

# **The Health of Sexual Minorities**

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## Public Health and Trans-People: Barriers to Care and Strategies to Improve Treatment

Emilia Lombardi

### 1 Introduction

The first half of this chapter is intended to familiarize public health practitioners, researchers, and students with the central issues of concern for an often stigmatized and marginalized group of lesbian, gay, bisexual, and transgender (LGBT) individuals, that is, trans-people. The second half of the chapter suggests ways to improve their health and well-being. Note that use of the terms transgender and transsexual varies from person to person, regardless of a person's desires to use medical resources to transition from one social gender to another. Therefore, throughout this chapter *trans* is used as a shorthand term to refer to transgender and/or transsexual people. I also recognize that there is great diversity among trans-people. This chapter refers most specifically to those who have transitioned socially from one gender to another. When a trans-person does not identify as either a man or a woman, gender-neutral pronouns are used (e.g., sie and hir). I begin with a review of what is known about public health and trans-people from recent studies.

Results published in the peer-reviewed literature have consistently shown that most trans men and women have experienced some form of violence, prejudice, or discrimination. In a recent study, approximately 60% of a sample of trans-people in the United States had experienced some form of harassment and/or violence, and 37% had experienced some form of economic discrimination (Lombardi et al., 2001). In a study conducted in Los Angeles, 30% of a sample of trans-women reported being fired from their jobs, and 29% reported discrimination in housing (Reback et al., 2001a). A San Francisco study found that 83% of trans-women and 85% of trans-men had experienced some form of verbal harassment (Clements, 1999). Furthermore, trans-men experienced more job discrimination than trans-women (57% vs. 46%), whereas trans-women experienced more physical abuse than trans-men (37% vs. 30%) (Clements, 1999). These group-based experiences parallel individual trans-people's experiences in society, includ-

ing within healthcare systems. Selected vignettes are provided below for further depth of understanding into the issues that trans-people encounter.

A revealing example of healthcare discrimination against a trans-person is the experience of Tyra Hunter (Fernandez, 1998). After being hit by a car, she was refused treatment by the paramedics who responded to the accident once they discovered that she had male genitals. She subsequently died from her injuries, and her mother was awarded \$2.9 million in her wrongful death suit. Another trans-person, Leslie Feinberg, previously detailed the discrimination she received when she visited the emergency room (Feinberg, 2001). The physician examining her ordered her out of the emergency room even though she had a temperature above 104 degrees, and told her that her fever was the result of her being a very troubled person. Finally, the documentary film entitled *Southern Comfort* followed the last year in the life of Robert Eads. Eads was a trans-man who died of ovarian cancer when his attempts to find a medical provider failed as none of them wanted to treat a transgender patient (Davis, 2001).

Other trans-individuals face similar problems accessing health care. Although overt forms of discrimination such as those just described have been reported, other more insidious factors affect trans-people's access to health care. Major issues for many trans-people involve having their identities validated and their lives seen as authentic by the people around them. Their appearances, legal identities, or even just the knowledge that a given person is trans may limit access to and the provision of quality care in health care facilities. The basis of discrimination against trans-people lies in social norms that identify individuals as either a man or a woman, as discussed below.

### 1.1 Genderism and Transphobia

In large part, societal beliefs concerning sex and gender underlie the problems experienced by trans-people. Certain definitions may help clarify the biases experienced by trans-people in society. *Heterosexism* is defined as "an ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community" (Herek, 1991 pp. 89). *Sexism* refers to the inequality that results when one gender (usually men) has privilege, power, or access to resources over another (usually women), combined with the rigid application of social norms to specific genders and the belief in the existence of two static genders. *Genderism* is defined as the ideology that people's physical sex and psychological, social, and legal genders are linked and binary, and that anything different from this condition is abnormal. Cope and Darke (1999) identified specific beliefs concerning trans-people based in genderism:

Biology is destiny. A person with a penis must be a man, and a person with a vagina must be a woman.  
 Trans-people are confused, if not mentally ill.  
 Trans-people are frauds.

Genderism is related to sexism and heterosexism but ought to be considered in addition to, and distinct from, these related forms of bias. All three forms of discrimination concern the changing societal norms with regard to sex, gender, and sexuality and the conflict that occurs between groups of people socially defined (Sakalli, 2002; Guindon et al., 2003). Politically, the groups organized around sexism and heterosexism tend to be allied with one another and against other groups (e.g., feminists and gay rights activists versus social and religious conservatives). Nonetheless, many of the same people who support the human rights of women and LGB individuals believe that physical sex (genitals) and gender are connected and immutable. Genderism lays the foundation for *transphobia*, which is defined as the hatred and unease people have toward those whose gender identity and/or presentation differs from the sex they were assigned at birth (Cope & Darke, 1999).

In sum, genderist rhetoric employs a belief in two distinct sexes and genders (usually ordained by some higher power) and a rigid coupling of biologic sex and social gender. Such rhetoric values a consistent, gendered life as well as a biologic deterministic viewpoint. Many people promote the idea that gender is based on one's physical sex at birth, whereas others focus on socialization. As Mantilla (2000) explains, "As a radical feminist, I believe that gender does not reside for the most part in our bodies—it resides in our heads, where gender socialization occurs." Nonetheless, Mantilla fails to recognize that to be socialized as a man or a woman in society, sie must first be identified via physical characteristics before undergoing distinct forms of socialization. Furthermore, these views fail to allow for individual agency or understanding. Such perspectives are genderist in that they allow for only two genders that are linked unequivocally with one's physical sex and can never be changed. Put another way, they do not allow for a trans-person's own sense of agency, how sie identifies, or how sie reacts to social experiences. Thus, trans-people live under the threat of having their lives devalued or outright negated by those who hold genderist beliefs, which results in transphobia and trans discrimination.

Individuals who voice problems with the appearance of trans-people often see them as disruptive and threatening. This is then used as justification to discriminate against trans-people. A legal example of transphobia is dissected below:

Ms. Cormier, in her notes, contemporaneous or otherwise, writes that she had determined that Ms. Nixon, based solely on her appearance, could not remain in the training group. [Reasons For Decision, *Nixon v. Vancouver Rape Relief Society*, Heather MacNaughton, Tribunal Chair Vancouver, British Columbia, January 17, 2002]

The Vancouver Rape Relief Society argued that because Ms. Nixon was not born female, she does not experience what it means to live as a woman in society, including encountering gender discrimination against women. Thus:

Rape Relief asserts that unless it can decide who is a woman for these purposes, its integrity as an organization devoted to promoting the interests and welfare of women will be so compromised that its right to be such an organization under s. 41 is rendered meaningless. [Vancouver Rape Relief Society v. Nixon et al. 2003 BCSC 1936 (2003)]

In Winchester City, California, a similar battle erupted over who gets to define people's gender but this time from a socially conservative point of view. The California state legislature and governor passed a law protecting trans-people from discrimination. Nonetheless, there were people who disagreed with this change and sought to limit its scope within their school districts.

Acting on a suggestion by Westminster City Councilman Kermit Marsh, he persuaded the board majority to rewrite the district policy in a way that satisfied O'Connell's office while still rejecting the idea that victims of discrimination may determine their own gender. Following Bucher's lead, the three trustees approved language that defines a person's gender as his or her biological sex or, in the case of discrimination, what it was perceived to be by an alleged discriminator. [Rubin, 2004]

The change was eventually allowed in the Winchester City school district. In both of the legal cases presented here, different groups argued that individuals cannot determine their own gender. Both deemed it important to protect certain groups of people from trans-people.

Note that the well-being and safety of trans-people were never considered in these decisions. The chair of the British Columbia Human Rights Tribunal wrote the following:

Following her expulsion from the Rape Relief training, Ms. Nixon said that the healing work that she had done with BWSS was undone and that she felt the same symptoms as she had following her abusive relationship. Her sense of herself and of her identity as a female was undermined. . . . I conclude that the impact of the actions of Rape Relief was exacerbated by the very difficult period of time that Ms. Nixon had experienced just prior to the incident. [MacNaughton, 2002]

Ms. Nixon's experience of transphobia resulted in her experiencing secondary victimization, that is, further victimization even as she was attempting to recover from her initial experience of violence. Ms. Nixon's own experiences of violence were not seen as legitimate by the members of Rape Relief. Similarly, the lives of trans-people were not seen as authentic by the Winchester City school board. The experiences of trans-people in these two legal cases are not uncommon. Many people in society—regardless of their social or political beliefs—do not understand or acknowledge the experiences or lives of trans-people. The idea that one's genital sex can be distinct from one's gender is very difficult for many people to accept, especially people whose beliefs are based on fixed ideas of male and female. It is these sorts of societal views that directly and indirectly affect the health and health care of trans-people.

## 1.2 Identification of Trans-People

Substantial variation exists in how trans-people choose to self-identify. For instance, Gutierrez (2004) interviewed trans-women of color and found that they resisted being labeled as transgender. While they viewed themselves as young women, they believed that placing themselves in a transgender category denied them authentic identities. As one young trans-woman stated, "We're women. We're not transgendered. We're who we are. That word transgender. It really does irk me" (Gutierrez, 2004, p. 72). The interviewee went on to say, "Transgender makes it sound like I'm a transformer or something, or a toy that could change into something to another. . . . I think if someone's gonna portray themselves as a woman they should be considered as a woman" (Gutierrez, 2004, p. 72). This same woman acknowledged that one reason some organizations seek to classify people like herself as transgender is to provide documentation for funding agencies or for other bureaucratic reasons.

Despite the variation in how trans-people choose to identify, the primary issue they face is that their identities and lives are not accepted in society or are accepted only under specific circumstances. This includes both trans-people who have more radical gendered lives as well as trans-people with more traditional gender identities. Ultimately, most trans-people have to deal with genderism and transphobia in virtually every aspect of their lives, including health care settings. Trans-people are subjected to both interpersonal and structural prejudice and discrimination, which in practice are very difficult to disentangle. In the absence of institutional guidelines, many health care professionals have only their personal beliefs to draw upon and are unprepared to treat trans men and women effectively, often to the detriment of the trans-people.

## 1.3 Treatment of Trans-People

Homeless and domestic violence shelters are contexts that are often gender-segregated and therefore likely to refuse services to trans-people. Instead of placement in facilities being based on social identities, placement of trans-people in facilities is often based on their genitals. In the case of domestic violence shelters, many trans-women are turned away because their presence is considered threatening to other women (Cope & Darke, 1999). This is done with little regard for the harm and threats that trans-women are experiencing.

A qualitative study conducted in Boston, Massachusetts exposed significant problems that trans-people encountered in accessing health care (GLBT Health Access, 2000). Findings from focus groups with trans-people revealed that health care providers blatantly refused to treat them or even to refer to them as the gender in which they lived their lives. Furthermore, providers were reported to lack the necessary information concerning routine health care of trans-people. From the participants' perspective, trans-people reported a reluctance to identify themselves as trans to their providers for fear of discrimination or over

concern that their medical information might be disclosed to other sources (e.g., insurance companies), which might lead to them being denied benefits and entitlements, such as comprehensive health care coverage. In sum, fear of prejudice and discrimination from health care providers were behind many trans-people's reluctance to utilize many types of health care, including human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) education.

Focus groups conducted in San Francisco, California examined HIV/AIDS risks and health care issues for trans men and women (San Francisco Department of Public Health, 1997). Consistent with findings from Boston, participants in San Francisco reported problems accessing health care and discriminatory behavior on the part of providers. In particular, participants reported that HIV/AIDS prevention programs did not adequately represent their lives. Self-esteem issues were reported as having strong connections with unsafe sexual practices for trans-people. The need to have their lives and identities accepted was very important—so important that many trans-people placed themselves in risky situations to validate their identities. Some believed that insisting on condom use would lead to their rejection as sexual partners.

Trans-men felt especially invisible with regard to HIV/AIDS prevention programs, as many providers assume that they only have sex with nontrans-women. The reality is that many trans-men are at risk for HIV/AIDS because they identify as gay/bisexual and have sex with men, and/or because they are involved in intravenous drug use. Most HIV/AIDS programs are not explicitly designed for trans-people. Even those that include trans-women often neglect trans-men (Clements, 1999). As in health care settings, HIV/AIDS programs do not acknowledge the full lives of trans-people but focus exclusively on their genitals; for example, trans-women are categorized as men who have sex with men in HIV/AIDS surveillance programs. Again, prejudice and discrimination against trans-people can most often be traced to the notion that biologic sex and social gender are immutably linked.

The criminal justice system offers another setting where genderism and transphobia are institutionalized and result in harm to trans-people. Jails and prisons have policies similar to those of many domestic violence and homeless shelters: if someone has a penis, sie is housed with men, and if someone has a vagina, sie is housed with women, regardless of hir identity or other physical traits. For trans-women, such policies often lead to sexual assault and other forms of violence. When Kelly McAllister, a preoperative transsexual, was arrested for causing a public disturbance, she was placed in protective custody with a nontrans-man, who then sexually assaulted her (Libaw, 2003). If Ms. McAllister had been a postoperative trans-person, she would have been placed in a woman's facility. To be postoperative, however, requires resources (notably money and access to trans-specific services) that many trans-people lack, including those who are arrested for vagrancy if shelters refuse to admit them, prostitution if they cannot obtain other employment, or trespassing if people complain that they are using the wrong restroom.

A study of trans-women in prison found them to be more sexually active than other inmates (Stephens et al., 1999), in part because they trade sex for safety. Given that most prisons do not allow inmates access to condoms, trans-women who exchange sex for protection in prison are at risk for HIV/AIDS infection. With the imminent threat of violence, however, trans-women may not consider HIV/AIDS protection to be a priority.

Even among those who view themselves as accepting of trans-people, their acceptance can be problematic if it fails to encompass the actual lives of trans-people. Social scientists have been charged with using the information they gather about trans-people to support their theoretical viewpoints about gender while ignoring the specific lives of trans-people (Namaste, 2000). Namaste considers such work limited in scope, as it denies trans-people visibility and authenticity. As a case in point, Eyre et al. (2004) conducted a study on the lives of a community of African American male-to-female transgender adolescents and young adults. Although the authors stated that they deferred to their participants' meaning of transgender and used pronouns that their participants preferred in their article, they failed to present the lives of their participants in a manner that allowed them true authenticity. For instance, the authors mentioned that a specific style of dress used by young women in the community "had been *appropriated* (italics mine) as a popular look by transgenders at the time of the study" (Eyre et al., 2004, p. 151). Why *appropriated*? Why didn't the authors instead refer to a style of dress used by all feminine-identified individuals within a specific community? Eyre et al. (2004, p. 166) concluded by stating, "But hormones are not magic wands; both transgender and trade operate under a consensual illusion which may be less and less necessary to sustain as homophobia in the contextualizing culture diminishes." Their conclusion ignores the possibility—indeed likelihood—that their participants were expressing an identity that is as real to them as it is to other young women rather than a mechanism to protect themselves from homophobia.

#### 1.4 Other Forms of Bias Against Trans-People

Knowledge about trans-people has greatly increased in recent years in the United States and other societies through books written by trans-people (see especially, *She's Not There: A Life in Two Genders*, by Jennifer Finney Boylan) and sympathetic representations of trans-people on television, radio, and other media. Such exposure can cause problems by creating a specific image of trans-people. Instead, trans-people have varied risks and experiences. Whereas the same social forces that affect nontrans-people also affect trans-people, such forces can both exacerbate and ameliorate the impact of transphobia on people's lives. Two primary stereotypes of trans-people exist: one of a white, middle-class, older trans-woman and the other of a young trans-woman of color involved in sex work. Trans-men are not usually thought about in discussions of transsexual or transgender issues. Even within trans-activism, much of the rhetoric comes explicitly from a U.S. perspective

with its orientation toward a consumer health model (Namaste, 2000). Even studies that examine the health of trans-people (primarily trans-women) find that not all trans-people have the same risks, as discussed below.

Whereas trans-women have high reported prevalence rates of HIV/AIDS infection, trans-women of color, especially African American trans-women, have reported rates as high as 60% (Clements-Nolle et al., 2001; Reback, 2001b; Nemoto et al., 2004). An explanation for this finding is that, in addition to transphobia, many trans-people have to deal with racism, poverty, and other oppressions due to social structures and biases. Furthermore, access to both trans- and nontrans-related health care resources are curtailed for many trans-people because they cannot afford it or because facilities are biased against trans-people who do not fit a specific social image. Trans-women who are shunted to the margins of society may become involved in sex work as a way to earn their incomes, but this may hinder their access to even trans-related services because of biases against providing services to sex workers (Namaste, 2000).

A geographic bias also exists in that most services for trans-people exist in large cities. Those who live in rural areas are likely to face significant barriers to accessing any kind of health care, as per the experiences Robert Eads, which were thoughtfully documented in the film *Southern Comfort*. A political factor to consider at the national level is how a country's health care system is structured. Namaste (2000) analyzes how trans-activism mirrors the consumer-based health system in the United States. The U.S. focus on services on demand ignores those without the resources to purchase health care. Countries with nationalized health systems have other institutionalized forms of discrimination against trans-people. For instance, Namaste (2000) found that one type of gender clinic in Canada imposes a harsh system of rules and regulations on trans-people, with health care providers demonstrating exploitive behavior.

In sum, health care for most trans-people—especially those who are poor—is lacking for the reasons discussed above as well as others. The end result is that many trans-people either choose to go without health care or find alternatives to formal systems of care. An underground distribution of hormones and other services exist that trans-people use to shape their bodies to better resemble the gender in which they identify, but these alternatives may have other costs. In particular, sex hormones can be toxic at high levels; without medical supervision, their use can lead to serious health problems. Trans-people may also be at risk for HIV/AIDS infection through the sharing of needles and injecting equipment when administering hormones (Bockting et al., 1998; Nemoto et al., 1999; Sebastian, 1999; Wiessing et al., 1999). Trans-people have resorted to using back alley surgeons or cutting themselves out of desperation because they cannot access or afford health care (Murphy et al., 2001; Press, 1998). Trans-women have utilized liquid silicone to alter their bodies as a cheaper alternative to plastic surgery but often face serious health consequences as a result of this practice (Wiessing et al., 1999; Davis, 2004; Fox et al., 2004; Gaber, 2004; Rosioreanu et al.,

2004). Despite these risks, trans-people utilize alternative avenues rather than traditional health care services because they are less expensive, less discriminatory, and lack gate-keeping mechanisms.

I believe it is a mistake to base health and social policy on an image of a specific trans-person in the media or on a particular stereotype of a trans-person. For example, Jennifer Finney Boylan, the author of *She's Not There: A Life in Two Genders*, is in a privileged position both socially and economically, which no doubt abetted her transition from one gender to another. Few other trans-people have her resources. Health and social policy must be based instead on the range of resources available to most of the population. Requiring trans-people to have had expensive, difficult-to-attain medical procedures only adds to the problems experienced by those who are socially and economically disadvantaged. More supportive health and social policy will better enable trans-people to attain their goals of social integration without placing their lives at risk.

## 2 Summary and Solutions

As I have previously described, genderism is related to sexism and heterosexism. Together, these three forms of bias represent assumptions about gender, sex, and sexuality that are currently operating in the United States and other societies to oppress people, specifically trans-people. Genderism refers to how a person is ascribed a gender and to the response people have to any individual who fails to fit within their normative understanding of men and women. Genderism results in the policing of gender identities and expression. All members of society—not only trans-people—are constantly evaluated based on whether they look or act in a manner that is consistent with the gender they are identify as or present as. As entrenched as genderism might seem within the United States and other societies, the problems trans-people experience as a result of genderism are not insurmountable. What follows are some suggested solutions.

### 2.1 Identifying Trans-People

A first issue with which healthcare workers and organizations need to grapple when serving trans-people concerns labeling. In this chapter, I use trans as a short-hand notation for transgender and transsexual, even as this terminology may not be acceptable to everyone, especially when referring to a broad group of people (Valentine, 2002, 2003). Although the term transgender is generally accepted as a political label, is not widely accepted as an individual label. Gutierrez (2004) presented four young women who were transitioning from male to female and do not refer to themselves as transgender, but as women. Other recent studies have likewise found that many people who transition from male to female identify as women and not as transgender or even transsexual (Clements-Nolle et al., 2001; Reback, 2001b).

The connection with sexuality is equally problematic, as different groups identify in different ways. Valentine (2002) referred to one woman who identified as being gay (attracted to men), whereas Gutierrez (2004) referred to a young woman who identified as a lesbian (attracted to women). Both were identified as male at birth, both identified as women, both claimed to be homosexual, yet they were oriented toward different genders. Although this complexity does not mean that labels such as transgender, transsexual, or even trans cannot be used, it does mean that these labels are imprecise and should not be used to deny the identities and lives of anyone, including those seeking healthcare services.

Given a choice of male/man or female/woman, some people may make their decision based on how they identify (how they want staff to treat them), whereas others may base their decision on their current legal sex status. It is important for health care providers to decide what information is actually needed (e.g., identity, legal sex, genital status) and to be explicit and consistent in asking everyone for the required information, not only those they think might be trans-people. An explicit, open-ended option for any sex/gender information requested would be helpful, as it would allow people to be specific about their sex/gender status. Regardless, most people want to be referred to as the gender they are presenting as, and thus health care providers ought to use gendered pronouns based on the person's gender presentation. When in doubt, it is respectful to ask people politely which pronoun they prefer be used when referring to them.

## 2.2 Housing and Bathroom Facilities

Gender segregation creates problems for trans-people. In large part, the concern is whether trans-women can be housed with nontrans-women. As mentioned previously, conflict has resulted over the inclusion/exclusion of trans-women with other women in homeless, criminal justice, and bathroom facilities, even as the situation has also been described for substance-use treatment facilities and domestic violence shelters (Cope & Darke, 1999; Lombardi & vanServellen, 2000).

A spokesperson for a homeless shelter explained, "We can certainly handle inappropriate behaviour that might be aggression or alcoholism or anger management or those types of things. It's the other behaviour that relates to women feeling uncomfortable around pre-operative transgender clients, related to sexuality, that is the issue for us" (Benzie, 2004). Nonetheless, this same individual also stated, "Post-operative transgender women would continue to be welcomed at the centres" (Benzie, 2004). The main issue for most facilities is how to accommodate trans-women who have not had genital surgery, even as those in need of shelters seldom possess the resources for genital surgery.

While the previous discussion seems to imply that trans-women are somehow threatening to other women, the real issue may well be the

shock that people experience when they discover that trans-people do not have the genitals they are expected to have. Two related issues that are all too often overlooked are the safety of trans-women in men's facilities and how best to accommodate trans-men in gender-segregated facilities (Libaw, 2003).

Solutions to accommodate trans-people may take many forms. An important principle underlying all of them is to acknowledge that trans-people are welcome and work with them to accommodate their needs rather than stigmatize them. There is no a priori reason to assume that trans-people behave any differently than nontrans-people. Thus, existing regulations concerning harassment and violence are adequate to deal with most situations involving trans-people as well as nontrans-people. Trans-people choose to use whatever facilities respect their gendered lives and are safe for them. In instances where assimilation is not possible or is unsafe for trans-people, alternatives include designating a private area for trans-people to sleep and creating gender-neutral bathrooms and shower areas. If bathroom and shower facilities are limited, staff might establish specific times to allow trans-people to use these facilities.

Trans-people ought to be expected to follow standard codes of appearance, but requiring them to wear any particular clothing or appear in any manner contrary to their gender identity is very distressing to them and may create or exacerbate existing problems. In other words, it is possible for trans-people to respect dress codes without the requirement that they appear as the gender associated with their biologic sex.

### **2.3 Education and Training of Staff**

I believe it is critically important for all health personnel—administrative, research, and clinical staff alike—to be educated on trans issues, including transgenderism, transsexualism, and cross-dressing. Ambiguity causes problems for trans-people in health care settings. Thus, staff ought to be explicitly trained in how to deal with trans-people so they respect their identities and lives. In some geographic areas, there may be people available to conduct trans-issue education and training for staff at low or no cost. There may also be opportunities at professional meetings to provide trans-issue education and training to public health professionals and students. Furthermore, information is available on the Internet (Table 1) and published in peer-reviewed journals and books that can inform health care professionals about respectful strategies to ensure the safe inclusion of trans-people in health services.

Clients also need to respect the rights of trans-people. It is thus essential for health care providers to ensure that trans-people are treated fairly in their agencies and to make it known that discrimination against any client would not be tolerated. One strategy is to write and post nondiscrimination policies that refer to gender identity and expression and encompass a range of identities and behaviors among trans-people.

Table 1. Online Resource List for Trans Issues

Organization	Web site	Mission
The National Center for Transgender Equality (NCTE)	<a href="http://www.nctequality.org">www.nctequality.org</a>	A 501(c)3 social justice organization dedicated to advancing the equality of transgender people through advocacy, collaboration, and empowerment
Tom Waddell Health Center Transgender Team	<a href="http://www.dph.sf.ca.us/chn/HlthCtrs/HlthCtrDocs/TransGendprotocols.pdf">www.dph.sf.ca.us/chn/HlthCtrs/HlthCtrDocs/TransGendprotocols.pdf</a>	To outline the clinic's protocol regarding the administration of hormones
Trans-Health	<a href="http://www.trans-health.com/">www.trans-health.com/</a>	To provide an online magazine of health and fitness for transsexual and transgender people
Transgender Resource and Neighborhood Space (TRANS)	<a href="http://www.caps.ucsf.edu/TRANS/">www.caps.ucsf.edu/TRANS/</a>	To provide culturally and gender-appropriate substance abuse intervention, HIV prevention, and mental health services to transgender people in San Francisco
Gender Identity Project—New York LGBT Center	<a href="http://www.gaycenter.org/program_folders/gip">www.gaycenter.org/program_folders/gip</a>	To offer transgender-identified people an opportunity to discover who they are and to build communities in an atmosphere of self-acceptance
<i>If You Are Concerned about Your Child's Gender Behaviors: A Parent Guide</i> (educational booklet)	<a href="http://www.dcchildrens.com/dcchildrens/about/subclinical/subneuroscience/subgender/guide.aspx">www.dcchildrens.com/dcchildrens/about/subclinical/subneuroscience/subgender/guide.aspx</a>	To provide a resource for parents who want information and advice on a child with gender-variant behaviors
Transgender Law and Policy Institute	<a href="http://www.transgenderlaw.org/index.htm">www.transgenderlaw.org/index.htm</a>	A non-profit organization dedicated to engaging in effective advocacy for transgender people in our society
Trans Accessibility Project: Making Women's Shelters Accessible to Transgendered Women	<a href="http://www.queensu.ca/humanrights/tap/">http://www.queensu.ca/humanrights/tap/</a>	A manual to assist shelters for abused women make the changes required to provide transgender women with the respectful and supportive services (also useful for other settings involving housing and facilities usage)

In conclusion, it is important to communicate to trans-people that they are welcome within one's agency, as many have come to expect negative treatment from agency staff and clients. Having information available that states the agency's support for trans-people and gender variance helps convey to trans-people that they are in a safe space. Ensuring that health educational materials refer explicitly to trans-people helps overcome biases against them and ensures they are no longer invisible to staff, other clients, and society at large.

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