Nine women in the study have embraced the Internet as a venue for meeting clients, in part because it allows them to screen their clients and increase their sense of safety. Chantal, 21, who identifies as "a very smart escort girl," described how she will often have lengthy telephone conversations with a potential client before agreeing to see them (in fact, conversation may be all that a man exploring his attraction to transgender women is looking for). Chantal said that she insists clients call her from an unblocked number, and that when doing an "out-call" to a place of the client's choice, she will enter the address into an Internet search engine and leave the location with a friend. Though Chantal enjoys the money and the opportunity to meet men, she recognizes that sex work involves a high-risk lifestyle: "I thank God I haven't come across a crazy lunatic."

Three of the women in the study who have engaged in Internet-based escort work told of explicitly trying to minimize their sexual contact while making money from clients. Keisha, who is 22 and strikingly tall, recently began concentrating on giving “the girlfriend experience”: dates that typically involves “making out” and cuddling but not oral or anal penetration. She also likes to develop what she calls “sugar daddy” relationships with older men who provide both monetary and emotional support, but who make few sexual demands. Previously, as a street-based sex worker in Manhattan and Queens, Keisha had been arrested several times and had a number of negative experiences with younger clients which led her to seek out “mature gentlemen” via the Internet. Keisha reported receiving \$200 to \$400 per date and earning \$800 to \$1500 a week in cash, making more money in fewer hours and in far more pleasant surroundings than during her experience on the streets. But she too worried the dangers about sex work: “The only thing I don’t like about this is I feel it might bite me in my ass.”

Another participant, Jada, 23, spent much of her first years living as a woman engaged in escorting and street-based prostitution, both in New York City and while traveling through the United States. A year before the interview she stopped having sex for money, she said,

Because there are other ways that you can make money, other than like risking being arrested or raped... You can get a sugar daddy, or you can get a real job. Or you can create a profile on [Internet site] and have phone sex with guys for money, and it’s not actual sex. Phone sex isn’t sex work.

Through the Internet, Jada has set up a phone sex account. Older clients often ask about her life: “Does your family accept you?” “When did you start doing this?” She also has an account on a dating and escort Internet site to meet older benefactors who are looking for company or someone to take care of: “It’s kind of an escape from their heterosexual life.” She noted:

Now that like I’m feminized and stuff. Guys will pay to be with me, not sexually, but just to have me as a trophy. I just use that to get to where I need to be.

Using both their Internet savvy and their youthful beauty, Jada and the others have found alternatives to traditional sex work that still involve sexualized performance but that may entail lower risk of HIV infection, even if they seldom identify reducing HIV risk as a primary motivation. Others have found non-Internet-based alternatives to sex work. For example, Rubi, 26, who is very passable as a woman, supplements street-based sex work income by dancing with men at a nightclub on Roosevelt Avenue in Queens for two dollars per song, keeping her birth sex to herself. All of these transgender women were young and thus relatively advantaged in the economy of sex, suggesting that such alternatives may not be open to all.

TRANSGENDER WOMEN AND HIV RISK

As detailed in Table 3, 34 percent of the transgender women in this study acknowledged having received a diagnosis of HIV infection, a rate comparable to the scientific literature on transgender women in the United States (Herbst et al. 2008). The study asked about sexual risks. During the past year, according to the 45 participants' own reporting: 35 (78 percent) had engaged in anal sex; 10 had unprotected receptive anal sex (22 percent of the whole sample); 22 (49 percent) had received money for sex; 19 (42 percent) had been the insertive or "top" partner in anal sex, including 14 of 22 (64 percent) participants who received money for sex; and 16 (36 percent) used psychoactive drugs before or during sex. The median number of distinct anal sex partners in the last year was 3, and 4 for oral sex, though 13 participants (29 percent) reported 10 or more anal sex partners in the last year and 21 (53 percent) had 10 or more oral sex partners. Most participants reported consistent condom use: of 35 participants who had had anal sex in the last year, 31 (89 percent) said that they or their partner always or almost always used condoms. Just one participant acknowledged using condoms inconsistently for anal sex and having multiple partners. We did not systematically ask about the use of barriers during oral sex, but many active sex workers in the study said they routinely had their clients wear a condom during fellatio.

Table 3 – HIV Status and Sexual Risks

HIV Status and Sexual Risks		
	n	%
HIV Diagnosis (of N = 44*) (self-reported)		
Overall (N = 44*)	15	34
Latina/Latino/Hispanic (N = 19)	9	47
Black/African American (N = 17*)	4	24
White (N = 2)	1	50
Multiple ethnic identities (N = 6)	1	17
All with Latino identity (N = 22)	10	45
All with black identity (N = 21*)	4	19
All with white identity (N = 6)	2	33
All with Native American identity (N = 1)	0	0
Age		
Below 30 years of age (N = 21)	2	10
30 years and older (N = 23*)	13	57
<i>* One participant refused to disclose HIV status.</i>		
HIV Testing Among Those Not Diagnosed with HIV (N = 29)		
In the last year	27	93
In the last six months	26	90
Experience with Paid Sex (N = 45)		
Received money for sex (in the last year)	22	49
Sex as a way to make money (ever)	41	91
Sex work ever among those with some college (N = 14)	12	86
Number of Anal Sex Partners in the Past Year (N = 45)		
0	10	22
1	7	16
2 – 5	11	24
6 – 10	6	13
Over 10	11	24
Engaged in anal sex in past year	35	78
Among those who Engaged in Anal Sex, Past Year (N = 35)		
Unprotected receptive anal intercourse	10	29
Penetrative anal sex	18	64
Drug use before or during sex	16	46

Source: interviews with 45 transgender women in New York City, December 2008 to April 2009.

The challenges of consistent condom use. We asked participants what makes it difficult to always use a condom. Though the question was not always successful at immediately eliciting discussion, some participants were forthcoming about their exceptions to protected sex. Iris, 25, an active sex worker, first said

that she only had unprotected sex with her boyfriend when she “gets caught up in the moment.” Later in the interview she acknowledged that she might occasionally forgo condoms with a client who “I’ve known for a while, like a while-while.” She then added that she is more likely to have unprotected sex when she feels threatened with violence: “If I feel threatened in some way, then I’m just kind of like ‘Go on and get it over with,’ so when they’re finished I can leave.” Finally, Iris acknowledged that she also may make an exception for very attractive men: “If they’re sexy, ‘Now, boo, you can get it.’”

At least four participants – including HIV-positive and HIV-negative women – volunteered that they might forgo condoms with good-looking men, which some tied to their pursuit of sex with men as a way to validate their feminine attractiveness. For example, Celia, 25, an active sex worker, said she insists on condoms for anal sex “almost all the time,” but, like Iris, she might not with “pretty boys”: “Out of six pretty guys I’ll probably like choose like two of them I won’t use a rubber on.” Celia had recently been the victim of a mob attack in her neighborhood, and added that she is less likely to use a condom when she gets depressed, and that she gets depressed a lot. Camille, 50, HIV-positive and a recovering drug user, said she is most likely to have unprotected sex, “When the boy is really cute, or if I’m drunk.” Conversely, Laura, 48, who is now a peer outreach worker, always figured that more attractive men might be higher-risk partners:

If he was real good-looking, I’d insist on a condom. Because of the fear that if he’s so good-looking, he could have sex with anyone. One has to take precautions. (*Si era muy guapo, pues yo le exigía condón, por el temor de que estaba tan guapo, se fuera con cualquiera. Pues, uno tiene que prevenirse.*)

Participants said that many male partners themselves insist on using condoms. However, 41 of 45 said that men had tried to get them to have sex without a condom. To aid in the design of prevention materials – for both transgender women and other at-risk populations – we asked participants for examples of what men will say to convince them to have unprotected sex. Jada, 23, provides a common script:

“I’m clean.” That’s the first thing they say. And the question they ask you is, “Are you clean?”
“We’re both clean. Then we should have no problem.”

Other responses included appeals based on sexual pleasure, or one’s appearance or presumed lack of disease:

- “I don’t have anything.”
- “I’m healthy.”
- “You don’t have to worry about me.”
- “You dissing me? I don’t have AIDS.”
- “Look at my nails, I get a manicure every week.”
- “I haven’t had sex in a while.”
- “I only do this once in a while.”
- “I really like you.”
- “I only have one wife. I don’t see nobody else.”
- “Let me just put the head in.”
- “I’m not going to cum inside of you.”

-
- "I don't have a condom."
 - "I'm allergic to condoms."
 - "They irritate me."
 - "I can't feel anything with the condom on."
 - "I can't cum with the condom on."
 - "I just want to feel it."
 - "It's too small for my penis."
 - "My penis won't get hard."
 - "I just want to bust in your mouth."
 - "I don't believe in condoms."
 - "I'll give you more money" (the most common appeal in the context of sex work).

Study participants reported that seldom do men provide test results or other paperwork that confirm their lack of viral infection, either in casual encounters or in more long-term relationships, where trust is presumed or demanded by one's partner.

Malía, 38, a former crack smoker and sex worker, recalled the complexities she faced when a man brought up the topic of condoms:

It's up to the transgender woman if she wants to use a condom, also. It has to be two people. Because sometimes there's one that wants it and the other one don't. A lot of men ask the transgender, "Do you want to use a condom?" You know that's a tricky question because if you say "yes" and he doesn't want it he'll tell you to get off the car. Understand that there's men that do that. They'll play that tricky question to see if, "Oh, you don't use condoms, you're probably sick." And then there will be some of them that will ask and didn't want to use the condom. And I would say, "OK, no problem," under the influence of drugs and drinking.

Though consistent condom use can be a challenge for all genders, various participants reported that men may consider transgender women particularly available for unprotected sex. To Mina, 28, some men presume they can forgo condoms with her, "because they think that we're like freaky and we do anything they want." Tyra, 18, said that in her one year of living as a woman she has had to frequently resist men's expectations that she is available for either unprotected or casual sex:

They be thinking that all trannies like to do that [unprotected sex], or that all girls like to give [oral sex], or just [penetrate] you just to be [penetrating] you, and not know you. I ain't down with it. I ain't [having oral sex] for money, or I'm not [having oral sex] for one day, and I just met you for half a second.

In the context of discussing safer sex and HIV prevention during an interview, most of the women in the study accepted the importance of using condoms. One interviewee, Coco, 45 and HIV-positive, confided that she feels like using condoms is a "chore" and "too much of hassle." At least two participants mentioned the heightened pleasure they get from unprotected oral or anal sex. Keisha described her approach to protection and pleasure with her boyfriend, with whom she routinely uses condoms:

We get tested together. Even though we know each other's status, we don't do it unprotected, because he's [from Africa], and there's an AIDS epidemic there, and he's very conscious of that... We always practice safe sex, but I never know what he's doing when I'm not there... I know enough black women in my life that's gotten it from their boyfriend or husband who was on the down low having man-to-man sex or man-to-transgender sex and gave it to them. So I definitely know that you can get it, even from your boyfriend, and even if you're getting tested regularly.

Keisha then described her one episode of unprotected sex with her boyfriend, and the memorable feeling of intimacy:

I got out of jail, and he was drunk, and he missed me a lot. And things got wrapped up in the moment... I don't regret that it happened. I like to be honest. It was really amazing, and it made me feel so much closer to him. To tell you the truth, I would acknowledge that it wasn't the safest, but out of all the people to take a risk with, I was glad it was him... It was my boyfriend, and I love him.

Sex work and HIV risk. Interviews offered many indications of how commercial sex work may increase the risk of HIV infection and transmission. In sex work, unprotected sex becomes a commodity, compensated through a medium of exchange. Most of the study's sex workers said they have been offered extra payment for "raw" or barrier-free sex. Though many said they were immune to such offers, extra money for unprotected sex can be a routine temptation, particularly for those in financial straits, whether due to the costs of gender transition, drug dependency or other socio-economic marginalizations. Marisa, for example, said that she believes her willingness to take extra payment for unprotected sex when she was having a slow night on the stroll or when she was desperate for money for drugs may well have been the cause of her HIV infection. On the other hand, Sharice, a recovering drug user, said that her experience with sex work made her more practiced at handling men who plead for, or try to pay for, unprotected sex:

I was in the prostitution world, in the game of sex for money. So I'm so immune to it. Protection must be there. There's no getting around it.

As discussed above, earning money through sex facilitates an active sex life, often a high-volume sex life with multiple partners. Though most participants reported that they insist on condom use with paying clients for both anal and oral sex, some mentioned how violence, the fear of violence or the fear of non-payment could lead to compromised situations and, possibly, to risky sex.

Epidemiological research finds that transgender women report that they tend to take greater precaution when having sex with clients and casual partners than with primary partners (Nemoto et al. 2004b). Nevertheless,

transgender women sex workers have higher rates of HIV infection than do transgender women who are not engaged in sex work, and also have higher HIV prevalence than male sex workers and female non-transgender sex workers (Operario et al. 2009). Study interviews suggest that involvement in sex work may contribute to sexual risk-taking in non-sex work contexts, as described in the following section.

Risks in primary partnerships. The stigmatization and sexual objectification that many transgender women experience may undermine safer sex practice in romantic relationships. At least five participants noted how the pursuit of trust or intimacy, a lack of self-esteem (compare Clements-Nolle et al. 2008), the fear of rejection (Bockting 2008) or the difficulty of finding a man interested in a relationship (Melendez and Pinto 2007) had led them to forgo the use of condoms in their non-commercial relationships. Sex without condoms may be common in settled relationships among couples of all genders and sexualities. But service providers and study participants noted that transgender women may have few sources of personal validation, and thus may ascribe particular importance to their primary partnership and seek to establish the maximum level of intimacy, including through a willingness to forgo the use of condoms. Lola, 36, told how she always used condoms with clients, but that her sex work experience led her to look for intimacy and affection in non-sex work contexts:

I never did unsafe prostitution, even for more money. But, I used to confuse intimacy with unsafe sex. When I met a guy in a more personal state, like in a bar or a neighborhood or a gym... I would engage in unsafe activity, which I thought was really being intimate with the person. I was confusing intimacy, because I needed that in my life. With the clients it was just, "OK, I'll call you in three months." I didn't have intimacy. So when I met someone in a gym, I thought it was intimate, but it was really unsafe. Maybe that could be a point you could point out – it's not being intimate, it's being unsafe.

Like some others in the study, Lola emphasized the importance of finding a man who is willing to walk down the street with a transgender women, who will kiss her on the mouth, who is interested in more than just her physical parts:

I think men, even if they are very aroused, feel funny if they are going to kiss a "man." You know, "I'll [penetrate] her, as a woman." Kissing her, touching her, caressing her, dining her, wining her, that's not something they'll do. They're man enough to [penetrate] you. I often say, "It's not that I'm not woman enough for men, it's that men are not man enough for me." I hear sometimes from some of the girls who got kissed, "Girl, he kissed me." That's where the real euphoria came in for them: "Oh my God, girl, his mouth!" I'd be happy for them. They got a kiss.

Melendez and Pinto (2007) found similar sentiments in a qualitative study on love and relationships among transgender women in New York City, in which various interviewees noted the difficulty of finding a man who would accept a transgender woman as a full-fledged romantic partner: "I guess the woman side of us wants to

please our man"; "A lot of us settle"; "To make this person happy, you know, you feel as though if you don't use it [a condom] it's going to be closer, it's going to make him love you even more." In this study, transgender women related unsafe sex to social isolation and the desire to attract and to please men. To Camille:

The life we live is too fast, quick. And with me – a cute boy, and then it goes. We don't think. We have to take more time to do our relations, because we're so lonely. The majority of the transgendered are so lonely and we're desperate for affection. A person that is lonely, that has been all his life struggling and battling with society, and with people and with neighbors, with family – if you meet a cute boy, and the boy do goo-goo eyes at you, there you go.

The satisfactions of sex and romance can counteract the hardship of the transgender life. To Kelli:

A lot of the girls tend to put themselves out there, like a whole lot. Whether it's for money or no money. And if a boy tells them the right things they tend to do whatever the boy asks them to. The same thing with a lot of genetic females as well, but especially with young transgender girls.

One New York City shelter director noted that many young transgender women show a tendency to "overdoing everything stereotypically feminine," including submissiveness during sex, which may manifest itself in not insisting that partners use a condom during anal penetration. When asked what might put transgender women at increased risk of HIV, Jada said:

A lot of transgender women crave affection and they like to feel feminine. So they'll do what a guy asks her to do, to feel more feminine. I've noticed that in a lot of them. They like to be man-handled... I think because a lot of them have self-esteem issues. They're willing to believe their boyfriends. They'll fall into it. Someone with high self-esteem would say "No, I don't trust anyone like that. I'm not having any kids, so why wouldn't he use a condom?"

The social isolation and economic vulnerability that many transgender women face may contribute to a willingness to have unprotected sex. For example, Chantal, 21, moved in with a 53 year old white man in part to get out of the homeless shelter where she was living. He told her flatly, "I don't believe in condoms." Chantal accepted his refusal to wear protection during anal sex, even without confirmation that he did not have HIV or other sexually transmitted infections, such as by getting tested together. She said she felt secure because he was honest with her and always spoke to her with respect:

He was the only guy I was sleeping with, and he didn't sleep around with any other t-girl. So I just trusted him... He's faithful towards me. We talk about it all the time. I know he's honest.

A few months later, Chantal was back at the homeless shelter and had ended the relationship with her older boyfriend, in part because he had called her a "nigger" during an argument. The director of Chantal's shelter

said that he often had to confront residents who were willing to have unprotected sex with men who take care of them in some way:

Anyone who feeds them, gives them a place to stay, they love. That's what they equate with love.

Safer sex awareness. Epidemiological studies have established the high prevalence of HIV among transgender women. But it would be misguided to see this as a population ignorant of HIV risk. Recall from the beginning of this section that 22 percent of transgender study participants had acknowledged having unprotected receptive anal sex in the past year, thus a majority, 78 percent, had reported not recently engaging in this high-risk sexual practice. Though many mentioned having made exceptions to condom use, 89 percent reported always or almost always using a condom during anal sex. Furthermore, routine HIV testing seems to be well-established among transgender women in this sample. Of those who had not received a diagnosis of HIV infection, 26 of 29 (90 percent) had been tested for HIV antibodies in the six months prior to the interview. HIV screening is common even among some who are not sexually active: two participants who had recently begun their gender transition and had been abstinent in recent years said that they still get tested for HIV every three months to confirm their negative status, in part because they are involved in programs that encourage regular testing, but also because a negative test result gives them a sense of accomplishment and can serve as a motivation to stay safe while belonging to a high-prevalence community. Although transgender women as a group are at great risk of HIV infection, many are cognizant of this threat and of how to protect themselves (compare Wilson et al. 2009).

TRANSGENDER WOMEN AT PARTICULAR RISK

In addition to transgender women involved in sex work, epidemiologic and qualitative research have identified a number of transgender sub-populations that may be at heightened risk of HIV infection and transmission. These groups are worthy of special focus when designing of prevention programs.

Young transgender women and those of recent transition. New transgender women, especially those who begin living as female early in life, appear to be uniquely vulnerable to HIV and other health risks (Nuttbrock et al. 2009a). Adolescents and young adults may have greater difficulty in managing the emotional stresses of changing gender or of being a target of stigma. The New York City Transgender Project found that during adolescence gender-related abuse was strongly related to major depression but that this association declined markedly during later life stages (Nuttbrock et al. 2009b). Transgender persons who

transition during adolescence may face a greater risk of domestic discord and isolation from their families, homelessness, interruption of education, and difficulty in gaining formal employment (Garofalo et al. 2006; Wilson et al. 2009). Younger women may also confront greater challenges being an object of sexual attention if they lack experience navigating sexual encounters or negotiating around safer sex.

Younger transgender women appear particularly inclined to involvement in sex work (Sevelius et al. 2009). We did not systematically ask study participants with sex work experience when they first had sex for money, but personal narratives indicate that many began in the midst of their gender transition, and at least four reported that they became sexually active at the same time they began to engage in sex work. New women may be in greater demand as sex workers. Beyond the appeal of youth, those of recent transition who have never taken female hormones or testosterone blockers, or have used these substances for a limited time, can have a greater ability to sustain an erection and to penetrate partners, a service frequently sought out by clients looking for a “fully functional” transgender woman. A number of interviewees said the need for money to quickly enhance their feminine appearance made them especially interested in sex work at the early stages of gender transition. Others noted that their need to have their gender validated through sex with men, including men willing to pay to be with them, was also strongest during this period. As Savanna recalled of her coming out period:

I think transition causes so many insecurities, and especially as a woman you want your femininity validated. So I think [sex work] holds at least a double-sided appeal because you get money – which we all need, it’s fast money – and then there’s the validation.

The ways sex work can facilitate an active sex life may be particularly salient for new transgender women. At least three younger participants mentioned their awkwardness around having to disclose their unique gender identity when meeting men, and all three pointed out that fear of embarrassment or a hostile reaction is much less of an issue on a transgender sex stroll or through Internet escorting websites that explicitly cater to men looking for transgender women. For Chantal, the opportunity to meet men through the Internet made it easier for her to become sexually active:

I didn’t have sex until I started escorting. Because I don’t meet a lot of men. And even if I do meet men on the streets, I get nervous because I don’t know how to come up to a guy and talk to him, and if he tries to come up to me I avoid talking to him... My thing is, if I meet a guy and he finds out I’m transgender, on the streets, I don’t like the embarrassment. I don’t want to feel like, ‘Eew, you’re transgender,’ and they walk away. That makes me feel so low. That’s why I know that if I wasn’t an escort, I probably wouldn’t be sexually active at all... Because I don’t know how to talk to a guy... Craigslist guys, they know I’m transgender.

Chantal described how being a sex worker gave her confidence and helped her overcome her hesitation around having sex as a woman. She also acknowledged that her inexperience put her in risky situations. When she first began escorting at age 19, her lack of practice negotiating around sexual activity led clients to try to convince her to have anal sex when she did not want to, or to have sex without a condom:

It's like, "OK, I can pretend that I know about sex." The funny part is when I started I didn't know nothing about sex. Pretending you know what a "top" [insertive partner] and a "bottom" [receptive partner] is – I didn't know what that meant at the time... I guess they spooked that I was naïve, and they would just force me to do things. Now I'm in charge, and whatever I say goes. I still get paid for it, but I say what I want to do or what are my limits. Basically, I make the rules.

Being at once sexually active and sexually inexperienced may increase HIV risk, especially for young women who are also dealing with social displacement and the emotional challenges of gender change.

Transgender women of African descent. African-American transgender women have particularly high rates of HIV infection. In a recent meta-analysis of studies on transgender persons in the United States (Herbst et al. 2008), African-American male-to-female persons were found to have had a higher HIV prevalence than transgender women overall in both tested populations (56.3 percent versus 27.7 percent) and in studies based on self-reporting (30.8 percent versus 11.8 percent). In San Francisco-based studies, African-American transgender women were far more likely to be involved in commercial sex work (Sevelius et al. 2009) and to report higher rates of substance use and unprotected receptive anal sex while engaging in sex work (Nemoto et al. 2004a). In the New York City Transgender Project, as mentioned earlier, 48.1 percent of 121 African-American transgender women tested positive for HIV antibodies (Nuttbrock et al. 2009a). Project researchers hypothesize that HIV risk among New York City African-Americans may be compounded by the "multiple jeopardy" they face being black, female, belonging to a sexual or gender minority, and frequently being of lower socioeconomic status (Hwahng and Nuttbrock 2007). Notably, in New York City and elsewhere HIV rates among black men who have sex with men – who may also face such a situation of "multiple jeopardy" – are significantly higher than for men of other racial or ethnic groups (CDC 2008; Jenness et al. 2009).

This small-scale study was not able to establish statistically significant correlates of increased HIV risk for black transgender women, but interviews did suggest some bases of vulnerability. Sex work was widespread among black study participants, even among those who indicated that they grew up in stable, middle class households or who had significant education, as 8 of 10 black participants who had attended college had ever had sex as a way to make money. Furthermore, black participants typically began living as women at an early age, at a

median of 18 years of age, with 18 of 22 transitioning before turning 21. (This is comparable to the study population as a whole, which was largely comprised of women of color.)

Black transgender women may also be at heightened risk because of the level of HIV prevalence among their partners. Some black women in the study said they prefer to have relationships with black men. In New York City, black men have a higher prevalence of HIV than do men of other ethnic or racial groups (3.3 percent for black males versus 2.2 percent for Hispanic males, 1.1 percent for white males and 0.3 percent for Asian and Pacific Islander males), and are more overrepresented among men with recent HIV infection (U.S. Census 2000; NYC DOHMH 2009). To the extent that black transgender women tend to have sex within their own ethnic community, this may compound their vulnerability to HIV infection.

While black transgender women may prefer black men as romantic partners, at least three study participants involved in commercial sex work (two black and one Latina) said that they tended to avoid black men as clients because they perceived that they were more likely to make greater sexual demands, to get violent or to refuse to pay for services rendered (compare Hwahng and Nuttbrock 2007; Bernstein 2007: 226, n. 15; Curtis et al. 2008). Flor, 27, described a widespread avoidance of black clients among Latina sex workers in Jackson Heights:

I'm afraid of black guys. Because I've heard that they are a little bit, how can I say this, a little bit violent... They might hit you or they might rob you... They really make me afraid. Some [transgender women] have had bad experiences. They've gone with black men, who don't want to pay, or sometimes they hit them. And they tell us about it. (*Los morenos me dan miedo. Porque me han contado que son un poco – ¿cómo podría decir? – como un poco violentos... O te pueden golpear o te pueden robar... Como que les da miedo. Por que hay unas que han sufrido las experiencias. Se han ido con ellos, y no les quieren pagar, o a veces, les pegan. Y ellas nos cuentan a nosotras.*)

Keisha, like some other African-Americans in the study, said that she almost exclusively has had romantic relationships with black men. Nevertheless, after having negative experiences as a street-based sex worker with a number of younger clients whom she described as “street” or “thug,” she now avoids clients from a range of cultural backgrounds: African-American, Latin American and Middle Eastern:

When men come from cultures where women may not be as respected, I try not to deal with those men... because they have weird views of women and their place in society.

Perceptions of black men as sexually aggressive or prone to violence can be encouraged by stereotypes and mythologies that pathologize black men. However, concerns about violence and the tendency to have sex within

one's own ethno-cultural community may combine to increase the HIV risk of African-American transgender women by, for example, undermining their perceived ability to negotiate safer sex.

The Latina immigrant transgender experience. New York City has a large population of Latina transgender women, including a significant number of recent immigrants from Latin America. In this study, six participants were born in Puerto Rico and eight others came from other Latin America countries, including six from Mexico. They described the particular challenges of being both immigrant and transgender, often complicated by a lack of legal residency. Though Latina transgender women in the United States are not as routinely viewed as a group at higher risk of HIV infection as are African-American transgender women (Herbst et al. 2008), Hispanic participants in the New York City Transgender Project tested positive for HIV at an alarmingly high rate (49.6 percent of 246 participants), and in this smaller study reported the highest HIV infection rate of all ethnic groups (Table 3).

For many immigrants in this study, New York City has become a place to live fully as a transgender woman. At least four participants said they began taking hormones to look more feminine while still living in Latin America, but tended to maintain a male identity and dress in “unisex” clothes or wear women’s outfits only by night. Nevertheless, three Mexican participants said they came to the U.S. not to live as women, but in pursuit of greater economic opportunity, like many non-transgender compatriots. Low-wage service sector employment was far more common among immigrants than U.S.-born participants. But immigrant transgender women have also embraced sex work as an easily available money-making opportunity: 13 of 14 Latina immigrants had ever had sex for money and 8 of 14 had done so in the last year.

For example, Flor migrated from Mexico at age 18 years and has worked in laundries and dry cleaners in Queens for much of the last nine years, the last eight living as a woman. A number of transgender friends involved in the sex trade encouraged her to try working the street (*trabajar en la calle*), telling her how much money she could make. Four months before her interview for this study, Flor was laid off from her laundry job and decided to try working the stroll and the bars on Roosevelt Avenue in Jackson Heights, Queens. Short, and with indigenous features, she quickly developed a largely Ecuadorian male clientele. She said that in some ways she preferred sex work to her laundry job, noting that she is her own boss and does not have to get up in the morning:

You go out and enjoy yourself. It's more fun. You've got time to go from bar to bar, or to talk to your girlfriends... We talk about our lives, the experiences we've had. (*Sales a divertirte. Hay*

más diversión y esto. Tiene más tiempo de meterte en barra en barra, o estar platicando con tus amigas... Platicamos de su vida, de nuestra vida, de las experiencias que han pasado.)

Though socially rewarding, street- and bar-based sex work is slow going and has not been particularly lucrative for Flor. At her previous full-time job, Flor earned \$370 a week, plus tips for deliveries. She figured that on a weekly basis, over four early mornings of sex work she takes home about \$400 to \$500 per week, making about \$40 each from 4 to 6 oral sex customers, and about \$100 each from 2 to 3 clients for anal and oral sex, plus the occasional client who just wants to look at her and masturbate (Flor says she has never accepted more money for unprotected sex). Flor noted that financially sex work is not that different than other jobs available to her:

It's not as much as they told me... Just enough to keep me going. (No es tanto como me habían contado... Solamente para irme sosteniendo.)

Sex work has provided enough income for Flor to send money to her mother in Mexico, to help with her siblings' education and to fulfill her role as an immigrant daughter. But she noted her earnings were far from steady. She also worried that, as an undocumented immigrant, if she were arrested on the stroll she might get deported to Mexico and suffer an enormous financial setback. Just before her interview, Flor sought out her previous employer to talk about getting her old job back.

Fear of arrest and deportation looms large among the undocumented. At least two Latina women in the study had been deported and then banned from the United States following prostitution-related arrests, but then returned anyway. Lack of residency also limits access to health care: 30 of 45 transgender women in the study receive subsidized medical coverage through Medicaid (available only to individuals with legal residency), while 5 of 12 participants who have no medical insurance are foreign-born (Table 1). Some undocumented immigrants said they tend to go to an emergency room when in need of medical care. Rubi, 26, said that she had yet to see a doctor in her five years in New York City, except when getting breast implants. Non-medical feminization procedures may be particularly common among Latina transgender women: in this study, use of injected silicone was more common among those who reported Latin American background (32 percent) versus those who did not (13 percent) (Table 2).

As in the case of transgender women of African descent, sex work was common among Latinas in this study, both among participants recruited in sex work venues and those who were not. Many found sex work an accessible way of making money, an occupation that provides autonomy but does not require one to learn English. Some immigrants spoke of the social support they receive from other transgender women in the sex and entertainment district of Jackson Heights. In the surrounding neighborhoods, transgender women often live

together, and one study participant said that prostitution is common in a house that she rents with other immigrant transgender women, a work-living arrangement also mentioned by service providers. Despite its importance to gay and transgender Latino social life in New York City, Jackson Heights has few HIV prevention services or other services for these communities.

Drug and alcohol users. A number of quantitative studies find that drug or alcohol dependence is a significant basis of HIV risk among transgender women. In Washington, DC, transgender individuals who acknowledge a drug problem were twice as likely to be infected with HIV than those who did not (Xavier et al. 2005). In San Francisco, transgender persons who reported injection drug use were almost three times more likely to be infected with HIV (Clements-Nolle et al. 2001b), and transgender women who reported stimulant use in the past year were more than four times more likely to report inconsistent condom use (Sevelius et al. 2009). However, in New York City length and intensity of substance use was not significantly associated with HIV infection in a multivariate analysis (Nuttbrock et al. 2009a). Qualitative research provides indications of how substance use might increase HIV risk. In a San Francisco study, sex workers reported that being willing to take drugs with clients could lead to extra payment or to access to a bigger pool of clients, and that some would numb themselves with drugs and alcohol as a way of dealing with having sex with men whom they found unappealing (Sausa et al. 2007, (Nemoto et al. 2004b), findings that were echoed in this study's interviews.

Alcohol- and drug-involved participants often tied substance use to the challenges of transgender experience. To Jasmine, a cocaine user now in recovery:

There's so much discrimination for transgender people. There are security issues. Unfortunately some of us don't look as real as we want to look. And society—. There's a lot of transphobia, a lot of homophobia. For me it was a way to escape.

Participants also noted how sex work, drug use and risky behavior are often intertwined. Sex work in general, and in particular being paid to use drugs with clients, could expose one to a milieu of drug use. Plus, one's willingness to accept extra payment for sex without a condom often hinged on how desperate one was to make money to feed a drug dependency. To Malia, 38, a former crack cocaine smoker:

If that man tells you he'll give you more money not to use a condom, you're going to do it. And that's the cause of HIV – there it is, drugs. Drugs more than prostitution. Anyway, it's both, because one leads you to another.

Laura recalled that she began working as a “sexoservidora” after becoming a heavy user of both alcohol and cocaine. She typically insisted on a condom for receptive anal sex, but would often forgo condoms with regular clients for a special date that involved glamorous surroundings and getting high:

There were a few clients who didn't use a condom. Sometimes they would say to me, “I'll buy you drugs. I'll take you to the nicest hotel in Queens. I'll give you this [extra payment].” You're in the street, you're doing this [using drugs]. Well, you've got no other alternative. So you might tell him, OK... That was his reward [sex without a condom]... Almost always it's drugs that leads someone to have unsafe sex. Drugs make you forget about the condom. (*Habían unos clientes que no lo usaban. A veces me decían, “Te voy a comprar droga. Te voy a llevar al mejor hotel de Queens. Te voy a dar esto.” Uno esta en la calle, esta haciendo esto. Pues, no le queda otra alternativa. Puede decirle que sí... Esto era la recompensa... Casi siempre, yo digo, por la droga le lleva a uno tener sexo no seguro. La droga es una cosa que te olvida del condón.*)

However, the experience of many of the younger study participants challenged any routine association between substance use, sex work and HIV risk among transgender women. At least two younger sex workers who acknowledged regular drug use said that, for them, being in an altered state did not undermine the use of condoms. As Kelli put it, “It's sort of more of a reflex for me now.” Meanwhile, many of the younger participants insisted that they never mixed alcohol or drug use with sex, particularly commercial sex work. Jada, 23, acknowledged that she tried to disassociate herself from having sex with unattractive clients, but said she never used alcohol or drugs to tolerate the experience:

When I did it I escaped. I was there physically, but mentally I wasn't. And I was thinking, “Just hurry up so I can just leave”... I never, ever did sex work high or drunk or influenced, ever. I knew that I wasn't in full one hundred percent control... I just thought about my safety – suppose this guy tries me, I've got to get my mace quick. Versus if I'm high off weed, my reaction is going to be much slower to reach for the bottle. And the bad experiences that I did have with guys – it was always you had to be quick. I maced them, and I was real quick with it. But it was because I was sober. I think that a lot of transgender women and gay males, they don't want to do sex work so they'll go out there high to get them in the mood. And then they'll do it and then the guy could take advantage of them because they're high and they don't know what they're doing, and that's how they come up sick – HIV – because they're not sober.

It is possible that a generational shift has occurred among transgender women in New York City. Keeping in mind that our sample was not necessarily representative of all the city's transgender women, many of the study's older participants came of age during the height of crack cocaine epidemic in the 1980s and early 1990s and spoke of the ravages of substance use in their own lives and in the transgender community at the time. In contrast, while 6 transgender women under 30 acknowledged having had a period of chronic substance use, many others reported limited experience with alcohol and illicit drugs (most typically marijuana) and did not tie substance use to risky sexual practice. Notably, few of the younger participants mentioned engaging in sex work

to pay for drugs, versus paying for clothes or feminization procedures or seeking affirmation of their feminine appeal. This generational difference may in part be due to the fact that younger participants have had less time to become dependent on drugs or alcohol, or to recognize their use as a problem. But it also may be possible that chronic substance use is less common among transgender women in New York City today. Without minimizing the role that substance use can play in HIV transmission, it is likely a partial explanation of the continued high prevalence of HIV infection among transgender women.

Transgender women living with HIV. Transgender women infected with HIV can play a crucial role in reducing HIV transmission. A lack of prompt or continued HIV care may lead to higher levels of HIV-related morbidity and mortality among transgender women, and could lead to greater forward transmission if viral loads rise with untreated infection.

In a convenience sample of persons living with HIV in the United States, respondents who identified as transgender women were more likely than others (including men who have sex with men) to be younger, non-white, currently living in a shelter or subsidized housing, to have less education, to have a history of incarceration, and to be less likely to be on highly active retroviral therapy, although the study found no significant difference in CD4 cell counts or other measures of HIV-related health status (Melendez et al. 2006). In a multivariate regression analysis that controlled for race, age, poverty and incarceration history, the New York City Department of Health and Mental Hygiene found that HIV-infected transgender persons were significantly less likely than men who have sex with men to initiate HIV care within three months of diagnosis and less likely to continue in care (Merchant 2009). These findings point to the need for secondary prevention initiatives that include targeted efforts to assist HIV-positive transgender women enter into care and adhere to their treatment.

HIV-negative transgender women in New York City live in a high prevalence community and are likely to know first-hand others who are living with the virus, which may or may not be a protective factor against further HIV infection. Devon, 44 and HIV-negative, said that she learned the most about the need for HIV prevention from watching so many of her friends die from AIDS-related illnesses. She feels that knowing someone with HIV no longer served the same purpose:

A lot of people may know somebody that has it. But nowadays the drugs are stronger than they were back then. So you don't deteriorate the way you would back then. I've watched it go from stage to stage to stage, 'til you die. A lot of people, including trans women, they don't see

it from the beginning to the end... When you're actually involved in somebody's life who's really, really sick, then you take a look at life.

Improvements in HIV treatment have affected the way transgender women understand and relate to the virus. At least three study participants reported that HIV infection, instead of only being viewed as something fearsome and to be avoided, is sometimes discussed by transgender women as a means to secure housing and other benefits, or a way to obtain better treatment from service providers. Mercedes said that such an attitude exists among immigrant transgender women like herself:

I hear a commentary in the transgender community that some women who prefer to be infected say that it's because they get better benefits. On the other hand, those of us who are negative do not qualify for all those benefits. (*Yo escucho un comentario en la comunidad transgénero, que algunas de ellas que prefieren estar infectadas dicen porque se gozan de muchos beneficios. En cambio, nosotras que estamos negativas no calificamos para todos estos beneficios.*)

Nevertheless, HIV-related benefits are limited, and infected transgender women may continue to engage in risky forms of money-making to make ends meet. Lydia, an undocumented immigrant living with HIV, reported that after receiving her diagnosis she began to receive subsidies for HIV medication and primary medical care, but continued to engage in street-based sex work. She still needs the income, she said, and any daytime employment she might find would conflict with the many medical appointments she has, while late-night sex work is both familiar and fits with her schedule.

MEN WHO HAVE SEX WITH TRANSGENDER WOMEN

Transgender women are often considered a "risk group" because of their high HIV prevalence. It may be more accurate to locate the transgender population within a "structure of risk" involving groups of varied gender identities – including transgender women, male partners and the non-transgender partners of these men (Kammerer 2001a). Men who have sex with transgender women are at the center of this risk structure, but remain an elusive and poorly understood population (Mauk 2008).

We asked transgender women a series of questions about their sex partners. We supplemented these findings with in-depth interviews with men who acknowledged sexual experience with transgender women. Six men were recruited through word of mouth via a Manhattan-based social service that welcomes both transgender persons and their partners. All six live in New York City and were between 30 and 57 years old; five identified as African-American and one as Latino.

Transgender women participants report regularly discussing transgender attraction with their partners and were able to provide insight into the sexual appeal, sex roles and sexual risk between men and transgender women. We asked, “Why do you think some men want to have sex with a transgender woman instead of with a non-transgender woman or another man?” Participants said that some men appear to be looking for a willing partner for oral or anal sex. Often mentioned was men’s interest in transgender women’s unique appeal. Jasmine, reflecting a common theme, said: “A lot of men say they want the best of both worlds.” She and other participants described how many men are aroused by the combination of masculine and feminine, both in the anatomical sense (breasts and a penis), but also the juxtaposition of a nominally male body with a feminine gender expression or a female “softness” (compare Operario et al. 2008).

Participants also said it was common to encounter men who wanted to be penetrated by them, particularly in the context of sex work. Laura described men’s attraction to a “versatile” woman:

A transgender woman can serve as a man, or as a woman. She will satisfy you two ways... She must have a penis, because that is the curiosity, that is the fantasy that men look for. A beautiful woman, but with a penis... Most men look for a woman to put it in them. I say this because of my personal experience. I've worked in the streets, and the men weren't looking to put it in me. I always put it in them. That's what they are looking for. (*Una mujer transgénero le puede servir como hombre, y le puede servir como mujer. Le va a satisfacer dos veces... Tiene que tener su pene, porque esto es la curiosidad, esto es la fantasía que ellos buscan: una mujer bella, pero con un pene... Normalmente el hombre busca para que ellas lo introduzca. Lo doy por mi experiencia. Porque yo estando en la calle, no me venían a buscar para introducirlo a mí. Siempre yo lo introducía a ellos. Ellos buscan esto.*)

This male desire does not always sit well with transgender women. Some study participants remarked that they prefer to be the receptive partner in anal sex, which can affirm one’s feminine identity. Jamila, who enjoyed penetrating partners as a gay male youth, said that since beginning her gender transition she no longer had an interest in taking what she considers to be the male role:

If you come to me with that homo [stuff], you need to go on somewhere with yourself... Because I feel like if you're supposed to be my man, that's what you need to act like. And real men don't get [penetrated].

Some transgender women have little interest in having a partner acknowledge their penis. To Ramona, 26, who has never engaged in sex work:

I consider myself a female. I don't like to be in a relationship where a man feels that he even wants to see my private area or touch it or wants to do anything with it. I want to be with someone who looks at me like a female, considers me a female, doesn't even know about the

word “transgender.” The fact that there’s men out there that actually want to see, and feel and touch and do—. It kind of bugs me out.

According to participants, clients as well as non-commercial partners typically identify as heterosexual. For Coco, men’s interest in anal sex with a transgender woman is a way to avoid the gay label:

They see it as their way of making an excuse. “A woman digged my backside out – it’s alright, it’s not a man. It’s not *really* a man.” They really enjoy it, but they don’t want be labeled as gay. That scares the... out of a lot of men, to be called gay.

The desire for sex with a transgender woman – specifically, a woman with a penis – is a desire without a name, one that does not fit with accepted categories of sexual attraction or identity (Mauk 2008; Valentine 2008). Tisha described how men can express confusion and shame about this desire:

I’ve had men be fine with the fact that I’m transgender, and everything could seem perfectly normal. And then after the act is over, they—. “Oh I don’t feel right!” They tend to go into this phase where they feel like they’ve done something wrong, or they’re not sure with their sexuality, or they don’t know their sexual preference. They’re relying on you to tell them what they are... I’m not attracted to gay men. I’m not attracted to bisexual men. I’m very much attracted to heterosexual men. I believe that the men I sleep with are heterosexual.

Transgender women report that male partners have described sex with them as “taboo,” “exotic,” “freaky,” “intense,” an “experiment,” “something new.” The novelty and supposedly transgressive character of such sex can be part of its appeal. For example, Tisha said:

It varies with men. Every man is not the same. I’ve heard that it’s the adrenaline rush because it’s not the norm for society. A guy said it makes him feel like he’s being sneaky. He said with a woman it could be a very normal thing... With us, it could be something that could be very much like a scandal, you know something that people will like gasp for air, like, “Oh my God, I can’t believe—.”

The small epidemiological literature on men who have sex with transgender women finds that samples of such men report high levels of sexual risk-taking with transgender women and with their other partners (Coan et al. 2005; Bockting et al. 2007), and may underreport risky sexual practices like receptive anal sex (Coan et al. op cit.). Bockting and his co-authors hypothesize that guilt-ridden, furtive sexual activities may be less conducive to condom use (2007). Some transgender participants believe that men engaging in “scandalous” sex may be less focused on protecting themselves and their partners. When asked if men have sex with transgender women are more likely to engage in unprotected sex, Devon, a former sex worker, said that men new to the experience were often highly aroused and out of control, akin to someone under the influence of alcohol:

Yes, because they're doing things they've never done before. It's something exciting and new, "So let me just try it." It's a spur of the moment thing. It's like, "OK, come on let's just do it now." Condoms can be way over there in the drawer, and they don't want to go over and get it because it's going to mess up the mood... They're drunk. They don't want to walk because they're going to fall. They just want to do what they got to do right there. They're drunk with the excitement... And it's over just like that... To put it bluntly, it's a "chick with a [penis]." It excites the hell out of them.

Male partners' understandings of transgender attraction often matched women's perceptions. All six of the men interviewed began their sexual involvement with transgender women during adolescence or in early adulthood. All described first being trans-attracted upon seeing a very feminine transgender woman on the street – sometimes in the context of a neighborhood sex stroll – then coming to discover that they physically enjoyed being with a transgender woman and were attracted to a pronounced feminine presentation or the combination of femininity and male genitalia. All said they were attracted to non-transgender women and none described a sexual attraction to men, though two said they could be aroused by very effeminate men. Only one man acknowledged having been the receptive partner in anal sex with a transgender women, and added, "I would never want to be penetrated by a man." Another said he was interested in being penetrated, but likewise said, "It would have to be transgender. It would not be no man."

Male participants told of the struggle to acknowledge their desires without finding an adequate, socially-acceptable identity that matched those desires. Donald, 45 years old and college-educated, said:

It's just the fact that you're looking at this very feminine woman and the fact that she has a penis and it's just something that I like. I guess that was the hardest thing, just trying to figure out why I like it. But the point is that I do like it so I'm cool with that. People view sexuality and gender mostly in black and white and it's not a black and white issue. I think transgender women are more feminine. They work hard and they appreciate the fact that they are women and they try hard to keep that up. I think most men who are attracted to transgender women are attracted more for their femininity than anything else. Because you know, they are über-feminine, they are like kind of over the top feminine. And that's what men like.

These men noted other-than-physical appeals. For Héctor, 30, transgender women make fewer demands on their partners than do "generic women," referring to non-transgender or "genetic" women.

It's a whole different vibe because transsexuals are like more loving, you know. It's like they live for their perfect mate... I hate to tell the ugly truth, but generic women are headaches. That's the God's honest truth. They're headaches, you know. They're very demanding. They want it their way. If it's not their way, you know, it's just too much hassle. With a trans woman, we don't got to go through that... It's less drama with a trans woman.

Being less “demanding” and living “for their perfect mate” suggests that in the sexual realm transgender women may be perceived as more accommodating of men’s desires and less insistent about condom use. Two other men mentioned that part of transgender women’s appeal is that they cannot get pregnant, an understanding that also associates transgender women with unprotected sex. While it is unwise to generalize from the perceptions of a very small sample of men, if such bases of sexual appeal are widespread, it could help inform the risk of HIV transmission between transgender women and their partners.

Men also noted economic motives to partnering with transgender women. Yusef, 41, pointed out how transgender sex workers may appeal to low-income or homeless men.

A lot of guys, supposed to be men, quote-unquote, don’t have a place to live, so they use them for a place to live. They see they’re turning tricks, so they try to use them for their money, and this is how they’re using the girls... If they want to use them, a lot of guys won’t mind [that the transgender woman is involved in sex work]. If they got that hidden agenda, looking for money, or a roof over their head, or food, clothes on their back, yeah, they ain’t gonna pay it no mind.

Transgender sex workers may thus have particular appeal to men who are themselves socially marginalized. For example, three of the six male partners interviewed acknowledged that they had experience having sex with men for money. Héctor said that he is honest with partners about his sex work:

Some have been cool with it. They were like, “Look, daddy, you gotta make your money. I’m not mad because I do the same [thing] too.”

Just as transgender women spoke of the difficulty of finding a man interested in more than casual sex, each of the men interviewed spoke of barriers to stable relationships with transgender women. Donald, for example, had difficulty finding a woman interested in a long-term relationship:

There’s no gathering place or whatever. I went to clubs every now and again, but I found that to be a problem because most of the girls were working girls and looking for a score. And you know I found a couple on the Internet, you know, just belonging to some forums, but that has been fairly recently.

Will, who also has a college degree and is in his early 40s, was frustrated by how many transgender women are involved in prostitution, now that his own interest is in a finding a stable partner.

Initially I thought it was a sex thing, but right now there’s a companionship that I think that is needed. I think that’s hard too because so many of them don’t have professional lives for whatever reason, and because of that, you know, it’s hard for me to find somebody. Most of these girls are all into the nightlife, into the streets and those types of things, and you know I can’t deal with folks like that.

When Jay, 35, was asked what might put men who like transgender women at risk of HIV, he too mentioned the difficulty in finding a partner not involved in sex work. Trans-attracted men, he said,

They're always hopping from one to another. Because a lot of men that mess with trans they're trying to find that one that doesn't—, that pretty much doesn't prostitute, that has a job. So they'll go and they'll jump around and look for that one that's not out there prostituting. And you tend to run into a lot of girls that does before you find that one that has a job.

Five of the male partners believe that many men prefer paid sexual liaisons because of a reluctance to be seen publicly with transgender women or to have any social commitment with them. Ivan, 57, who is now in a steady relationship with a transgender woman, said:

There are some guys who feel comfortable dating a call girl, a transgender call girl, because they're just there for that moment, that evening, and they [the men] go back to their so-called straight life afterwards. It allows them to hide who they are... No one finds out. And physical safety, because once you embrace this, if you're in a relationship, somehow or other—I don't know if you still use the word "spook," I know it's sometimes "clock"—you run the risk of your partner getting spooked and it comes to the conflict of having to defend your masculinity... No man wants to be told that he's less of a man because he's dating someone who they don't perceive to be the right type of partner.

Both transgender women and male partners must navigate the potential for violent encounters. Just as transgender women face harassment on the street, so too can men who walk with them. Says Héctor,

It's scary, because it just shows how people are ignorant. Like it could be me and my girlfriend on the train, and like, "Yo, that dude's a man!" You know, it's like they spooked the T, as they call it. I got into fights because of it, arguments. I almost got shot, you know, for just being with a tranny. And it's like, wow, is it that serious?... It made me feel like, like I was belittled... It makes me feel like I'm being looked at as a f-- just because I'm seeing a tranny. Little [stuff] like that really used to wreck my last nerve. And it used to hurt. Now I'm just like, You know what? If they can't accept it, "F--- you. Go f--- yourself. It's who I am."

Men who have sex with transgender women lack community and social support and can face rejection both in public and from family and friends, perhaps even more than other sexual minorities. Even men who are interested in building healthy relationships with transgender women face significant barriers, which may contribute to promiscuity and HIV risk among both transgender women and male partners.

THE CHALLENGES OF TRANSGENDER HIV SURVEILLANCE

Transgender women and their sex partners also represent a challenge to the public health surveillance of HIV and AIDS, as medical data frequently fail to capture transgender status or acknowledge differences between birth sex and current gender. In New York State, the Provider Report Form used for reporting cases of HIV infection collects no information on birth sex, but since 2005 its “gender” question has included the categories “male,” “female,” “transgender male-to-female” and “transgender female-to-male.” The Center for Disease Control and Prevention’s national HIV/AIDS Reporting System (HARS) asks only for sex at birth (male/female/unknown), though the new electronic eHARS system will also allow the collection of gender identity. Using available data, a 2009 investigation by the New York City Department of Health and Mental Hygiene’s HIV Surveillance unit located 75 cases of HIV diagnosis reported between 2005 and 2007 among “male-to-female” transgender persons, and the documentation of an additional 269 cases of HIV or AIDS between 1983 and the present among individuals whose medical chart review reports found mention of transgender, transsexual or “transvestite” female status (Merchant 2009). Together, these sources represent a preliminary total of 344 cases of HIV infection or AIDS diagnosis among transgender women in New York City, which may be only a small portion of the total.

Even testing data using the new Provider Report Form that includes transgender categories is likely to miss cases of HIV among transgender women because patients may identify (or be identified by providers) as either female (often their preferred social identity) or male (their given and often legal sex), and not as “transgender male-to-female.” To examine this issue, we asked study participants how they identified their sex or gender when getting tested for HIV. While “transgender” and “transgender female” were common forms of self-identification, so too were “female” without any recognition of one’s birth sex, or “male” without an acknowledgement of one’s gender identity. In practice, this leads to transgender women being classified as non-transgender, possibly as heterosexual women or as men who have sex with men.

Table 4 – Sex and Gender Identity at HIV Screening

Question: “When getting tested for HIV, how have you identified your sex or gender?”
(Multiple responses permitted).

Sex and Gender Identity at HIV Screening		
Sex and Gender	n	%
Transgender/transgender female	21	47
Female	20	44
Male	6	13
“They don’t ask”	1	2

Source: interviews with 45 transgender women in New York City, December 2008 to April 2009.

The lack of reliable estimates for either the number of transgender women in New York City or for the count of HIV-infected transgender women undermines attempts to estimate HIV incidence or prevalence or HIV-related mortality among transgender women.

The existing surveillance system is also unlikely to capture HIV infection and transmission among men who have sex with transgender women. The list of “expanded behavior codes” on the New York City Department of Health’s field investigation form does not yet include sex with transgender women as a risk factor. Thus, an HIV-infected man who has sex with transgender women may represent himself during case investigation as someone who only has sex with women, or may acknowledge having sex with a man (that is, a natal male). Such men may be categorized in surveillance databases as heterosexual men, men who have sex with men, or as persons of unknown transmission risk.

THE LEGAL, CULTURAL & SERVICE LANDSCAPE IN NEW YORK CITY

Scholarly literature has lamented the dearth of “trans-friendly” health care and other services in the United States (Bockting et al. 1998; McGowan 1999; Clements-Nolle et al 2001a; Kammerer et al. 2001b; Davis 2009). New York City, however, has a growing network of informally-connected providers – including shelters, support groups, and health services – that welcome transgender women and men or explicitly appeal to this population. The city is also home to growing movements for “trans-empowerment,” “trans-justice” and transgender legal advocacy. Study participants pointed out that support groups and other organizations have become important bases of socialization and self-esteem, and an alternative to sex work as a locus of transgender community. Furthermore, these providers and services exist as an organizational structure that could carry out government-supported programs to assist transgender persons and their partners.

Health care access. At a recent transgender forum in the Bronx, a South Bronx native discussed her transition in the late 1990s, recalling how “We played our own doctors.” She noted that since then there has been an expansion of discussion boards for transgender persons on the Internet and a constant growth of medical services in New York City, including a network of doctors who are knowledgeable about transgender health issues and who provide access to hormones. But as study interviews suggest, a culture of homegrown, non-professional body modification continues to exist among transgender women. This culture may be both a result and a cause of the reluctance of some transgender people to seek routine and timely professional care.

Health care access among transgender women is further limited by a lack of access to health insurance (particularly among undocumented immigrants), and by providers' lack of awareness of or sensitivity about transgender persons' gender expression and unique health needs. When we systematically asked study participants if anything discouraged them from going to the doctor or getting tested for HIV, few acknowledged transgender-specific barriers. One woman of recent transition said it was embarrassing to disclose one's gender in hospitals and clinics, while another said that stigma against transgender women used to keep her away from health care providers but that the situation had improved. Thirty-four participants said that nothing prevented them from seeking medical care. However, when we probed about whether providers and fellow patients were welcoming towards transgender women, we heard additional mentions of transphobia, although many participants said that the lack of understanding towards transgender people was something they were used to or that was to be expected. For example, Sonia, 31, an undocumented immigrant who said she typically received medical care at the emergency room of a large hospital, first said she faced no barriers to medical care, but when asked about how she got treated at the hospital she noted:

It's very difficult, yes, but you put up with it. Because you can't go anywhere else. (*Es muy difícil, esto sí, pero una se aguanta. Pues, no puede ir a otro lado.*)

Many participants said that they availed themselves of health services that specifically cater to transgender clients or to sexual and gender minorities in general. Given transgender women's high HIV prevalence and need for gender-confirming procedures, improving health care access remains a pressing issue. Felicia, 36 and HIV positive, sees a need for:

A sensitivity training towards the transgender. It's just not the medical part, it's just with everything. They need a lot of transgender sensitivity training... on how to talk and how to treat transgenders, because it's horrible, it's really horrible."

Legal protections and law enforcement. In 2002, the Council of the City of New York passed a law explicitly prohibiting discrimination on the basis of gender identity or gender expression, and in 2004 the City's Commission on Human Rights released guidelines for the law's implementation that led to changes at a number of different agencies. More recently, The Gender Expression Non-Discrimination Act passed the New York State Assembly. If made into law, this act would make attacking a person because of their gender identity or expression a hate crime, as it is for violence based on sexual orientation, race, religion, age or disability.

Despite specific legal protections, transgender persons still face discrimination – in employment, housing and other realms – as well as gender-related violence and harassment. In this study, many women mentioned

difficulties with the police. Two participants mentioned being arrested for suspicion of engaging in prostitution when they were not doing so. Another participant, Keisha, told of getting hit with a taser by a client, then facing a hostile reaction when she reported the incident to the police. Officers were at first respectful, until she informed them that she is transgender. To Keisha, their response was part of a pattern of uncomfortable questioning by both authorities and service providers:

[They asked] “Did you not tell him you were transgender? Why were you meeting him for?” All these questions they were not asking me before all of a sudden became an issue. So I was like, “Because I’m transgender, I automatically I have to be trying to be fooling him? You’re trying to say it’s my fault?” And that’s from professionals. Even like at hospitals, the doctors are pretty objective, but they still ask the same questions. And it’s embarrassing.”

To Carrie Davis (2009), transgender persons are frequently held responsible for being “gender transgressors,” instead of having their gender expression accepted and their civil rights respected.

In New York City jails and holding facilities, the Department of Correction assigns detainees and inmates according to their genitalia (Sylvia Rivera Law Project 2007). While being placed in a general male population can increase transgender women’s vulnerability, at least three participants mentioned the benefits of having a feminine presentation in a male facility. To Crystal, 41 and HIV positive:

Maybe it was the 18 months being treated like the queen. I loved it. The men were all so sweet. The young ones, the old ones, they treated me like tuna [a non-transgender woman], tuna from the can, girl. They would order me sneakers, they would cook for me, they would sew for me, they would iron for me, they would wash for me, just to try and have sex. Because there’s so much vigilance, you really can’t get into anything heavy, so all you could give them is a little touch here, a little tease here, and a little titty here. And for that, they’ll die! If it’s for a picture, they’ll kill themselves. Imagine the real thing that they could just touch you briefly: “But you owe me \$35 in commissary!” Girl, you have to whore in jail too. I’d rather be with men than with women. I survive very well with men. I have no trouble with men.

Housing. Securing safe, affordable housing has been a challenge for many study participants. Beyond the struggle to afford a place to stay in the New York City market, transgender women must also deal with landlords who may object to having a gender non-conforming tenant on social or religious grounds. In 2006 the Department of Homeless Services began assigning residents to its shelters on the basis of their preferred gender identity, not their genitalia or birth sex. However, the one study participant who mentioned having stayed in a woman’s shelter described a hostile climate and said that she preferred to be housed with men. Thus shelters for both women and men may be unwelcoming places for transgender persons, making it difficult to get housing benefits as homeless shelters are the entry point for access to subsidized housing in New York City.

(Davis 2009). As mentioned above, a lack of stable housing may be a risk factor for HIV infection. Meanwhile, many transgender women have obtained subsidized housing after receiving a diagnosis of HIV or AIDS, contributing to the view of infection and disease as a pathway to social stability.

Employment and public assistance. Few transgender women in this study were formally employed at the time of the interview. Aside from some of the immigrant transgender women, few reported significant employment experience outside of sex work. Unlike sex work, where colleagues and clients alike tend to understand and accept one's transgender identity, pursuing formal employment may expose transgender women "to a potentially hostile work environment" (Sausa et al. 2007). Given mainstream society's discomfort with gender variance, transgender persons may attempt to avoid situations in which they have to discuss their gender and physical makeup in a professional environment, as when applying for a job.

In the absence of formal employment, many study participants pursue various forms of public assistance as a way to stabilize their economic situation. Of the 37 participants we formally asked, 14 said they received Supplemental Security Income (SSI) payments after having been diagnosed with a physical or psychological disability that prevents them from working. In addition, at least one other woman used to receive SSI before being imprisoned, and two younger women had been told about the benefit from other transgender women and were considering applying for it. One of them, Jada, said:

I know SSI is like a safety net. I can't really blame transgender women for kind of working the system. This life is very, very, very hard. A lot of them say, "Oh, you don't want to work a real job, you just want to collect an SSI check." A lot of transgenders don't have the self-esteem to go out and apply for jobs. They're often laughed at and criticized and not taken seriously. So that's why they'll say, "I'm going to get on SSI so I can stabilize myself, and then I'll pull dates or I'll get a sugar daddy to pay for my feminization surgery or whatever I need." You shake your head like you've heard it before. It's just an easy way out. A quick way out to use the system. A lot of them are also using housing. They are housed by different organizations, like New York/New York Housing which is like mentally ill. They'll go to the doctor and the doctor will like diagnose them with a mental illness and then put them in an apartment. And I can't blame them. A lot of people are like, "That's not right." It's just that a lot of people don't understand how hard it is, and that transgenders go through desperate measures to get what they want. And they don't really mean any harm. They're just trying to get ahead in life. And I can't blame them for that. I don't put a girl down because she is on SSI or is on housing.

Like sex work, government benefits are a big part of the economic lives of many transgender women, at least among those with legal residency status. Complicated by both discrimination and low educational attainment, the lack of access to formal employment for transgender women may contribute to HIV risk, as it can lead to

earning a livelihood through sex and can encourage social instability. Furthermore, the dearth of employment opportunities can make benefits related to HIV diagnosis look more inviting.

HIV prevention priorities of transgender women. At the end of each interview, we asked participants what type of programs for transgender women they would most like to see in New York City and how they would design an HIV prevention pamphlet. The most common feedback was that consistent condom use still needs to be encouraged. Some participants advocated for HIV prevention messages that remind transgender women to protect themselves and not trust what their partners or clients might say. Others said that prevention materials should use images of beautiful transgender women and language that is both compelling and culturally relevant. A number of participants saw a need for greater support for HIV-negative transgender women, in part to undermine the perceived association between getting infected with HIV and receiving improved care and more extensive benefits. Participants also called for job preparedness programs, sensitivity trainings for medical and social service providers, and for pressuring the police to take more seriously cases of violence against transgender persons. Study participants encouraged direct outreach to transgender women, including to those who are actively engaged in sex work or are in the midst of their transition. At least two women advocated for a peer outreach model, where women could receive education and support from each other. Others mentioned the utility of support groups or the benefit they got from belonging to the movements for transgender justice and empowerment.

A changing landscape for transgender women. New York City's transgender women's community suffers an extremely high rate of HIV infection. But the experiences of study participants suggest that community members may be somewhat less vulnerable now than in recent decades. For example, routine unprotected sex may no longer be as common as some older transgender women say that it was in the 1980s (even in the context of street-based sex work). Lily, who was diagnosed with HIV at the age of 18 in the mid-1980s said:

I wasn't using protection because condoms at that time wasn't so popular. It wasn't a thing like nowadays – condoms are everywhere, free condoms and outreach and all of that stuff. Or agencies. There wasn't no agencies giving condoms out at that time.

Now, condoms are easily available – in 2008, the City of New York handed out more than 40 million free NYC Condoms. HIV testing is pervasive and routine among many transgender women, a “sign of resiliency” that “speaks to a willingness to participate in risk reduction behaviors” (Wilson et al. 2009). In addition, problematic drug use among transgender women may have declined relative to the peak of the crack cocaine and heroin

epidemics in New York City in the 1980s and early 1990s, while “quality of life policing” that began under Mayor David Dinkins has pushed much street-based prostitution into venues that are arguably safer for both sex workers and their clients. Furthermore, transgender women have a greater visibility in popular culture, with representations moving beyond stereotypes of the abnormal “Other” to include television characters and reality show participants who appear more mainstream but are nonetheless identifiably transgender. Though transgender women still face harassment, some older women in the study said the streets of New York City feel safer now. As Devon recalled:

Fifteen or twenty years ago you couldn't walk through certain parts of Brooklyn. And if you were detectable, you would get beat up, or shot at. If you came through there and nobody could tell, it was OK. But everybody is not like that. To be honest, everybody can't walk through a crowd of people and nobody's going to tell. Some people have hair problems, some people are big. Everybody's different. Back then it was not accepted as it is now. Now you can go anywhere you want to go. You really can. Society has changed.

CONCLUSIONS

This report has attempted to analyze the great risk of HIV infection among transgender women in New York City, a vulnerability that is particularly pronounced for black and Latina transgender women. In addition to the effects of poverty, stigma, limited education, and isolation from family and mainstream society, the high prevalence of HIV is, for many transgender women, related to the centrality of sex to their lives, identities and personal economies.

Commercial sex work is an often lucrative occupation that is particularly available to transgender women, who can face extraordinary barriers to more formal employment. The sex trade may be the one industry where being transgender is an advantage (Davis 2009), as transgender women often get paid more than similarly situated non-transgender sex workers. Money from sex work has allowed many of the women in this study to enhance their feminine appearance through clothes, hormone treatments and surgical procedures, and thereby increase their sense of self-esteem and safety. Though participation in sex work was sometimes related to drug or alcohol dependence or other bases of social marginality, even many of the study's better-educated women or those with limited substance use have embraced sex work as a way to earn a living. Sex work may be particularly hard for transgender women to resist, not only because other avenues of employment may be closed to them, but because sex work can be encouraged by peers and, often, by men who view transgender women as sexually available for a price.

Beyond commercial sex work, societal attitudes can create lots of opportunities for sex, though a number of participants of recent transition noted an awkwardness around having sex or pursuing romance as a woman. Many transgender women in this study acknowledged that having sex with men can provide a particular affirmation of their appeal as women. Another common theme in the interviews was the difficulty of finding a man willing to have a relationship or to show affection, which may lead some transgender women to engage with high-risk men or to try to make themselves more appealing through a willingness to have unprotected sex. Even the pursuit of one's feminine appearance can directly contribute to transgender women's risk of viral infection through unsafe practices associated with the injection of hormones and silicone, often purchased on the black market and administered without a doctor's supervision.

In this study, participants appeared well aware of HIV, how to prevent it, and the benefits of getting testing and knowing one's status. HIV-negative transgender women in this study reported a very high rate of recent HIV screening. A caveat: our sample was small and not randomly selected, thus these results do not preclude the existence of a harder-to-reach segment of the transgender community that avoids HIV testing or more routinely engages in high-risk sexual practices. In this study's interviews, risky sex was seldom presented as the product of ignorance about the risk. Though unprotected sex was sometimes associated with not caring about one's body or one's future, it was more commonly understood – particularly in the context of romantic partnerships – as a way to pursue intimacy, approval, self-esteem, sexual pleasure, an emotional connection, or a way to relieve one's sense of social isolation, motives that were often linked by participants to the social stigmatization and sexual objectification that affect many transgender women. Some participants and service providers mentioned that transgender women may embrace a stereotype of female submissiveness, which can lead them to accept male sexual demands. Furthermore, offers of extra payment for condomless sex provide a frequent temptation to transgender sex workers. High-risk sexual practices of male partners of transgender women may also contribute to HIV transmission among these groups.

Challenges to transgender health exist at many levels – individual, interpersonal and structural (Herbst et al. 2008). As the Centers for Disease Control and Prevention noted in a recent policy statement on transgender HIV prevention:

HIV/AIDS is not always a priority issue in the transgender community because so many other basic survival issues outweigh it. In order to effectively reach this community, HIV/AIDS prevention and care programs might be incorporated into a broader outreach effort, such as job training or general access to health care (CDC 2007).

HIV prevention initiatives should both be broadly concerned with transgender well-being – through programs that support education, employment and access to health care – and targeted to the specific experiences and cultural understandings of transgender women and gender-non-conforming persons, rather than seeing transgender women as a subset of men who have sex with men or of women in general. Such an approach might acknowledge the prevalence of sex work instead of dismissing it as a social evil, while at the same time attempt to provide alternative means of making money and alternative bases of social support and community.

POSSIBLE INTERVENTIONS

The following is a list of possible interventions that would enhance HIV prevention for transgender women. These proposals do not represent an established transgender HIV prevention agenda, and some are more appropriate for non-governmental HIV service providers than for governmental agencies to consider. This list attempts to consider which initiatives might be most useful and to stimulate further discussion among governmental agencies and non-governmental service providers with an interest in reducing the burden and consequences of HIV in this community.

1. Improvements in transgender HIV and health surveillance. Medical and public health data frequently fail to capture transgender status or acknowledge differences between birth sex and current gender. Transgender women who contract HIV may be categorized in public health records by their female gender identity or by their male birth sex (and thus as men who have sex with men). Though transgender HIV surveillance has recently improved, a series of further changes would refine the system.

a) Since 2005, the New York State Provider Report Form for HIV testing data has included check boxes for “transgender male-to-female” and “transgender female-to-male.” Transgender women may not identify or be identified as “transgender male-to-female” but may enter into medical reporting systems as simply male or female. A two-step question that allows respondents to detail both their birth sex (male, female or intersex) and their current gender identity (male, female, transgender male-to-female, transgender female-to-male, other) would more fully capture the fluidity of gender identity and provide more accurate surveillance data than a single query about gender, which may be mistakenly interpreted by providers as asking about birth sex and not gender identity. Asking separate questions about gender and sex would allow public health authorities to more accurately track health conditions among different sex and gender categories, including HIV incidence and prevalence among transgender women (Sausa et al. 2009). As of this writing, the Centers for Disease Control and Prevention is moving towards allowing jurisdictions to report both birth sex

and gender identity information through its new eHARS system. Jurisdictions including the New York City Department of Health and Mental Hygiene could coordinate with the CDC to ensure that data collection and reporting are consistent at the local and national levels.

b) Including separate questions about sex and gender would require training the providers of HIV testing services about the differences between birth sex and gender identity, as well as how to best ask about these differences. Such questions are potentially sensitive for both transgender persons and persons whose gender matches their assigned sex at birth. Thus, effective training could avoid creating a barrier to care in medical or social service situations.

c) New York City's Field Investigation Form, used by Bureau of HIV's Field Investigation Unit during secondary investigation on HIV-infected persons, now includes fields for both sex at birth and current gender. The form also has a set of HIV-risk-related "expanded behavior codes," last revised in 2005, that includes "transgender female-to-male" and "transgender male-to-female." A particularly useful addition to these codes would be a notation for men who report having had sex with a transgender woman, to capture cases of male partners of transgender women.

2. Create HIV prevention education materials and campaigns that appeal to

transgender women. Study interviews found that transgender women embrace a female identity and are unlikely to recognize themselves in campaigns that are targeted to men who have sex with men. The lack of transgender-specific HIV prevention literature was cited in the 1999 New York City Transgender Needs Assessment (McGowan 1999), and to this day few HIV prevention materials mention or use images of transgender persons or their partners, losing an opportunity to raise awareness of HIV risk in a very vulnerable community. One exception is the Department of Health's "Protect Yourself Against Hepatitis C" campaign that focuses on transgender women and transgender men who inject silicone or hormones. Inclusive HIV prevention campaigns might recognize the specificity of transgender experience and acknowledge that individuals may not see themselves as either simply male or female or – given the fluidity of gender – as gay or straight. Targeted prevention campaigns could specifically address transgender women and their partners. Recognizing transgender as a category, and a category at risk, should not only encourage transgender women and men, and their partners, to get tested and protect themselves, but could also help to erode ignorance of and stigma towards this population. The following are ideas for specific educational materials suggested by the findings of this needs assessment:

a) A Healthy Body Guide for transgender women. This resource could incorporate HIV prevention education into a broader guide on transgender women's health, including discussions of: (i) the need for transgender-specific health care and the benefit of having a health care provider experienced in caring for transgender persons; (ii) the challenges of gender transition; (iii) hormones and their physical effects; (iv) the risks of hormone and silicone injecting; (v) the risks of sex work, and alternatives to sex work; (vi) the importance of consistent condom use in preventing HIV and other sexually transmitted infections; (vii) special concerns of sex and HIV risk in longer-term relationships; (viii) non-sexual health issues that transgender women may face, such as prostate health.

b) HIV-related myths and staying safe. This resource could encourage transgender women, particularly young women of recent transition, to stay safe by explicitly confronting different HIV-related "myths," including those that reflect an erroneous or incomplete understanding of HIV transmission. It could also target men who have sex with transgender women. Examples of such myths might include the following: (i) that you can tell a person's HIV status by looking at them; (ii) that it's OK to forgo a condom "because the guy is cute"; (iii) that it's safe not to use condoms with a long-term partner whom you love or trust; (iv) that because you cannot get pregnant, anal sex does not require a condom; (v) that only the receptive partner in anal sex is at risk for HIV infection; (vi) that oral sex contains no risk of viral transmission; (vii) that using drugs or alcohol is a good way to enjoy sex; (viii) that the "heterosexual" sex you have with a man is of a low-risk for HIV transmission even if it involves anal intercourse; (ix) that the person who says "I never do this" is necessarily telling the truth; (x) that men who have sex with transgender women are otherwise only having low-risk sex with non-transgender women; (xi) that testing negative for HIV gives one license to engage in unprotected sex; (xii) that being infected with HIV is no longer a big deal; (xiii) that being on HIV medications means that you cannot infect anyone; (xiv) that it is the other person's responsibility to disclose their HIV status or ask about yours.

c) A guide for transgender women involved in sex work. Such a resource could be produced by interested organizations, perhaps working with some of the city's support groups for sex workers. It could touch on some of the following topics: (i) tips for condom negotiation, and what to say when the client offers more money for "raw" sex; (ii) other tips on how to stay safe while on dates; (iii) how being drunk or high undermines the ability to react in dangerous situations or can cloud judgment and allow unsafe sex to occur; (iv) how depression can lead to reckless sex; (v) a reminder to also have safe sex in one's non-commercial relationships; (vi) the importance of saving money (e.g. to pay for one's transition)

and taking care of one's finances; (vii) alternatives to street-based sex work for those who are ready to quit, and resources for those looking for formal employment.

3. Develop transgender-specific HIV prevention education involving peer outreach.

Some study participants and service providers cast doubt on whether printed educational materials would be sought out and read, particularly by transgender women with limited literacy. One option is to create videos to be available via computer or used as the focus for discussion by the city's many transgender support groups. Another option is to communicate educational content through a peer outreach program that would combine the delivery of printed materials with one-on-one or small group discussion. Such an approach could take advantage of the strong social networks and powerful sense of community that exist among transgender women in New York City. Whatever the format, such materials should be available in multiple languages.

4. Increased on-line HIV prevention resources for transgender persons.

Expanded on-line content can also address the HIV prevention and care needs of New York City transgender populations. Web pages of interested organizations could, for example, include basic information about HIV prevention while addressing specific issues of concern for transgender women – such as the challenges of staying safe during gender transition and the promotion of safer practices for the injection of hormones and silicone. On-line content could also provide links to resources for transgender women and men in New York City, including, but not limited to, transgender-sensitive healthcare providers, assistance with HIV testing and partner notification, finding shelter or a support group, and assistance with employment, name change and other legal issues. Such pages could also link to relevant materials from other organizations or jurisdictions, such as the Lesbian, Gay, Bisexual and Transgender Community Center's video, "Transgender Basics," and the training curricula and other resources available through San Francisco's Center for AIDS Prevention Studies and Transgender Law Center. Although not all transgender women are familiar with navigating the Internet or using hand-held devices for social networking, it is likely that a growing number are.

5. Increased HIV testing among transgender women.

Though testing rates were high in this study, the sample may have missed harder-to-reach transgender women who avoid regular HIV testing. Community advocates suggest that the relative lack of "trans-friendly" health providers and testing clinics discourages transgender persons from knowing their status. One way to reach transgender women who have avoided regular testing is through a social network recruitment strategy. Such network-based testing could focus on transgender sex workers and immigrant transgender women.

6. Education and capacity-building to make services more accessible to transgender persons.

Advocates and service providers frequently cite capacity-building around transgender issues as a priority for improving transgender persons' access to medical services, housing and other forms of social support. Both New York City's Lesbian, Gay, Bisexual and Transgender Community Center and the Transitions Project of the University of California, San Francisco, have created such capacity-building curricula for both community-based organizations and local health departments. A guide for medical providers that discusses both physical and psychological challenges of transgender experience might be particularly useful.

7. Intensify provider outreach to HIV-positive transgender women. Many transgender women have little connection to medical providers and may have a distrust of the formal medical system. The Department of Health and Mental Hygiene study of HIV-positive transgender women cited above (Merchant 2009) found that transgender women were less likely than men who have sex with men to initiate HIV care within three months of diagnosis and less likely to continue in care. Providers of HIV care and treatment services could be encouraged to intensify outreach to transgender women for initiation and coordination of care. One possibility is to develop a peer navigation program that would involve HIV-positive women counseling and supporting newly diagnosed individuals. Partner notification may be uniquely challenging for transgender women with HIV, who may have experienced violence and stigma because of their gender and who may be particularly wary of notifying past and present partners about their infection. An enhanced partner services program may assist transgender women with the challenges of such disclosure.

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STUDY QUESTIONNAIRE

(note: questionnaires in Spanish and for male partner interviews are available on request)

Introduction: The New York City Department of Health and Mental Hygiene is exploring how it can improve and expand programs that serve transgender women, particularly programs that may help prevent the spread of HIV. In this interview, I want to ask you about your social and sexual experiences. Many of the topics are quite personal. Please feel free to not respond to any topic you would rather not discuss. There are no right or wrong answers – we just want your honest opinions.

A01. Interviewee number: ____ A02. Interview date: _____

A03. Interviewer: _____

A04. Place of interview: _____

A05. How and where recruited: _____

A06. Age: _____

A07. Where born (country, state or U.S. territory): _____

A08. (*If not from NYC*) What brought you to New York City: _____

A09. How long have you lived in the New York City area: years ____ months ____ whole life ____

A10. Borough/city of residence: _____ A11. Zip code: ____

A12. What is your racial or ethnic identification (*may check more than one*):

Black/African-American _____

Hispanic/Latina/Latino _____

White _____

Asian or Pacific Islander _____

Native American _____

A13. Family countries of origin: _____

A14. Highest level of education (*choose one*):

Less than high school diploma _____

GED _____

High school diploma _____

Some college (or A.A.) _____

College degree (i.e. B.A.) _____

Graduate degree _____

A15. If not are not in school, why did you stop your education?

Identity

B01. What sex did you have at birth?

Male _____

Female _____

Other _____

B02. How do you identify your gender now?

B03. Do you consider yourself transgender?

Yes _____

No _____

If yes: B04. When did you begin to come out as transgender or live as a woman? Age ____

Body Modification

Have you ever:

- | | |
|---|--------------------------------|
| C01. Taken female hormones? | Yes ___ No ___ |
| C02. Taken a testosterone blocker/Spirolactone? | Yes ___ No ___ |
| C03. Had sexual reassignment surgery? | Yes ___ No ___ Surgeries _____ |
| C04. Injected silicone? | Yes ___ No ___ |
| C05. Injected silicone at a "pumping party"? | Yes ___ No ___ |
| C06. Ever used someone else's syringe to inject hormones or silicone? | Yes ___ No ___ |

If ever taken hormones (C01 = Yes)

C07. How old were you when you began taking hormones? ____

C08. Have you obtained hormones:

- | | | |
|-------------------------------|------------------|-------------|
| From a doctor? | currently: _____ | ever: _____ |
| From a friend? | currently: _____ | ever: _____ |
| By buying them on the street? | currently: _____ | ever: _____ |
| Other sources _____ | | |

C09. Do you ever take more than the prescribed dose? (If yes, why?)

C10. Have you ever been unable to take hormones on a regular basis? (If yes, why?)

C11. Do you think taking hormones affects your mood or your judgment?

C12. (*if not post-operative*) Do hormones affect your ability to get an erection?

C13. Do you prefer to inject hormones (*versus take pills*)?

Is there any advantage to injecting hormones?

Housing

D1. In the last few years, in what types of situations have you lived? (i.e. *own place, with friends, shelter*)

D2. Where are you living right now?

- | | |
|---|----------------|
| D3. Are you currently homeless? | Yes ___ No ___ |
| D4. Have you ever been homeless? | Yes ___ No ___ |
| D5. Have you ever lived in a shelter? | Yes ___ No ___ |
| D6. Have you ever lived in foster care? | Yes ___ No ___ |

Economics

E1. Do you currently have a formal job (*one you pay taxes on*)? Yes ___ No ___

E2. In the last few years, how have you made money or supported yourself?

E2a. Do you receive SSI (disability) or other kinds of public assistance? Did you in the past?

Have you ever:

E3. Had sex with someone as a way to have a place to spend the night? Yes ___ No ___

E4. Had sex with someone as a way to make money? Yes ___ No ___

(If E4 = yes) Where have you done sex work, now or in the past? (*the street, clubs, escorting, Internet-based*)

E5. If you are currently involved in sex work, how long do you think you will continue?

E6. Beyond making money, does sex work have any other appeal? (*i.e. excitement, affirmation of being an attractive woman*)

E7. How much do you spend each month on your feminine appearance (*i.e. on clothes, accessories, makeup, medical or cosmetic procedures*) \$ _____

E8. Has the cost of enhancing your feminine appearance ever made you despair or do something you wish you hadn't? (*i.e. do something illegal, sleep with someone who frightened you*)

Sex Partners

F1. Why do you think some men want to have sex with a transgender woman, instead of with a non-transgender woman or another man?

F2. Who are your sex partners – do they see themselves as gay, straight or something else?

F3. Do you think men who like transgender women are more willing to engage in risky sex?
Do men who like transgender women think they can do whatever they want with them?
Does it depend on where you meet them?

Sexual Risk

G1. May I ask, how many sex partners have you had in the past year?

Anal sex: _____ Oral sex: _____ Vaginal sex: _____

In the past year,

G2. Have you had receptive anal sex without a condom? Yes ___ No ___

G3. Have you been a "top" (penetrative partner) during anal sex? Yes ___ No ___

G4. Have you used drugs before or during sex? Yes ___ No ___

G5. Have you had sex in exchange for (receiving) money? Yes ___ No ___

G6. How consistently do you use condoms for anal sex?

All the time _____

Almost always _____

More than half the time _____

About half the time _____

Less than half the time _____

Never or almost never _____

Not applicable _____

G7. When or with whom do you tend not to use condoms? (*i.e. with primary partner*)

G8. What makes it difficult to always use a condom?

G9. Are there circumstances in which you might be more likely to have risky or unprotected sex? (*i.e. when depressed; when drunk or high; when your partner is very attractive; when feeling coerced; when afraid of violence; soon after coming out*)

G10. Do men ever try to get you to have sex without a condom? Yes ___ No ___

If yes: What are some of the things they say to try to convince you to have unprotected sex?

G11. If you have sex without a condom, are there techniques you use to reduce the risk of getting or spreading HIV? (*i.e. choose partner with same HIV status, pull out before ejaculation, be a bottom or top, using lots of lube, post-exposure prophylaxis*)

G12. Do you think there is anything about the way transgender women live that puts them at increased risk for HIV infection?

HIV

H1. When was the last time you were tested for HIV? Month _____ Year _____ Never _____

If ever tested:

H2. May I ask, what was the result of your last HIV test?

Positive _____
Negative _____
Don't know _____
Inconclusive _____ (elaborate)

If negative: H3. For you, how big of a priority is it to avoid HIV infection?

If positive: H3a. What was going on in your life when you think you became infected? (*What kind of risks might you have been taking?*)

If positive: H4. Are you currently receiving HIV-related medical care? Yes ___ No ___

H5. Does anything discourage you from going to the doctor or getting tested for HIV?

H6. When getting tested for HIV, how have you identified your sex or gender?

H6a. Where do you usually go to get tested for HIV or sexually transmitted infections?

H7. Have you ever had any other sexually transmitted infection? (*i.e. syphilis, Chlamydia*)

List: _____

Other Topics

Sexuality: I1. How do you identify your sexuality?

Straight/heterosexual ___
Gay/homosexual ___
Bisexual ___
Other _____

Violence: I3. Have you ever been the victim of violence due to your gender identity?

Yes ___ No ___ Possibly ___

Incarceration: How much time have you spent in jail or prison or juvenile detention,

I4. In the past year: (enter one) Days ___ Months ___ Years ___

I5. In your whole life: (enter one) Days ___ Months ___ Years ___

I6. If arrested in the past year, for what charges: _____

I7. If ever arrested, what was it like being a transgender woman in a male prison?

Insurance: I8. Do you have health insurance? (and if so, what kind?)

None _____
Medicaid _____
Private _____
Other (*specify*) _____

Mental health: I9. Have you ever received a psychiatric diagnosis? Yes ___ No ___ DK ___

(If yes) Diagnoses: _____

Services

J1. Where or from whom have you learned how to “transition” or live as a transgender woman?

Has the Internet been an important source? Yes ___ No ___

J2. Which HIV- or transgender-related services have you used recently?

J3. Where or from whom have you learned the most about how to avoid HIV infection?

J4. If you could design a pamphlet to help transgender women avoid HIV, what would it say?

J5. What other programs could the City of New York create to improve the health of transgender women? (*i.e. encourage condom use, encourage regular testing, housing, jobs, mental health or drug use support, target specific transgender sub-groups, etc.*)

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