Human Immunodeficiency Virus and Sexually Transmitted Disease Disparities Among Transgender Persons

To the Editor:

We read with interest the editorial of Clare Barrington on our recent article, evaluating the prevalence of Human Immunodeficiency Virus, Hepatitis B Virus, and Hepatitis C Virus Infections Among Transgender Persons Referred to an Italian Center for Total Sex Reassignment Surgery.[1,2]

We would like to comment on the role of health assistance disparities for transgender people worldwide. Experiences of transphobic discrimination and victimization negatively impact on mental health, and the lack of social support has been found to be associated with a higher rate of undiagnosed human immunodeficiency virus (HIV) infection.[3] To accurately assess the prevalence of HIV infection and of other sexually transmitted diseases (STDs) in the transgender population, it is essential to create centers that can offer a comprehensive, multidisciplinary, and adequate support to these patients. The Italian experience of Osservatorio Nazionale sull'Identità di Genere (national observatory for gender identity; www.onig.it) is an example of cooperation of 7 centers for the diagnosis, support and health care of transgender people. Unfortunately, Osservatorio Nazionale sull'Identità di Genere is especially addressed to the people who intend to undergo sex reassignment surgery (SRS) and therefore a part of transgender individuals who give up on surgery is not assisted in this setting. Indeed, this transgender population might miss important healthcare issues including those related to STDs.

We agree with Barrington that it is important to understand the fluidity in identities among transgender patients. However, because of this fluidity it is difficult to include this population in strict categories required by statistical analysis. A recurrent problem in the data collection systems is the way in which we collect and report data related to sex and gender, which is often incomplete or too simplistic. These difficulties could in part explain why we considered in our study only a specific subpopulation patients undergoing SRS. Namely, we found the comparison with other studies seldom reliable due to the lack of uniformity in the transgender population samples. In our opinion, there are also major ethical issues that hinder an objective classification.

Barrington mentions the Wilson and colleagues study[4] showing that users of SRS services were found to have significantly lower estimated odds of suicidal ideation and risky behaviors. In our study, a younger age at SRS would appear to be protective against HIV infection. This suggests that access to the SRS can reduce the incidence of risky behavior and thus long-term consequences on mental and physical health of these people. To strengthen this evidence, we are performing a prospective study that correlates potentially risky behaviors, and physical and mental health indicators including STDs.

Finally, we would also like to make clear that HIV preexposure prophylaxis is still not offered free of charge in Italy as well as in the majority of countries worldwide. Therefore, few people have access to it, and this practice is extremely underused. We would recommend it especially to transgender sex workers who might be more frequently in the condition to have to discuss or negotiate condom use.

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