

# California HIV/AIDS Update



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## Transgendered People: An “Invisible” Population\*

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In terms of useful information for designing and implementing HIV prevention efforts, transgendered people may well be considered an “invisible” population. Very little empirical research specifically attempts to target this group, and systematically collected data from other sources are scarce, primarily because many standard data collection forms allow for only two genders, effectively obscuring information from any transgendered respondents.

### Background

There are a number of reasons why transgendered people, as a group, may be especially at risk for behaviors that can lead to HIV infection. First, because transgendered people suffer an inordinate amount of discrimination/misunderstanding from mainstream society,<sup>1</sup> including, in many cases, from social service providers and potential employers, they have fewer social and financial re-

sources with which to deal with life issues. In addition, many of them are rejected by their families as well,<sup>2</sup> and as a group have formed only an uncomfortable alliance with the gay community. This lack of social/financial support is likely to contribute to survival sex and drug use in any population; it is especially the case for transgendered youth and adults who may lack other options. In this sense, the hostile social context in which transgendered people exist may contribute to a climate that encourages riskier behaviors such as sex-for-pay.

Second, the majority of transsexuals (both in this sample and in the general population<sup>3</sup>) are Male to Female (MTF) transsexuals. Particularly for pre- and non-operational MTFs, sexual partners are likely to come from a group at high-risk for HIV: males who have sex with males. A preferred sexual role as a receptive partner

\*Please see the Appendix (pages 83, 84, 85) for a discussion of transgender identity labels.

(particularly for anal sex) adds to the level of risk. This combination of high-risk sexual behaviors with high-risk partners increases the risk of HIV infection dramatically.

Finally, some transgendered people have a risk of contracting HIV from needles shared for hormone injections. This behavior occurs because many transgendered people do not have access to prescription hormones and needles (because of financial or other concerns).

### **Purpose**

The primary purpose of the study was to collect information about knowledge, attitudes, and behaviors related to HIV/AIDS in a sample of transgendered people. This includes information about awareness of and access to HIV-related resources and information, as well as behaviors that more directly relate to HIV exposure and transmission, such as sexual and drug-related behaviors. Although this group has rarely been the target of previous research, the data that are available reveal that transgendered people as a group have a much higher prevalence of HIV infection than non-transgendered people. For example, a study in Israel found that 11.1% of MTF transgender prostitutes were HIV positive, compared with 1.1% of female prostitutes.<sup>4</sup> In another study from Canada, 50% of MTF transgenders recruited from the streets who had had HIV tests were HIV positive.<sup>5</sup>

One important goal of this study is to illuminate which specific risk factor(s) may be driving this higher-than-average rate of HIV infection. Ultimately this information will provide a basis for the design and implementation of interventions specifically targeting transgendered people.

### **Sample & Method**

This study was part of a larger program funded by the State Office of AIDS in which 13 local sites conducted behavioral surveillance on one of four populations defined as priority groups in the *California HIV Prevention Plan*: substance users, sex industry

workers, transgendered people, and people of color. Participants for this study were recruited in several northern California communities by local organizations from a variety of sources, including bars, nightclubs and businesses known to cater to transgendered people, transgender meetings and support groups, and street locations. Existing transgender contacts were used to post advertisements for participants as well. While this is a convenience sample and not a probability sample, the broad variety of recruitment sources should help to insure that the sample is not uni-dimensional, and is at least moderately representative of the transgendered population in the areas from which it was recruited.

Interviews were administered in a face-to-face setting by outreach workers who were trained for the task. These interviewers also provided post-interview HIV prevention education to the participants. The interview was developed by the State Office of AIDS and Nancy Corby, Ph.D., California State University, Long Beach, in conjunction with the local service organizations selected to participate. It consisted of seven sections covering 1) information specific to the population of interest, 2) demographic information (e.g., age, income, and education), 3) knowledge and attitudes about HIV/AIDS, 4) resources and education about HIV, 5) sex with main partner, 6) sex with other partners, including numbers and types of partners, and 7) substance use. A total of 287 interviews were conducted, but data collected by one of the interviewers was discarded due to recording irregularities. The data from the remaining 232 interviews were included in the analyses that follow.

### **Results**

Participants in this study were primarily MTF transsexuals (based upon inconsistency between sex-at-birth and gender identification) who ranged widely in age and race. They endorsed a variety of transgender labels, highlighting the confusion and lack of consensus surrounding labeling in this population. The "typical" respondent was about 32 years old (SD. 12.3), was born male (84%) but identified

as female or both (75%). She was currently living, or had plans to live in her transgendered identity full-time (75%). She may be on hormone therapy (50%), but had probably not had genital surgery (97%). Of the 48% who were tested and received their results, 20% tested HIV positive, and another 4% refused to divulge their results.

### Behavioral Risk Factors

There was little evidence that current needle-sharing behavior was driving the high prevalence of HIV infection in this group. Although almost 16% of these respondents had shared needles at some point in the past, less than 1% reported current needle-sharing for injection drug use, and under 5% reported ever sharing needles for hormone or silicone injections. Many respondents specifically mentioned that they had quit sharing needles, and/or quit using injection drugs as a result of the fear of contracting HIV/AIDS.

In contrast, there was ample evidence of sexual behaviors that put these respondents at risk for HIV. Nearly a quarter of the respondents (24%) reported earning money for sex during the previous six months. Since this typically involves high-risk behaviors with high-risk partners, participation in this practice could contribute significantly to the incidence of

HIV-infection. Given that sex-for-pay—sometimes termed “survival sex”—is often used as a last resort by people with no other resources, this high rate may be at least partly attributable to the barriers to social

**Table 1**

<b>Percentage of respondents reporting one or more of the following types of partners</b>	
Injection drug using partners	16%
Transgendered partners	13%
Male partners who have sex with (other) transgendered partners	12%
Male partners who have sex with men	10%
HIV+ partners	5%
At least one of the above	40%

services experienced by this group.

Previous studies have provided evidence that people who are HIV positive, injection drug users, and men who have sex with men all pose an increased risk of exposing a sexual partner to HIV. Additionally, because the rate of HIV infection is quite high in the transgendered population, they may also be considered high risk partners. Table 1 shows the percentage of the respondents who reported sex with these partners during the past six months. It should be noted that these figures underestimate the actual incidence of several of the behaviors because a number of the participants responded “do not know” to questions regarding the gender(s) of their sexual partners’ other partners, their partners’ HIV status, and their partners’ injection drug use.

Another factor that has been associated with increased risk for HIV is having multiple sex partners. A quarter of the respondents had 5 or more partners during the previous six months, and a small percentage (4%) reported 50 or more partners during that time period. However, the vast majority (87%) had 10 or fewer partners.

Of the nearly half of the respondents who had attempted to access social services of some type, 36% reported experiencing barriers such as having a bad experience in the past, or being told by the service agency that transgendered people were not welcome. Nearly 25% reported difficulties getting a job because of gender issues, and 28% were unemployed. These social circumstances could be contributing factors in the decisions that members of this group make about sex for pay and other risky behaviors.

### Knowledge

Although respondents were generally knowledgeable about what constitutes safer sex, they were less realistic about their own level of risk. Over half of this group estimated their personal risk as “less than” most people, and only 15% estimated their risk as “greater than” most people. As a group, this constitutes an unrealistically optimistic assessment which could contribute to riskier behavior. Some of these

respondents reported relying on ineffective methods of risk-reduction. For example, a few reported trying to reduce their risk by making sure that a potential sexual partner “looks healthy.” Although this particular practice did not appear to be widespread, the extent to which people rely on such false assurances as the apparent health of their partner can be an obstacle to effective risk-reduction. Subsequent research needs to explore these sorts of beliefs in a more systematic fashion.

**Conclusions**

Behavioral surveillance is a useful technique for illuminating the specific risk factors that are contributing to HIV seroconversion within a particular population. However, the next step may be to collect more data on the underlying causes, such as the risky thinking and unrealistic estimates of risk mentioned above. As we begin to understand the social and psychological barriers to behavior change within a particular population, we will be able to develop and implement programs that will more effectively re-

duce the impact of the AIDS epidemic on these communities.

**Appendix**

**Population & Background**

The transgendered population consists of a number of diverse segments, and the terminology used to describe this diversity can be confusing, both to those within and those outside the transgendered community. Therefore, it may be useful as a first step to lay out the more commonly accepted meaning of each term as specifically as possible.

The term “transgender” is generally considered to be an umbrella term, encompassing a number of smaller categories, including “transsexual,” “transvestite,” “cross dresser,” “drag queen,” “female impersonator,” “intersex,” and “gender-bender.” Each of these smaller categories are intended to represent a more specific instance of a transgendered

**Table 2. Transgendered Identity Labels<sup>2,6</sup>**

	<b>Dress as Non-Biological Sex?</b>	<b>Sexual Orientation</b>	<b>Motivation for Cross-Dressing</b>	<b>Identify as Non-Biological Sex?</b>
<b>Transsexual</b>	Yes, usually full-time/ as much as possible	Any (most common is biological males who see themselves as heterosexual females)	To express core gender identity	Yes; frequently seeks gender confirmation surgery and/or hormone therapy
<b>Transvestite</b>	Yes, at least occasionally; may range from only select items of clothing (such as undergarments) to complete cross-dressed attire	Any (most common is heterosexual males, followed by homosexual males)	For sexual/erotic gratification and/or to express “non-core” gender identity (e.g., a biological male expressing the “feminine” side)	Primary gender ID is consistent with biological sex, but may secondarily identify with non-biological sex. These people typically do NOT seek surgery.
<b>Cross dresser</b>	Same as above	Any, but this term is rarely used in homosexual circles	Same as above	Same as above
<b>Female/Male impersonator</b>	Yes, usually for performances	Any, but this term is more often used in heterosexual circles	Ostensibly for performances, although oftentimes people in this category identify primarily as either transvestites or transsexuals	Not necessarily; see “motivation for cross-dressing”
<b>Drag Queen/ King</b>	Yes, usually for performances	Any, but this term is most often used in homosexual circles	Same as above	Same as above
<b>Intersex/ Hermaphrodite</b>	Born with biological characteristics of both sexes; may dress as preferred gender	Any	To express core gender identity	Yes, in the sense that biological sex is mixed and core gender ID is usually either male or female

“state.” Table 2 delineates the important concepts associated with each of the labels used in this study.

### Key Points About Identity Categories

The defining characteristic is gender identity. The primary difference between the two main sub-categories—transsexuals and transvestites—is whether their core gender identification is consistent or inconsistent with their biological sex. Although transsexuals and transvestites both *present* the opposite of their biological sex, transsexuals are presenting who they feel they are, while transvestites are presenting an illusion. That is, at least part of the satisfaction for many transvestites comes from the sense of presenting a convincing image of what they are *not*. An old tradition in female impersonation is for the performer to take off the wig at the end, revealing (indeed, reveling in) the illusion. In contrast, a performing MTF transsexual would be unlikely to do anything to detract from her appearance of “female-ness.”

Gender identity and sexual orientation are separate. The term “sexual orientation” describes a person’s sexual (and/or emotional) attraction to the same sex, the opposite sex, or both sexes. Gender identity, in contrast, describes *what gender a person feels s/he is*. A great deal of confusion can be avoided by noting that these two concepts are independent of one another. That is, note that for each category in the table below, sexual orientation is listed as “any.” In some cases, a term may have gay or straight “connotations” because it is used more often in those circles. However, it is inaccurate to assume, for example, that a MTF transsexual will become/is a “straight” female—one who prefers men as sexual partners. (This is often, but not always the case.) During and/or after transitioning, a MTF transsexual may prefer males, females. Or in a true feat of label-defying behavior, an MTF transsexual may prefer transgendered people as sexual partners. This is also true for female to male (FTM) transsexuals.

### Cautions Regarding Labeling

Although I attempt to concisely define each of the labels in terms of its important features, there are some caveats surrounding labeling generally, and attempting to categorize transgendered people, specifically.

Many transgendered people fall outside of, between, or across categories. Transgendered people not only call into question the traditional dichotomy of male/female, but they also sometimes defy more sophisticated categorization. For example, how do we categorize someone who is biologically male, but whose core gender identity seems to be equally male and female? Is a MTF transsexual who performs as a female a “female impersonator?” (What if she is post-op?) Is someone who identifies as his/her non-biological sex, but never expresses this identification in terms of cross-dressing, hormone therapy, or surgery “really” a transsexual? There are many examples of people who do not quite “fit” into the tidy boxes we have created. Nonetheless, the structure can be useful to the extent that it helps us to understand the phenomenon. It is important, however, that we do not take it as proscriptive (that is, we understand that it does not mean that all transgendered people “should” fit into the boxes), and that we acknowledge that it is an imperfect structure (that is, we remember that some transgendered people do not fit into the boxes).

Many transgendered people do not identify with the “correct” category because they are not typical of the members of that category. The “typical” transsexual is a person who is born male, but identifies as a heterosexual woman. For a FTM transsexual who becomes a gay man, it may be difficult to identify with this label, in part because he is not what most people think of when they say “transsexual.” In a similar way, a heterosexual male transvestite may have difficulty because people mistakenly assume that he is gay (although note that it is actually some-

what *less* common for transvestites/cross dressers to be gay than straight). Additionally, even a "typical" member of a particular category may simply not feel an affinity for that identity label.

Labels may carry stigma. The labels themselves may for some people have negative connotations. For example, many of the MTF respondents in this sample who did not identify with the transgender label explained that they identified simply as women. This included pre- as well as post-operative transsexuals. Given that this shift in identification often comes once the person begins successfully "passing" as the preferred sex, it may stem from the desire (and the newfound ability) to escape the stigma associated with transsexualism.<sup>7</sup> Ultimately, since the goal is to transition to the desired sex, as the trappings of the biological sex and sex role begin to fall away, it should be expected that the new identity will begin to play a more prominent role than the label which denotes the conflicted state.

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