The HIV prevention needs of African American transgender women living in the southern region of the United States

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Abstract: We conducted a qualitative descriptive study to examine the HIV prevention needs of African American transgender women living in one state in the southern region of the United States. A purposeful sample of 15 transgender women, 18 to 35 years of age, participated in the study. Semi-structured interviews were used to examine the HIV prevention needs of this group of women. Four themes emerged from the data: the desire to be affirmed as a female but remain invisible; high risk contexts; there is a need to nullify discrimination and stigma; and additional resources are needed for HIV prevention efforts. The findings underscore the significance for programs designed specifically to address the unique HIV prevention needs for transgender women of color.

Subjects: Gender affirmation; Intersectionality; Adverse Health Outcomes; HIV risks; Health care access

Keywords: African American; transgender; women; HIV prevention; interview

1. Introduction
Although transgender Americans are rapidly becoming more visible in society, many continue to face discrimination from others, including healthcare providers (Bradford, Reisner, Honnold, & Xavier, 2013; Jaffee, Shires, & Stroumsa, 2016; James et al., 2016). The ability to identify those who self-identify as transgender is significant when looking at issues related to population health (Jaffee et al., 2016). For individuals who identify as transgender, it is difficult to estimate their existence independent of other sexual minority groups that have garnered more attention, such as gay men and lesbians (Baral et al., 2013).

ABOUT THE AUTHOR
Judith B. Cornelius is a doctoral prepared nurse who has written papers on topics of the HIV prevention needs of African American at-risk women and adolescents. Her main interest is on safer sex communications and the use of technology to enhance risk reduction knowledge. She received her BS degree in Nursing from Hampton Institute, her MS degree in Nursing from Hampton University in Hampton, Virginia. She received her PhD from Rush University Medical Center in Chicago, Illinois. She is currently working at a university in North Carolina.

PUBLIC INTEREST STATEMENT
HIV prevention has become a significant public health initiative with the goal of reducing new infections by 75 percent in the next five years and by 90 percent in the next decade. While enormous progress has been made there is more work that needs to be done. One group that is being targeted for increased HIV prevention efforts is transgender individuals who live in the southern region of the United States. It is essential that we focus on the four key strategies to end the HIV epidemic: Diagnose, Treat, Protect and Respond. Strategies to end the epidemic should give a voice to those who are at greatest risk of becoming infected.
The number of transgender individuals living in the United States (U.S.) is not well known. One source estimated that 0.5 percent of the total U.S. population is transgender (approximately one million adults) (Meerwijk & Sevelius, 2017). Another report estimated that 0.6% or 1.4 million adults identify as transgender, and 44,750 of them live in North Carolina (Flores, Herman, Gates, & Brown, 2016). Approximately 16% of transgender individuals (n = 160,000) in the U.S. reported being African American. In another report, approximately 0.7 % (n = 150,000) of youth 13 to 17 years of age identified as transgender (Herman, Flores, Brown, Wilson, & Conron, 2017). One primary reason for this disparity in data is that U.S. census data only allows two gender responses: male or female, a choice that does not accurately reflect a transgender individual’s identity. As a result, researchers have to rely on self-reported data from isolated studies that have numerous limitations to generalizability.

2. Theoretical foundations
Gender affirmation and intersectionality are key theoretical concepts guiding our research. Marginalized individuals are often stigmatized and discriminated by others who do not understand or support their gender identity (Sevelius, 2013). Transgender women represent a multitude of diverse experiences that can vary by culture and settings, hence the healthcare setting. The theoretical lens of intersectionality informed the methodology for this study. With an intersectional analysis, we examined ways in which gender identity intersects with race and the health care setting power differential that makes transgender women of color vulnerable to engaging in health promotion behaviors to reduce negative health outcomes and HIV risks (Crenshaw, 1989). Through this intersectional lens, it is possible to understand that health care experiences for transgender women of color will vary based on their individual experiences (racism, discrimination) with health care providers and its relationship to their HIV risk reduction behaviors.

3. Literature review

3.1. Risk for HIV infection and adverse health outcomes
To be considered transgender is difficult to quantify because being lesbian, gay, or bisexual (LGB) defines sexual identity, while transgender status expresses gender identity (Centers for Disease Control and Prevention [CDC], 2016). In terms of population health, a growing concern related to HIV transmission is the high rate of infection among African-American transgender women. This population reports the highest rates of new HIV infection in one of the southern states (North Carolina) in the U.S. (CDC, 2019; Flores et al., 2016; Roary, 2014).

Transgender women face individual, interpersonal, and structural experiences that greatly increase their risk for contracting HIV (Grant et al., 2011). Our review of the literature indicates that in the past six years few studies have explored the HIV prevention needs of transgender women (Cahill, Valadez, & Ibarrola, 2013; Hoffman, 2014; Poteat et al., 2015; Sevelius, 2013) and even fewer have explored the HIV prevention needs of transgender women of color living in the southern region of the United States (LeMartine, Brennan-Ing, & Nakamura, 2018). HIV is transmitted within social and sexual networks. In the South, a significant number of factors have created the ideal environment for HIV to flourish in the African-American community (Roary, 2014). In the transgender community, these drivers include inadequate access to HIV testing and transgender-specific HIV prevention education, a shortage of health specialists especially in rural areas, lack of social and legal recognition of their affirmed gender, exclusion from employment, and lack of access to care, and the discrimination and stigma associated with HIV, particularly in the Bible Belt region of the country (10 states with above-average religiosity rankings, including North Carolina) (Rosenberg, 2018). HIV prevention efforts are most effective and efficient when delivered within sexual networks with high rates of HIV. In these networks, gender role norms and belief systems redefine HIV risk based on infectiousness and infectivity (Cortopassi, Driver, Eaton, and Kalichman (2019).

Transgender women engage in high-risk sexual behaviors similar to individuals with histories of sexually transmitted diseases (STDs), those with sexual impulsivity, and MSM (Baral et al., 2013;
Centers for Disease Control, 2019). Gamarel and others (Gamarel et al., 2016) found that motivation and sexual relationship types had a profound impact on high-risk behaviors among transgender women. In their study, transgender women and their cisgender male partners reported discrepant relationships (monogamy vs. open agreement). These disagreements influenced their motivation to use condoms with outside partners and serodiscordant primary partners.

While there are similar HIV-related concerns in other populations, unique challenges for transgender women exist. It is commonly known that some transgender women use substances as a form of coping with the increased stressors of living as a transgender person (Cornelius & Whitaker-Brown, 2016). Intravenous drug use, with substances such as heroin or methamphetamines lowers resistance to suggestions from a sexual partner and increases risky behaviors to obtain drugs. In addition to needle use and reuse for drugs, transgender women use needles for cosmetic and medical purposes (e.g., to inject silicone to feminize parts of the body) or to inject female hormones (Cornelius & Whitaker-Brown, 2016). Since some male-to-female (MTF) transgender persons, those born male but transition to female, experience issues with accessing healthcare or insurance, sharing needles to administer hormones is not uncommon (Vanderbilt University School of Medicine, 2017).

3.2. Health care access remains a priority
Healthcare access is a major issue for transgender women due to experiences with humiliation, stigma, and discrimination within the healthcare system (Cornelius & Whitaker-Brown, 2016). Given the limited amount of data that are available on persons who identify as African-American transgender women, HIV prevention interventions developed specifically for this population should take into account the various psychosocial, social, and economic conditions under which HIV risk behaviors occur. This will require an examination of risk behaviors specific to African-American transgender women. Currently, the CDC, (2016) is partnering with community-based organizations to pursue high-impact prevention strategies for transgender women as a goal for the National HIV/AIDS: Strategy Update 2020. Thus, making transgender women a priority for the development and implementation of HIV prevention programs. The findings of this study can inform the development of theory-based interventions specific to this population.

3.3. The present research
This paper will describe a qualitative study that examines the intersection of gender identity (affirmation), high risk behaviors, and the HIV prevention needs among 15 transgender women of color. Qualitative methods have been found to be advantageous when examining issues of intersectionality due to its strength in generating an understanding of the phenomena of interest from the perspective of the participant.

4. Methods
4.1. Procedure
The first author developed an interview guide, which consisted of seven questions. The open-ended questions covered the following topics: disclosure of transgender status to healthcare providers, access to care for HIV prevention, sexual risk-taking behaviors, experience with specific HIV prevention programs, and if you could develop a program what would it be named, how would you design it and what information would be included. Probes, such as can you provide an example or could you explain further, were used to gain an understanding of the specific HIV prevention needs of this population. When necessary, some questions were subsequently repeated to enable participants to expand on their responses.

After receiving Institutional Review Board (IRB) approval from the University of North Carolina at Charlotte, the research assistant (RA) known to the first author as a transgender woman of color was recruited from a community-based organization to assist with the project. Once trained, the RA assisted with recruitment and retention efforts with the project.
4.2. Sampling
The RA worked with the research team in the identification of participants. Given that this population is socially stigmatized and hard to reach, snowball sampling was used to identify candidates. This technique has been found to be an effective recruitment strategy for hard-to-reach populations by allowing researchers to reach participants through their social networks (Hendricks & Blanken, 1992), and it is a practical method used to reach a target audience for descriptive qualitative studies (Faugier & Sargent, 1997). The RA reached out to the first four participants who were part of her social network. These participants informed others of the project through their clubs, families, friends, and at entertainment venues. To decrease bias likely in a close-knit, homogenous group, we also posted information about the study on popular transgender websites. If interested in the study, prospective participants contacted the RA, who then screened the candidate for eligibility based on age, race, transgender status (MTF) and state of residency.

Eligibility requirements included: self-identification as an African-American transgender female, 18 to 35 years of age, and a resident of North Carolina. Due to travel constraints and funding, we only interviewed participants in Charlotte (Mecklenburg County). We selected the age range of 18 to 35 years because transgender women of color begin to transition by the age of 18 years, and the majority transition before age 44 (Cornelius & Whitaker-Brown, 2016; Grant et al., 2011). Also, sexual activity is highest in this age range, which would allow participants opportunities to provide recent recalls of sexual risks and HIV prevention needs.

4.3. Setting
The participants chose the setting for their interviews. They were interviewed in public settings such as clubs, a friend’s house, participant’s home, and at the university in Charlotte, North Carolina (see Table 1).

4.4. Data collection
Data collection began in December 2015 and commenced in December 2017. The project was part of a larger study, which consisted of two separate but similar qualitative studies. The first study examined transgender women’s relationships with individuals, families, and organizations (Cornelius & Whitaker-Brown, 2016). The second study was conducted to examine the intersection of gender identity and health seeking behaviors within the context of HIV prevention needs in one southern state.

Before the interviews began, participants were informed of the consent process, gave verbal permission to participate and be audio recorded, were reminded they could withdraw at any time, and were encouraged to speak freely on the topic. The first set of interviews lasted approximately one hour. Participants were informed that the need for a second interview might be required to gain additional information. If a topic needed additional verification, the participant was contacted for a second interview. Findings were shared and verified with the participants just before they began their second interviews. The second interviews lasted less than 45 minutes, and 12 of the 15 participants were interviewed a second time. Three participants were not interested in returning for a follow-up (second) interview. Data redundancy signaled that the quantity of information for analysis was reached. The interview process ended when data saturation was reached, and no new data was discovered. A verbal summary of key points from the interview was shared with each participant so that they could comment on the accuracy of findings. Participants were compensated for their time at a rate of $50 for the first interview and $20 for the second interview (total of $70).

4.5. Data analysis
The first author listened to each recorded interview. The interviews were transcribed verbatim and the data were de-identified. One member of the research team read and compared each transcript to the original recording noting corrections as needed. The content analysis methods of Neuendorf (2017) were used to code the interviews. These methods of human coding involved construction of a coding
| Pseudonym | Age  | Education | Romantic Relationship | Employment      | Recruitment source | Interview Minutes One/Two | Location         |
|-----------|------|-----------|-----------------------|-----------------|--------------------|--------------------------|-------------------|
| Ann       | 22   | GED       | yes                   | Hair stylist    | RA**               | 52, X*                   | Coffee shop       |
| Monica    | 20   | 10th      | no                    | Entertainment   | A Participant      | 50, 38                   | Friend’s home     |
| Gena      | 30   | 9th       | no                    | Store Clerk     | RA**               | 56, 40                   | University        |
| Wendy     | 28   | 10th      | no                    | Dog Groomer     | A Participant      | 54, X*                   | Participant’s home|
| Angela    | 22   | 10th      | no                    | Entertainment   | Website            | 53, 35                   | Friend’s home     |
| Shay      | 32   | 9th       | yes                   | Entertainment   | Website            | 50, 34                   | Club              |
| Jean      | 32   | 8th       | no                    | Hair Stylist    | A Participant      | 52, 32                   | Participant’s home|
| Jazzmane  | 18   | 10th      | no                    | Hair Stylist    | RA**               | 44, 40                   | Participant’s home|
| Whoop     | 27   | GED       | no                    | Entertainment   | RA**               | 50, X*                   | University        |
| Charly    | 19   | 9th       | no                    | Entertainment   | Website            | 49, 40                   | University        |
| Elaine    | 23   | 9th       | no                    | Entertainment   | RA**               | 50, 30                   | Participant’s home|
| Nicole    | 25   | 10th      | no                    | Entertainment   | A Participant      | 50, 35                   | Coffee shop       |
| Wendy     | 21   | 8th       | yes                   | Entertainment   | RA**               | 50, 40                   | Club              |
| Josey     | 35   | 10th      | no                    | Store Clerk     | A Participant      | 48, 38                   | University        |
| Mia       | 26   | 10th      | no                    | Hair stylist    | Website            | 40, 32                   | Participant’s home|

*X- did not return for a second interview

**RA- Research Assistant
scheme, coder training, and inter-coder reliability assessment. The analysis focused on sexual risk-taking and HIV prevention behaviors. Using an iterative coding process, key points were noted in narrative form.

4.6. Rigor
As part of an audit trail, to establish confirmability, the first author randomly selected three interviews for the development of a coding scheme (codebook) that included themes relevant to the aims of the study. From the three initial interviews, a form was then created with derived themes and space for new themes that might emerge from the data. Each research team member (n = 3) and two graduate students coded the transcripts individually, then compared and discussed the codes with other members of the team. To ensure confirmability with the coding process and to enhance rigor, inter-coder reliability (Cohen's kappa score of 0.081) was established with two members of the research team who carefully read the data for recurrent themes.

The PI developed the initial codebook. Before the remaining interviews were coded, two colleagues, with experience in qualitative research methods and sexual minority populations aided the data analysis process. Peer debriefing was achieved in meetings with colleagues knowledgeable about the health needs of transgender women, and this provided the research team with the opportunity to probe perspectives and biases that otherwise might remain unknown (Lincoln & Guba, 1985).

The remaining interviews were then read and coded for major themes. Each reviewer independently reviewed the data. The team met again to discuss revisions and to identify exemplars for each category. To reach consensus, an analyst triangulation (peer debriefing, data verification etc.) was utilized with the research team to check perception, understand the data, and to discuss any discrepancies or disagreements. Quotes with that exemplify each theme will be provided to illustrate the theoretical concepts explored here.

5. Results
African-American transgender women (n = 15) ranging in age from 19 to 35 years provided data for this study. Few (n = 2) had graduate equivalency diplomas (GEDs); the others dropped out before 11th grade (n = 13). They worked at jobs including: dog groomer (n = 1), hair stylist (n = 4), and store clerk (n = 2), and earned less than $30,000 annually. The majority (n = 8) reported having worked in the entertainment business doing beauty pageants. Few (n = 3) reported being currently in a romantic relationship with a live-in significant other (see Table 1). Four themes emerged from the data: transgender women are often invisible in healthcare systems; violence within interpersonal relationships and humiliations within healthcare contexts is common; there is a need to nullify discrimination and stigma; and additional resources are needed for HIV prevention efforts. To protect confidentiality, participants are identified by age and a pseudonym at the end of each quote.

6. Desire to be affirmed as female but remain invisible
Irrespective of their HIV status, at the time of the study, all of the participants had sought treatment from a healthcare entity. Presenting as a female, several (n = 7) of the women were asked questions such as, “Can you tell me when you last had your period?” In responding to this question, Ann decided not to identify herself as a transgender female, and thus remained invisible. Monica said, “Transgender is not an option for gender with the health intake form; it is just male or female. This makes us invisible.”

Self-disclosure as a transgender woman made many healthcare encounters awkward. While they appeared to be female, legal documents showed that they were male. Gena said, “I was going to the clinic to have blood work. I was more embarrassed by the fact that I went there [looking like a woman], but my driver’s license still had my boy picture. That sort of embarrassed me. It represented a conflict of interest and made me feel little.” Charly said, “They were going
over my paperwork, and it had my female name at the time. My legal birth name had not changed. I put down the name that I was currently using, and they just ignored it.”

After a woman decided to disclose her transgender status, she became a curiosity. “Once I decided to no longer remain invisible, I was an object of attraction, as if I was a freak show,” Monica said. “Like you know, you tell ‘em you’re transgendered, and the doctors and other staff are just coming in from all over to look at you like you are a freak.” Angela described her experience this way, “When I began to transition, I went to a health care agency. The nurse came into the room. She said my male name and indicated that she must have had the wrong room because this says that you are a male. I said, ‘well I am a transgender female.’ She said, ‘there is no way possible that you are a male,’ and she began to call doctors and nurses and all kind of people in the back to look at me and observe me. That was very embarrassing. Now I do not tell anyone about my transgender status.”

7. High risk contexts

7.1. Drug use

While many (n = 11, 73%) of the participants admitted to engaging in substance use and abuse, they did not go to drug rehabilitation facilities. Because many did not have medical insurance, they lacked access to treatment. Drug usage ranged from marijuana, cocaine, and ecstasy, to heroin. The only drug treatment they experienced was when they were incarcerated. There they could not get to the drugs and experienced withdrawal. “I went to jail for a long holiday weekend,” Shay recalled. “I had the shakes bad because I could not get any drugs. When I was released, it was weeks later, and I had gone through withdrawal. I was physically weak and did not have any money. That was a great time for me to quit.”

Josey also failed to get the help she needed to give up drugs, and described her downward spiral this way:

“When I was addicted to drugs, I um, actually came into a large sum of money, um, due to a car accident. I did not realize that I had a problem with drugs. It was just from one thing to another thing, having unprotected sex, group sex with three or four people. It was a nonstop party.”

7.2. With violence comes humiliation and treatment avoidance

Violence existed in the women’s relationships with sexual partners and they were humiliated when they sought treatment from healthcare providers. Three of the women expressed that they had experienced intimate partner violence and rape. They did not report these incidents out of fear of the court system, a source of criminal injustice for them. Mia described the imbalance of power in relationships this way, “Some of my friends are prostitutes, and as prostitutes, they do not have power in sexual relationships. They are paid to perform certain sexual acts. Sometimes they are even raped and not paid, and they do not report it or seek treatment.”

Not seeking health care after a rape was because of the insensitivity from health care providers resulted in treatment avoidance. Whoopi indicated that she did not want to face the judgment and insensitive treatment from health care providers after a rape. “I have never been a victim of violence and rape, but many of my friends have been brutally beaten and raped because they were transgender.” Jazzmane said. “The men did not accept them being transgender. They did not report the beating or rape to the police.” Not acknowledging a person by their preferred gender or name occurred with health care providers and they were dealing with the rape.

Federal organizations and healthcare agencies continue to label transgender females in their surveillance data as MSM, which adds to the humiliation they face within healthcare systems. Hence, transgender women become more marginalized when working with healthcare providers. The stripping of personal worth with rapes and beatings is amplified when they enter the healthcare system. Elaine objected to being classified as a male. She said, “I think that we are identified
as gay men, even though we are transgender females. I do believe that there actually needs to be special teaching about the healthcare of this group of women.”

8. The need to nullify discrimination and stigma

8.1. Desire to be treated as a human being
These women were part of a cohesive network and were concerned about each other. They also wanted to nullify the effects of discrimination and stigma. They wanted to be treated with the dignity and respect that they desired as human beings. When asked how the HIV prevention needs of transgender women could be addressed, Angela said, “The bottom line is that a transgender person is a human being with a family. They have mothers. They have fathers. They have sisters. They mean something to somebody, so treat them as such.”

Stigma is seen as a process of rejecting human differences in the form of social control (Phelan, Link, & Dovidio, 2008). Even healthcare providers stigmatized their transgender patients. Few transgender women demanded respect. Some providers called the women by their correct pronouns (she/her), while others continued to use the incorrect pronouns (he/him). Mia recalled “being called a ‘mister,’ and I am a ‘miss.’ I did correct this, and ever since this mistake it has not happened again.” Whoop disagreed and said that she has had to correct health care providers on which pronoun to use with every health care encounter.

9. The intersection of transgender identity and HIV prevention

9.1. Transgender specific HIV information
When asked how HIV prevention programs could better meet their needs, many said that specific HIV prevention programs to address their unique needs were unavailable in North Carolina. “I do not know if any transgender-specific HIV workshops are offered,” Jazzmane said. “If I had to design my own workshop, I would discuss compassion. Compassion goes a long way. I think there could be more one-on-one networking, real life experiences, you know, things of that nature. Instead of trying to make it something big, you know, start small, and say that you’re a team of three or four good transgender girls, and you know how they live.” Ann nodded her head in agreement with this statement.

9.2. Privacy is a major concern
Privacy was another concern. Transgender women were fearful of their status being disclosed by healthcare providers. “Personally, I know a lot of people who need help but are afraid for their privacy,” Whoop said. Another added, “People getting into their business and finding out about their status, and if their HIV status is positive or negative, then there is more stuff to consider with privacy.” Gena added, that privacy was also a significant concern that she had.

10. Additional resources are needed for HIV prevention efforts
When asked how they could improve the health and HIV prevention needs of transgender women in North Carolina, all (n = 15, 100%) of the women wanted additional resources. “If I had to improve the HIV prevention needs of transgender women in North Carolina, I would begin by starting a program where they could get medical attention because everyone is not blessed to have access or know how to gain access to health care. North Carolina is one state in which Medicaid was not expanded, limiting access to care for many.

10.1. Access to more resources
All of the women (n = 15, 100%) acknowledged that other states seem to have more resources. By comparison, North Carolina has limited resources, which has affected their access to treatment, medications, and housing. “In Atlanta, they have housing,” Elaine said. “They help transgender girls. They also have transportation and provide the girls access to certain doctors. They help with
getting your name changed and living your life on a day-to-day basis as a transgender. North Carolina does not have this.

10.2. Missed opportunities
As a state that stresses medically accurate age appropriate sexuality education many parents have decided to opt-out. As a result, there are missed opportunities for HIV prevention among youth. Mia said, “I would target the kids before they get out of high school because I know a lot of children transition early, as early as middle school or high school,” Nicole said. “I started transitioning in middle school, and in middle school a lot of people do not know all of the modes of transmission with HIV and AIDS.”

10.3. Limited funding
In the state, HIV resources have become limited since funding for some programs ended. Ann added, “There was a program in existence called dUp, and it was held at the Metrolina AIDS Project (MAP). It was for MSM, hence not transgender-specific. Now that MAP has closed there are limited HIV resources in the community. Not many of us can get to the health department unless we live close to a bus line.”

When asked to come up with a name for transgender-specific HIV programs, the women suggested: Safe Sex Clinic, The Women Within, Awareness and Prevention, Yes You Can B Safe, Taking Charge of Our Lives, No Glove No Love, Safe Sex or No Sex, and Abstinence Makes the Heart Grow Fonder. Shay said she would love to challenge the state of North Carolina to offer continuing education for job training and placement, healthcare programs, and public assistance to HIV-positive transgender women in the form of food stamps, monthly stipends, name-change assistance, and resiliency training. Elaine and Nicole agreed that programs such as this exist in New York and Atlanta, but not in a large metropolitan area such as Charlotte.

11. Discussion
The current study is one of a few to examine the HIV prevention needs of African-American transgender women in North Carolina or any southern U.S. state. With the enactment of the Affordable Care Act, a major access to care initiative, more transgender individuals are seeking health care and encountering more healthcare providers. The current presidential administration has promoted a plan to end HIV by 2030. However, while the uncertainty of health care accessibility is being debated and funding for treatment to end the spread of HIV, resources are limited in this state.

In this study, transgender women stated that they felt invisible in the context of healthcare systems. This invisibility is the result of an individual being marginalized by family and/or society, and being seen as anomalies (Kosenko, Rintamaki, Raney, & Maness, 2013). Consistent with the literature, the sample in this study referred to gender insensitivity and displays of discomfort within the healthcare context (Kosenko et al., 2013; Radix, Ard, & Elliott, 2018).

Sexual orientation and gender identity (transgender male to female) data are not being collected accurately. As a result, there are missed opportunities for HIV prevention efforts and screenings. For example, gender abuse, intimate partner violence, victimization, and parental support are dominant risk factors for HIV among transgender women (Poteat, Reisner, & Radix, 2014; Wilson, Iverson, Garofalo, & Belzer, 2012), but are frequently not discussed during the healthcare intake process.

Violence within interpersonal relationships and humiliation within healthcare contexts remains an issue for this population. Consistent with the literature, participants indicated that healthcare providers are generally aware that it is not acceptable to discriminate against sexual minorities, but there is still a belief among transgender individuals that it is not safe for them to disclose their status (Rentmeester & Sallans, 2015; Rounds, McGrath, & Walsh, 2013). Consistent with the literature, many participants reported discomfort in sharing their transgender status with healthcare providers,
and that providers were uncomfortable knowing this information (Botsford, Allen, Andert, Budge, & Rehm, 2018; Radix et al., 2018). Maragh-Bass et al. (2017) identified that transgender patients would be willing to disclose their gender identity and sexual orientation if they received care in a LGBT friendly environment. This willingness to disclose or not disclose is representative of societal oppression and barriers that transgender women face when navigating the healthcare system. Reports of humiliation, denial of care, and substandard care have been reported by transgender patients within healthcare contexts (Kosenko et al., 2013).

Despite such incidents, transgender women have been known to be resilient (Basar & Oz, 2016). Further, none of our participants reported depression and other mental health issues. The participants in this study had participated in our previous research. As a result, many of them may have felt comfortable discussing their experiences with the research team. They felt empowered to provide ideas to the research team on their HIV prevention needs.

Participants agreed that additional resources were needed to address ending the HIV epidemic in North Carolina. To begin, there is limited education addressing the health and HIV prevention needs of the transgender population in the state of North Carolina. In a recent survey of schools of nursing in North Carolina, Cornelius, Enweana, Alston, and Baldwin (2017) found that time devoted to teaching transgender healthcare to nurses remains low (less than five hours or equivalent to only one class period). This is consistent with time devoted to teaching this content in medical schools (Stanford Medicine Project Transgender: The Missing “T” in Medical Education, Stanford Medicine, 2016). As a result, healthcare providers in North Carolina may have limited knowledge about the HIV prevention needs of transgender women of color. This lack of knowledge of transgender issues may have negative consequences for patients such as delays in seeking healthcare and mental health treatment, strained communications between healthcare providers and patients, and individual and systematic discrimination in healthcare systems (Eliason, Dibble, & DeJoseph, 2010). Further, when these patients present for healthcare, but do not feel comfortable disclosing their gender status, HIV prevention educational opportunities are missed. Second, opportunities to provide information on HIV risk in the context of coming out, resilience in the face of stigma and discrimination, dating and relationships, body image and sexual functioning, intimate partner violence, and community building and empowerment may be missed (Keatley & Bockting, 2015).

Attempts are being made by the CDC to address the specific HIV prevention needs of transgender women. However, despite the development of specific transgender programs, such as Life Skills (for young transgender women ages 16–24) and Girlfriends (for adult transgender women), many of our participants did not know about these programs. The participants referred to one program only, Defend Yourself (d up!), which is specifically for black MSM.

The development of any transgender-specific HIV prevention program should be grounded in theory. There are numerous intersecting factors with a transgender identity. In this study all participants were disadvantaged by their race (African American), gender identity (transgender female), and sexual orientation. They were victims of physical, systemic, and institutional humiliation, discrimination and stigma.

The findings of this study can inform healthcare providers of the need to address the HIV prevention needs of transgender women so that they can make the necessary referrals. Several (n = 12, 73%) participants expressed a great deal of enthusiasm about contributing to this research and that someone was interested in giving them a voice. Consistent with previous research, the women in our study wanted to be treated with compassion and respect. Rounds et al. (2013) reported that healthcare providers take an oath to provide healthcare without discrimination, yet transgender women did not feel that they always received quality care and respect. Participants reported that healthcare providers showed disdain and treated them as “freak shows” when they provided honest answers to health assessment questions.
Participants mentioned that many of their transgender friends were HIV positive. Findings from this study point to the need to stress prevention on primary and secondary levels. The LGBT health movement advocates for health care within safe spaces however this remains a priority health issue in some urban settings (Martos, Wilson, & Meyer, 2017; Phillips, Morriseau-Brock, & Patsdaughter, 2012). The Mecklenburg County Health Department is leading the charge to end the HIV epidemic by attempting to reduce new HIV cases in the county. The health department also plans to address the lack of community-wide comprehensive HIV education and testing and launch an initiative to combat the stigma surrounding this disease. A working document called “Getting to Zero Mecklenburg,” has been created and consists of three strategies: Education and Testing Strategy, Pre-Exposure Prophylaxis (PrEP) Strategy, and Treatment as Prevention (TasP) Strategy. The plan for addressing the needs of residents in the county does not specifically identify strategies for gender minorities such as transgender women. For example, access to affordable housing, or job training opportunities. It will be essential that gender-affirming care occurs at all stages of the HIV continuum (Sevelius, Patouhas, Keatley, & Johnson, 2014), and that the roles of economics, gender, and race be taken into consideration when deciding on HIV prevention efforts.

11.1. Limitations
In this study we examined the HIV prevention needs of African-American transgender women in one state in the southern region of the U.S. Snowball sampling was used as a recruitment strategy. This may be a limitation because participants may come from the same social groups. Another limitation of the study was that the sample was drawn from one region of the state. Although Mecklenburg County represents the largest metropolitan area in the state; it is likely that this area has the highest number of transgender women, therefore we were able to enroll a purposeful sample of participants. Response bias may have occurred during the interviews with socially desirable responses. We tried to minimize this by reminding participants of the importance of their participation in identifying the HIV prevention needs of transgender women in this state. Not all participants (n = 3) returned for a second interview therefore there may have been missed opportunities for additional data, despite achieving data saturation. Participants identified what was lacking and what was needed with HIV prevention resources. This information can be used to inform healthcare providers of the need for individualized HIV prevention programs for this population in the state.

12. Conclusion
The transgender women in this study felt the need to remain invisible in healthcare systems due to fear of rejection. Power imbalances exist in their relationships with sexual partners and healthcare providers, which places these women at higher risk for HIV infection. Transgender women’s knowledge about specific transgender HIV prevention programs was limited. The development of HIV prevention programs for transgender women of color should focus on primary and secondary prevention methods for HIV prevention. Respect, compassion and privacy are needed to make prevention efforts successful with transgender women. While the findings of this study add to the literature on the HIV prevention needs of this population, more research is needed as we continue to implement Education and Treatment, PrEP and TasP strategies on population levels.

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