

‘Seeing People as They See Themselves’:

Health Care and Access for Transgender and Gender Non-Conforming Individuals Experiencing Homelessness

Initial pull-out box: Key Terms

Sex: a medical term designating a certain combination of gonads, chromosomes, external sex organs, secondary sex characteristics, or hormone balances.

Gender identity: an inward sense of one’s gender, which may or may not be consistent with one’s biological sex.

Transgender: an umbrella term for people whose gender identity or expression does not match the sex and assumed gender they were assigned at birth.

Gender-nonconforming: refers to people who do not follow other people’s ideas or stereotypes about how they should look or act based on the sex they were assigned at birth.

In 1993, health care providers and activists in the Tenderloin neighborhood of San Francisco opened “Transgender Tuesdays,” a four-hour-per-week primary care service at the Tom Waddell Health Clinic providing multidisciplinary care and social support for transgender individuals. “We wanted to offer hormones as the come-on, but enrollment in primary care as the means,” says **Mark Freeman, FNP**.

Through a harm-reduction approach that allowed clinicians to administer hormone therapies without complicated protocols – thus reducing dangerous black-market acquisition of hormones – the clinic treated more than 600 patients in the first five years, and more than 1,000 in the first ten. “This success has proven one thing emphatically,” says Freeman. “There is no longer any reason, other than historical discrimination, why every health center in this country, private or public, hospital or community, cannot be providing services to transgender patients, just as it does to non-transgender patients.”

Recent studies estimate that 3.5% of the US population identifies as LGBT (lesbian, gay, bisexual, or transgender), with 0.3% identifying as transgender.¹ Among the population of transgender individuals, it is estimated that one in five have unstable housing or are in need of shelter services.² A disproportionately large percentage (20-40%) of homeless youth identify as LGBT.

While Health Care for the Homeless (HCH) providers have often been on the leading edge of advocating for these kinds of services, many clinics still lack inclusive and welcoming environments and ranges of service for transgender patients. “Accepting the patient into care, educating all staff members from clerical to administration on how to do so with respect and understanding, and then providing connections to any services

¹ National Health Care for the Homeless Council (NHCHC), “Gender Minority & Homelessness: Transgender Population,” *In Focus: A Quarterly Research Review of the National Health Care for the Homeless Council* 3.1 (September 2014), p. 1.

² NHCHC, “Gender Minority,” p. 1.

not already provided,” Freeman describes, “this is—or should be—the new standard of care.”

At the Boston Health Care for the Homeless Program (BHCHP), a program similar to the Tom Waddell model providing health care and community for transgender individuals runs on Thursday evenings. **Pam Klein, RN, ACRN, MSN**, is the Transgender Program Nurse Manager and HIV Nurse Case Manager at BHCHP. Klein completed her training at the Tom Waddell Urban Health Clinic and brought her concern for the transgender community to her work in Boston, where a Thursday-evening clinic opened in 2008. “Soon we started branching out into daytime,” Klein recalls. “This is really what we’re supposed to do. It’s great to have the evening clinic and the support group, and it’s a great place for new people. But we’ve really moved toward a program-wide effort to make this a safe space. We’re looking at making the entire program culturally competent, not just Thursday nights.”

In Massachusetts, access to transgender-related health services recently took a huge leap forward. In June 2014, Massachusetts became the third state (after California and Vermont) to cover treatments that are medically necessary for “gender dysphoria”—the medical term for the condition of persistent distress with one’s physical sex characteristics or sex assigned at birth—as a part of its government health plan for lower-income or disabled people. The range of services includes transition-related care—or medical care that helps a patient shift from one physical sex to another—such as gender-reassignment surgery and hormone-replacement therapy (HRT).³ Klein notes that additional services, such as facial feminization and electrolysis, should be considered necessary because they contribute to the safety of transgender individuals by allowing them more easily to “pass” and not draw negative attention in public.

Athena Harrington, 26, attends BHCHP’s Thursday night clinic. Despite having legally changed her name to Athena, staff at local hospitals have insisted on calling her by her birth name and using male pronouns, even after she asked them not to. Her experience at BHCHP has been overwhelmingly positive. “We are people, too,” she says. “We have health care needs, and we deserve equal treatment.” **Charlene Byrne**, 60, had a similar experience at a local hospital, but also found refuge at the Thursday clinic. “BHCHP is doing things right,” she says. “There is a willingness to reach out, be educated, know about the trans community, and use the right names and pronouns. At the hospital they were always calling me Charles. But at the Thursday clinic they know how important names and pronouns are.”

Transgender individuals are at an increased risk of homelessness due to such factors as family rejection or conflict, running away or aging out of the foster care system, violence and other victimization, and institutional discrimination.⁴ A study of LGBT youth service providers narrowed the primary causes of homelessness among

³ Jeremy C. Fox, “Massachusetts to Cover Range of Transgender Medical Care,” *Boston Globe*, June 20, 2014. <http://www.bostonglobe.com/metro/2014/06/20/state-cover-gender-reassignment-surgery-and-hormone-treatment-for-transgender-patients/a9OPrvqdUPmRoiAQugVwEO/story.html>

⁴ NHCHC, “Gender Minority,” p. 2.

transgender youth to running away due to family rejection (46%), being forced out by parents (43%), and aging out of foster care (17%).⁵

In addition to—and sometimes as a result of—these social challenges, transgender individuals face specific health risks that may lead to or be exacerbated by homelessness. These include higher rates of HIV/AIDS, substance abuse, depression and suicide, sexually transmitted diseases, abuse and victimization, eating disorders and obesity, and lack of access to medical care.⁶

The transgender population is dramatically medically underserved. Most insurance companies, including most Medicaid providers, exclude medically necessary care and services for transgender people such as mental health services, hormone therapy, and surgeries. In addition, transgender patients often avoid or postpone medical treatment as a result of negative experiences with providers and office staff who lack information or empathy to provide sensitive care. Such discrimination causes transgender people to delay necessary health care that is not transition related, often to the point of putting their overall health at severe risk.⁷

Postponing primary or routine care can have serious consequences for transgender patients. Lack of anatomy-specific care—even post-transition—such as routine Pap smears or breast examinations for female-to-male transgender patients can result in higher rates of certain cancers. The same is true for male-to-female patients who postpone prostate examinations.⁸ Notably though, the most recent U.S. Preventive Services Task Force (USPSTF) recommendation for prostate-specific antigen (PSA) screening was given a grade D (“Discourage the use of this service”). However, the USPSTF further recommends that patients discuss their prostate cancer risks with their health care professionals.⁹ To make such examinations more comfortable for the patient, providers may want to wait until a positive rapport has developed before broaching the topic of anatomy-specific care. Avoiding primary care because of stigma and lack of knowledge of the transgender experience can result in patients waiting until conditions are acute and then seeking care in emergency rooms, which is another place where they may encounter discrimination.

“In terms of accessibility, trans and [gender non-conforming] people may have to travel great distances in order to access sensitive care, or they may have to access care in a clinic setting rather than through a personal physician,” writes medical sociologist

⁵ NHCHC, “Gender Minority,” p. 2.

⁶ Robert Garafalo and Staci Bush, “Addressing LGBTQ Youth in the Clinical Setting,” in Harvey J. Makadon, et al (eds), *Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health* (Philadelphia, PA: American College of Physicians, 2008), pp. 75-99 (97).

⁷ Transgender Law Center, “10 Tips for Working with Transgender Individuals: An information and resource publication for health care providers,” http://www.trans-health.org/sites/www.trans-health.org/files/10_Tips_for_Providers.pdf

⁸ “Physical Exam,” Center of Excellence for Transgender Health, University of California, San Francisco, <http://transhealth.ucsf.edu/trans?page=protocol-exam>

⁹ U.S. Preventive Services Task Force, “Prostate Cancer: Screening,” http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/prostate-cancer-screening?ds=1&s=prostate_cancer

Taylor M. Cruz. “Even worse, it may force participants to delay care until they are required to resort to the emergency room: results suggest that those who primarily use the emergency room as a site of care tend to have the highest rates of postponement.”¹⁰

Trauma is also a major concern for the transgender population. Because transgender individuals who are homeless are more often in public spaces, they are at an increased risk for victimization.¹¹ As a result, it is helpful for clinicians to employ trauma-informed care when working with transgender patients. Communicating concern for the patient’s safety and comfort in the clinic setting helps transgender patients feel at ease and more likely to trust clinicians with sensitive personal information that may be relevant to their medical care.¹²

HIV rates among transgender individuals are more than four times higher than the general population (2.6% v. 0.6%). Further, 7% of those who have experienced homelessness are HIV positive, versus 2% of those who have no history of homelessness. It is often a survival strategy for transgender individuals experiencing homelessness to engage in sex work, or “the trading of sex or sexual acts for money, food, or shelter.”¹³ In addition, some transgender individuals use sex work to finance gender reassignment surgery or other gender-confirming procedures. Such behavior translates into much higher rates of HIV infection; 61% of transgender individuals who are HIV-positive report having participated in sex work for money.¹⁴

While not all who identify as transgender seek to transition physically to another sex, for those who do the process is often difficult and costly. Transgender individuals experiencing homelessness sometimes pursue illegal services in the absence of access to proper medical services, resulting in poor health outcomes such as hepatitis or disfigurement.¹⁵ Acquiring injectable hormone treatments on the street or from medical providers who do not monitor their use presents major risks for blood-borne diseases such as HIV or hepatitis C infection. In addition, transgender individuals sometimes exchange sexual services for hormone treatments, resulting in further health risks. Lack of access to health care and other support services thus becomes a major contributor to homelessness among the transgender population.

Personal and Structural Barriers to Health Care Access

¹⁰ Taylor M. Cruz, “Assessing access to care for transgender and gender nonconforming people: A consideration of diversity in combating discrimination,” *Social Science & Medicine* 110 (2014), pp. 65-73 (72).

¹¹ NHCHC, “Gender Minority,” p. 3.

¹² Emily L. Pitt and Elaine J. Alpert, “Violence and Trauma: Recognition, Recovery, and Prevention,” in Harvey J. Makadon, et al (eds), *Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health* (Philadelphia, PA: American College of Physicians, 2008), pp. 249-70 (265).

¹³ NHCHC, “Gender Minority,” pp. 3-4.

¹⁴ NHCHC, “Gender Minority,” p. 4.

¹⁵ NHCHC, “Gender Minority,” p. 4.

Transgender individuals experiencing homelessness face two major categories of barriers to accessing health care services. Personal barriers include fear of disclosing gender identity, perceptions that providers lack knowledge about transgender issues, and a general mistrust of providers and the health care system. Structural or systemic barriers such as lack of appropriate accommodations (e.g., gender-neutral restrooms and shelter services), limited choices for gender on legal documents and records, no access to partner benefits or considerations, and limited or unenforced laws protecting transgender rights create significant challenges for transgender individuals seeking support. The high rate of unemployment and employment discrimination affecting the transgender population introduces a further structural barrier. Limited incomes and the high costs of health care may make health services seem out of reach.¹⁶

While cities like San Francisco and Boston have made great strides in providing welcoming and comprehensive health care and shelter services for transgender individuals, especially those experiencing homelessness, other communities across the United States are just beginning to confront the challenges of serving this population. **Dolores Chandler, MSW**, works with the Pauli Murray Project of the Duke Human Rights Center in Durham, North Carolina. “What I’ve heard most often,” Chandler reports, “is that services for transgender homeless just don’t exist. A lot of shelter services in this community are religiously based, and that kind of gets in the way a little bit.”

In Houston, Texas, many of the homeless shelters are run by religious organizations, and few are supportive of the transgender community. **Kristina Arscott, LCSW**, is the Director of Behavioral Health Services at Health Care for the Homeless-Houston. “There are very few places to turn,” she says. What is important is having the ability to connect patients to community resources, even when those aren’t immediately visible. “There are at least two local clinics that provide care to the transgender community,” Arscott says. “As a case manager, I share the resources I know, such as special programs for LGBT victims of domestic violence or other organizations that are aware of what transgender patients face.”

Since shelters are usually segregated by sex, transgender individuals are housed with others of the same biological sex (i.e., what is given on one’s identification) rather than the presenting gender. This creates potentially dangerous situations in which transgender individuals face being harassed, assaulted, or raped in these contexts.¹⁷ The **Rev. Jennifer L. Ethridge, LMT, RMT**, is a Community Health Worker at the Charles Drew Health Center in Omaha, Nebraska. “Some shelters here are even asking, ‘What are you genetically?’ or ‘Do you have a penis?’” she explains. “This is in violation of all kinds of standards, and then a trans woman is forced to stay on the men’s side, where she gets assaulted.”

Lacking proper identification or only possessing documents that refer to the sex at birth poses the same problem. “There is a seemingly insurmountable barrier of

¹⁶ NHCHC, “Gender Minority,” p. 4.

¹⁷ Jaime M. Grant, Lisa A. Mottet, and Justin Tanis, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* (Washington, D.C.: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011), p. 80 and *passim*.

identification and legal documentation,” Chandler explains. “If the ID says they’re male, but they’re presenting as female, they’ll be housed with the men. This poses a huge risk for trans women who are homeless and trying to get access to shelter.” And the risk of harassment and abuse comes not only from other residents, but also from shelter staff who lack knowledge and sensitivity about transgender individuals.¹⁸

For homeless transgender and gender non-conforming individuals seeking health care, barriers are significant. Clinic registration forms often offer only two choices for “gender”: male and female. As in shelter situations, transgender patients are often compelled to report the same sex and name on their forms as is given on their official identification. For Ethridge, what matters is what the patient says. “If they say they’re female, then I’m careful to address them that way,” she explains. “Even if Alice has a full beard, I don’t question. Your name is Alice. It’s not my business whether she is pre- or post-op. It’s important not to ask unnecessary questions. Here in the Midwest a lot of people just don’t get it.”

For Dolores Chandler, these challenges extend far beyond the professional sphere. “As someone who is a gender non-conforming person and who is definitely masculine-identified, just going to the doctor is an intensely anxiety-producing experience,” Chandler says. “To have to go into a medical setting and have them call me ‘Miss Chandler’ makes me cringe. And having staff and providers continually make assumptions about my gender and my gender identity makes me feel alienated, unseen, not myself.”

For transgender and gender non-conforming individuals, seeking sex-specific services like gynecological care or prostate examinations can be so intimidating that many end up avoiding such vulnerable situations. Thirty-three percent of transgender respondents to the *National Transgender Discrimination Survey* reported delaying or not ever seeking preventive care due to discrimination and disrespect, and 28% did not seek care when sick or injured for the same reason.

Clinics can create more welcoming environments by implementing such steps as adding gender-neutral bathrooms, welcoming signage in public areas, and extra space or additional options to the “gender” category on intake forms to allow for further explanation, displaying signage that suggests inclusivity, and educating staff and providers on how to question patients about preferred name, gender identification, and pronouns rather than making assumptions. “If I go into a clinical setting and a provider asks me, ‘What name do you go by?’ and then calls me by that name, or asks me about pronouns and then uses those pronouns, it makes a difference,” Chandler says. “That’s what matters, that providers make an effort to see people how they see themselves.”

At BHCHP, the Electronic Medical Record (EMR) has been revised to include transgender-specific questions. “Most of our effort is geared to making the system work for everyone,” Pam Klein explains. “We ask everyone questions about gender identity, and then we have additional prompts in the EMR.” For example, if a patient identifies as female-to-male transgender, the EMR prompts questions about whether the patient binds breasts, which could present skin issues. For a male-to-female patient, the EMR prompts questions about tucking the penis, which can cause an inguinal hernia of the groin. The

¹⁸ Grant, Mottet, and Tanis, *Injustice at Every Turn*, pp. 4, 80.

EMR also provides multiple options under the “gender” category to allow the patient to self-identify as accurately as possible.

Cultural Competency Barriers

Another serious barrier to health care access stems from a lack of knowledge of transgender-affirmative care and cultural sensitivity among service providers. In one study, 50% of transgender individuals report having to educate their providers on transgender care.¹⁹ In addition to modifying documents and instructing staff and providers to ask appropriate questions of patients whose gender identities might not be immediately apparent, clinics can also serve transgender patients by employing principles of trauma-informed care in the health care setting.

Homeless transgender people encounter discrimination in nearly every aspect of daily survival, leading to persistent problems with anxiety, depression, and post-traumatic stress disorder (PTSD). Employment and housing discrimination lead to homelessness, and discrimination in shelter, rape crisis, and domestic violence assistance settings present further challenges for transgender individuals seeking support. By recognizing that most if not all transgender patients have suffered trauma in the form of discrimination, hate crimes, or violent assaults, health care providers can create safe environments rather than heaping more judgment and discrimination on transgender patients.

The *Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health* offers suggestions for practicing trauma-informed care with transgender patients:²⁰

- Communicate concern for the patient’s safety
- Diagnose and treat specific injuries or psychological problems related to ongoing or past victimization
- Discuss safer sex practices
- Inform the patient that symptoms experienced after a hate crime are valid and deserving of treatment
- Refer the patient to experts in the community who provide direct service to LGBT survivors of hate crimes
- Reframe the violent behavior as unacceptable and criminal
- Place responsibility for the violence unequivocally on the perpetrator
- Assure follow-up both for the presenting complaint and for comprehensive primary care

A welcoming environment starts with the security guards and receptionists who set the tone for patients entering the clinic. Members of the clinic staff who engage patients, take time to ask about names, gender identity, and pronouns, and who refrain from making faces or asking invasive questions establish an environment of safety and trust. Providers who recognize the likely history of trauma and promote harm reduction strategies for high-risk behaviors (such as condom-negotiation strategies for sex workers

¹⁹ NHCHC, “Gender Minority,” p. 4.

²⁰ Pitt and Alpert, “Violence and Trauma,” p. 265.

and needle exchange programs for drug use and hormone injections) address the reality of the lived experience of transgender patients.

Marissa Cruz, RN, MS, APHN, CNS works with homeless patients at NeighborCare Health in Seattle, Washington. Formerly homeless and transgender herself, Cruz brings particular insight to her work. “I became homeless as a result of being transgender,” she explains. Cruz identifies her situation as having been “precariously housed,” staying with various friends along the way. “Because my parents could not accept my transgender plight, my friends became the source of familial support.”

Cruz also experienced domestic abuse. “The hardest thing for me was the effect all of this has on self-esteem, worth, and access to resources,” she says. “Being homeless and relying on others for shelter made me feel like a burden. I had a hard time getting work and couldn’t always contribute.”

Finding trustworthy health care workers made a huge difference in Cruz’s experience. “The first clinic I encountered that provided me with respectful and competent care was at Lyon-Martins in San Francisco,” she says. “The doctors talked to me eye to eye, the nurses would smile when they greeted me, and even the lab aides were engaging. For the first time, I knew that they knew what I was going through, and what difficulties I was facing. It was a wonderful feeling. I started my health screening and updated my immunizations, got a prescription for reduced-cost hormones, and received a comprehensive information packet after my first visit.”

Clinics wishing to offer similar welcoming environments can start by incorporating transgender-specific cultural competency training for all staff members. Such trainings are often provided by local universities or LGBT advocacy groups. Clinics can also make it known in the community that they provide care for transgender individuals and care about transgender health by promoting and advertising transgender-specific services in local media or LGBT publications.

For Cruz, becoming a nurse was the best way to engage her community. “I have gained a voice that has more power and volume so I can have my say in medical institutions, schools, and society,” she explains. “But as a transgender individual, I will have a harder time, even to the point of getting in the door. It’s hard for trans people to find supportive services, but they are out there, and with some effort, you can also find your voice in the niche you have chosen.”

Jama Shelton, LMSW, PhD, is the Deputy Executive Director of the True Colors Fund and former Project Director of the organization’s Forty to None Project. Between 500,000 and 1.6 million youth are homeless each year, and up to 40% of these homeless youth identify as gay or transgender.²¹ The Forty to None Project is committed to reducing the disproportionate percentage of gay and transgender youth who are homeless from 40% to none.²² Shelton offers a number of ideas and challenges for institutions—especially clinics—to become more welcoming to transgender individuals of all ages.

Part of cultural competency is becoming educated on how to talk to and about transgender patients in the clinic setting. From providing intake forms with generous options for gender identification to making eye contact and smiling to using correct

²¹ Forty to None Project, “Mission – About Us,” <http://fortytonone.org/about-us/mission/>.

²² Forty to None Project, “Mission.”

names and pronouns, even the most seemingly minor gestures can make a huge difference.

“Clinic staff can listen closely to names and pronouns and work to get those right,” Shelton observes. “I often hear people say it’s just too hard to keep up with the pronouns. I challenge people on that. We learn new words and new uses for words and acronyms all the time. This is worth the effort.”

Clinic staff should also be aware that refusing to use preferred names and pronouns can result in “outing” a transgender individual and put them in significant danger. Along with possible physical risk from members of the community who may react with violence to someone outed as transgender, the outed individual also faces the risk of losing employment and housing when their transgender status becomes public knowledge.²³ Risk of suicide, which is already much higher among transgender individuals than the general population (41% v. 1.6% reported a suicide attempt),²⁴ only increases when someone is involuntarily outed and put at risk of losing friends, employment, housing, and well regard in the community. Outing or misgendering someone in any context, including a clinic setting, can have serious consequences and even become a contributing factor to homelessness.

Transgender individuals experiencing homelessness face many social and health disparities due to stigma and discrimination in various contexts, but clinics can implement simple solutions to make their environments more welcoming to this population. Transgender individuals living (and often working) on the streets also face greater and more serious health risks, so resolving barriers to access—especially to health care—should be a primary goal among service providers.

Images:

1. Head shot of Jama Shelton
2. Head shot of Dolores Chandler
3. Photos of Athena Harrington and Charlene Byrne
4. Boston EMR example
5. Intake form with only male and female choices
6. Head shot of Marissa Cruz
7. Clinic photo of Pam Klein with patient
8. Gender-neutral bathroom sign
9. Screen shot from “Transgender Tuesdays”
10. Photo of Mark Freeman with transgender client

Pull-out Box 1:

10 tips for Creating a Welcoming Environment

<http://transgenderlawcenter.org/issues/health/10tips>

²³ Grant, Mottet, and Tanis, *Injustice at Every Turn*, p. 154.

²⁴ Grant, Mottet, and Tanis, *Injustice at Every Turn*, p. 2.

1. Welcome transgender people by getting the word out about your services and displaying transgender-positive cues in your office. Use LGBT community centers, services, newspapers, and online resources to advertise. Rewrite intake forms to include “chosen name” and a third, blank option for “sex/gender.” Include a gender-neutral restroom.
2. Treat transgender individuals as you would want to be treated. Show respect, be relaxed and courteous, and speak to transgender clients as you would to any client.
3. Always refer to transgender people by the name and pronoun that corresponds with their gender identity.
4. If you are unsure about a person’s gender identity, or how they wish to be addressed, ask politely for clarification. Asking, “How would you like to be addressed?” or “What name would you like to be called?” can facilitate a good provider-patient relationship.
5. Establish an effective policy for addressing discriminatory comments and behavior in your office or organization. Ensure that all staff [receives](#) transgender cultural competency training and that there is a system for addressing inappropriate conduct.
6. Keep the focus on care rather than indulging in questions out of curiosity. In some situations, information about biological sex and/or hormone levels is important for assessing risk and/or drug interactions, but in many health care situations, gender identity is irrelevant. Asking questions about a person’s transgender status out of personal curiosity is inappropriate and can create a discriminatory environment.
7. Recognize that the presence of a transgender person in your treatment room is not always a “training opportunity” for other health care providers. Asking a patient’s permission is necessary before inviting a colleague or trainee into the situation.
8. It is inappropriate to ask transgender patients about their genital status if it is unrelated to their care. Whether a person has had surgery does not determine that person’s gender for the purposes of social behavior, service provision, or legal status.
9. Never disclose a person’s transgender status to anyone who does not explicitly need the information for care.
10. Become knowledgeable about transgender health care issues. Offer transgender-specific health care needs related to medical, social, and transition processes that improve patient-centered care and empowerment.

Pull-out Box 2:

Transgender Lexicon

Androgynous/Androgyne: having neither a feminine or masculine appearance, or blending masculine and feminine.

Cisgender (or cis): someone whose gender identity matches the sex they were assigned at birth. Opposite of transgender.

FAAB/MAAB: female assigned at birth, or male assigned at birth

Genderfluid: a way of articulating the changing nature of one's gender identity or expression.

Gender-nonconforming: refers to people who do not follow other people's ideas or stereotypes about how they should look or act based on the sex they were assigned at birth.

Gender binary: the system of belief that acknowledges only two distinct genders, cis male and cis female, rather than seeing gender as a spectrum.

Gender dysphoria: a persistent distress with one's physical sex characteristics or sex assigned at birth.

Gender expression: an external manifestation of gender, which may or may not conform to the socially defined behaviors that are commonly referred to as masculine or feminine. Gender expression may be unrelated to one's gender identity.

Gender identity: an inward sense of one's gender.

Gender queer: identifying as neither male or female, or a term for those who identify as both transgender and homosexual; can also refer to a non-binary gender identity (neither male nor female).

Intersex: a person born with any manner of supposed "ambiguity" in terms of physical sex characteristics.

Misgender: attributing a person to a gender they do not identify with.

Outing: To out oneself is to share an identity that was previously unknown to people, usually referring to sexual orientation or gender identity. To be outed is to have someone else share that identity without consent.

Passing: when used by trans people it can either mean that one is being read as the gender they identify as, or that one is being read as cisgender.

Preferred pronouns: the pronouns one prefers to be called. These can include he, she, they, ze, ey, and others. When in doubt about what pronoun to use, ask the client which pronoun they prefer.

Sex: a medical term designating a certain combination of gonads, chromosomes, external gender organs, secondary sex characteristics, or hormone balances.

Sexual orientation: the gender or genders one is attracted to.

Trans: short form of "transgender".

Trans woman: male-to-female transgender.

Trans man: female-to-male transgender.

Transsexual: this term often refers to binary trans people (trans men and trans women), or to trans people who physically transition in any way. Some dislike this term because of the focus it can place on physical transition.

Transgender: an umbrella term for people whose gender identity or expression does not match the sex and assumed gender they were assigned at birth.

Transition: the process trans people may go through to become comfortable in terms of their gender. May include social, physical, mental, and emotional components, things like changing one's name, taking hormones, having surgery, changing legal documents to reflect one's gender identity, coming out to loved ones, dressing as one chooses, and accepting oneself.

Pull-out Box 3:

Transgender Tuesdays: “They came for the hormones and stayed for the health care.”

Eighteen years ago, a team of HIV providers at Tom Waddell Health Center and transgender activists broke the mold by providing something crucially needed, along with hormonal treatment: respect and a new sense of community. In 1993, the “Transgender Tuesdays” clinic opened in the Tenderloin neighborhood of San Francisco. It was the first public health clinic in the country specifically targeted toward transgender people and their care.

The film “Transgender Tuesdays” features clinic staff and stars of the community to depict transgender life in San Francisco over the past decades. But it is the lives of these TG heroes (often unknown even by younger trans folk today) that provide pride in the present and hope for the future.

“Transgender Tuesdays” will be screened at the 2015 National Health Care for the Homeless Conference & Policy Symposium in Washington, D.C., May 6-9, 2015. To learn more or order a copy of the film, see <http://transgendertuesdaysmovie.com/index.html>.

Pull-out Box 4:

Transgender Resources

Primary Care Protocol for Transgender Patient Care
April 2011
Center of Excellence for Transgender Health
University of California, San Francisco, Department of Family and Community Medicine
<http://transhealth.ucsf.edu/trans?page=protocol-00-00>

Transgender Health Program Hormone Protocols (2012)
Callen-Lorde Community Health Center
New York, NY
<http://callen-lorde.org/our-services/sexual-health-clinic/transgender-health-services/>

Protocols for Hormonal Reassignment of Gender
Tom Waddell Health Center
Revised 05/07/13
<https://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransGendprotocols122006.pdf>

Guidelines and Protocols for Comprehensive
Primary Health Care for Trans Clients
Sherbourne Health Centre

Toronto, Ontario, Canada
April 2009

<http://sherbourne.on.ca/wp-content/uploads/2014/02/Guidelines-and-Protocols-for-Comprehensive-Primary-Care-for-Trans-Clients.pdf>

Protocol for Hormone Therapy
Fenway Community Health Transgender Health Program
Boston, MA
<http://fenwayhealth.org/care/medical/transgender-health/>

Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People
The World Professional Association for Transgender Health (WPATH)
2012

http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351

On Demand Webinars

The National LGBT Health Education Center, The Fenway Institute (Spanish and English), <http://www.lgbthealtheducation.org/training/on-demand-webinars/> These webinars are free and include the following titles among others (CME credits are also available):

- [Meeting the Health Care Needs of Lesbian, Gay, Bisexual, and Transgender People: The End to LGBT Invisibility](#)
- [Creating an Inclusive Environment for LGBT Patients and Staff at Your Health Center](#)
- [Optimizing LGBT Health Under the Affordable Care Act](#)
- [Meeting the Health Care Needs of Transgender People](#)
- [Understanding and Assessing the Sexual Health of Transgender Patients](#)

“Practice transformation: improving access to care and quality of care for unstably housed transgender and gender non-conforming persons,” March 27, 2015, 8:30 a.m.-12 p.m., East Coast Health & Housing Training, New York, New York, March 26-27, 2015.

“Practice transformation: improving access to care and quality of care for unstably housed transgender and gender non-conforming persons,” Learning Lab, May 9, 2015, 9 a.m.-2 p.m., 2015 National Health Care for the Homeless Conference & Policy Symposium, Washington, D.C., May 6-9, 2015.

Jama Shelton, LMSW, PhD, [Deputy Executive Director, True Colors Fund](#), Keynote Address, May 8, 2015, 8:30 a.m., 2015 National Health Care for the Homeless Conference & Policy Symposium, Washington, D.C., May 6-9, 2015.

Trevor Project

The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning

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(LGBTQ) young people ages 13-24. Suicide hotline: 1-866-488-7386. Crisis intervention, instant messaging, suicide prevention training:
<http://www.thetrevorproject.org/pages/programs-services>

Trans Lifeline

Trans Lifeline is a non-profit dedicated to the well being of transgender people. We run a hotline staffed by transgender people for transgender people. Trans Lifeline volunteers are ready to respond to whatever support needs members of our community might have. (877) 565-8860.

Lisa Mottet and John M. Ohle, *Transitioning Our Shelters: A Guide to Making Homeless Shelters Safe for Transgender People*, National Gay and Lesbian Task Force Policy Institute and the National Coalition for the Homeless, 2003.

http://www.thetaskforce.org/static_html/downloads/reports/reports/TransitioningOurShelters.pdf

Kristin M. Ferguson-Colvin and Elaine M. Maccio, *Toolkit for Practitioners/Researchers Working with Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning (LGBTQ) Runaway and Homeless Youth (RHY)*, National Resource Center for Permanency and Family Connections, Silberman School of School of Social Work, New York, 2012.

http://www.hunter.cuny.edu/socwork/nrcfcpp/info_services/download/LGBTQ%20HRY%20Toolkit%20September%202012.pdf

The Gay, Lesbian, Bisexual, and Transgender Youth Support Project and OutHealth!, "Personal Comfort Assessment Tool,"

<http://hcsn.org/sites/default/files/spiritweb/GLYS/Personal%20comfort%20assessment%20tool.pdf>