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In the Name of Brevity: The Problem with Binary HIV Risk Categories

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Abstract

According to the 'Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations' there are five groups of people at elevated risk of HIV, including 'transgender women or transgender men who have receptive anal sex with men.' Although cost effectiveness strategies and best practice lessons recommend targeting specific populations for HIV prevention, existing risk categories lack specificity, and may in fact cause further confusion. Existing categories of risk often perpetuate notions of gender and sexuality that can erroneously exclude, alienate, and stigmatize those who are at the highest risk and thus should be prioritized. We review the troubled history of the MSM category and the problematic conflation of trans feminine individuals and MSM in much of the existing HIV literature, and how this practice has stymied progress in slowing the HIV epidemic in the most at-risk groups, including those who do not fit neatly into binary notions of gender and sex. We draw from examples in the field, specifically among trans feminine people in Beirut and San Francisco, to illustrate the lived experiences of individuals whose identities may not fit into Euro-Atlantic constructs of HIV prevention categories.

Keywords

MSM; Trans women; HIV risk prevention; Beirut; San Francisco

Defining categories, erasing bodies: The troubled history of 'MSM'

The seeming self-evidence of the phrase 'men who have sex with men' and its acronym 'MSM,' could easily lead one to think that it constitutes a purely descriptive category, whose meaning is simple, well-defined, and stable. However, exploring the history of this category rapidly reveals how its uses and meanings are frequently questioned and continuously shifting. In the paper 'But do not identify as gay: A proleptic genealogy of the MSM category', Boellstorff (2011) illustrates how the MSM category underwent successive

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transformations to anticipate its own failure and stabilize a definition that continues to face crises. By examining how the meaning of 'MSM' has shifted throughout the years to the point where it now sometimes refers to an identity or a community, Boellstorff points out how 'MSM' is more than an acronym describing a simple and easily identifiable behavior.

According to Young and Meyer (2005), the terms MSM and WSW, though sometimes useful and accurate, can also render invisible important information on identity, community, and sexual culture. By separating people from their contexts in order to define them solely by their practices, the MSM acronym can actually prevent health professionals from reaching communities at risk for HIV. The lived experiences of people self-identifying as gay are not the only ones that fail to be captured by the use of the MSM category. In the same vein, others (Namaste et al., 2007) have pointed out that though 'MSM' aims to include all kinds of men – independent of their sexual orientation or identity – it does so by effectively erasing the specificities of bisexual lives. By only focusing on sex bisexual men have with men, the MSM category does not account for the complexity of HIV transmission and prevention for bisexual men.

The trouble with 'MSM' does not only lie in the way this category excludes certain men, certain communities, and certain identities. It also lies in the way it includes, by force, certain populations by defining them as 'men who have sex with men'. According to Khan and Khan (2006), it may be inappropriate to talk about 'men who have sex with men' in some non-Euro-Atlantic contexts. In fact, many organizations prefer the phrase 'males who have sex with males' to account for a myriad of male identities – 'man' only being one of them. By taking a look outside of the Euro-Atlantic context from which the MSM category emerged, it is possible to see how the word 'men' is far from being a neutral term. Khan and Khan (2006) note that, though the phrase 'males who have sex with males' may seem less problematic, it still cannot account for people who do not fit within the male/female binary and their sexual partners.

These critiques reveal that the apparent explicitness of the MSM category relies on three main erroneous assumptions: (1) the assumption that 'men' is not an identity; (2) that we know the bodies we are talking about – i.e., that the bodies of 'men', the 'male body' is something homogeneous, stable, and easily identifiable; and (3) that we know the sexual practices in which these bodies are engaged – i.e., that the phrase 'men who have sex with men' is enough to describe a sexual behaviour.

Young and Meyer (2005) addressed and criticized the idea according to which 'men who have sex with men' could, in and of itself, appropriately describe sexual behaviour. As Cindy Patton (2002) notes, 'MSM' often supposes anal intercourse between men, even though those men may not engage in anal intercourse, especially in non-Euro-Atlantic contexts (Moody, 1988). By producing a largely implicit association between male-male sexuality and anal intercourse, the MSM category acts as a way to produce and naturalize homosexuality. Khan and Khan (2006) pointed out that the term 'men' – as well as 'male' – is far from being free of any notion of identity. In this paper, we draw on these critiques to analyse further the question of the body assumed by the MSM category. We argue that, by assuming a body without naming it, the use of the MSM category has stymied progress in

slowing the HIV epidemic in some of the most at-risk groups, including those who do not fit neatly into binary notions of gender and sex.

Numerous works from anthropologists and feminist scholars have shown the variability of gender roles and norms throughout ages and cultures. Following the research of American sexologists John Money and Robert Stoller on intersex and transsexual individuals, Oakley (1972) introduced the distinction between sex and gender into Feminist Studies. Separating biological characteristics from identities, roles, or notions of femininity and masculinity allowed feminists to reveal the absence of causality between biology and social norms regarding sex. However, as early as the 1980s some feminists critiqued the way the distinction between sex and gender tended to reinforce the idea that gender was a social construct that submits to variation while sex was 'natural' and 'stable' (Dorlin, 2008). As the historicity of sex was being examined (Laqueur, 1990), scientific discourses on sex underwent the scrutiny of historians, philosophers, and social scientists. Feminist studies of science played an important role in demonstrating how the categories of sex constituted an arena of debate and struggle within biomedical sciences (Fausto-Sterling, 2000; Oodshourn, 2001). Since the 17th century, Euro-Atlantic conceptualizations of sex have adopted a binary model. However, throughout history, successive definitions of sex – humeral, gonadic, hormonal, genetic – failed to prove the existence of two, and only two, perfectly distinct sexes. Epistemological changes in the definition of sex aimed to stabilize this binary model even though it cannot account for multiple forms of intersex, as well as for transgender bodies. Far from being an effective and universal concept, the binary of sex constitutes, for biomedical sciences themselves, an 'epistemological obstacle' (Dorlin, 2008).

More recently, critiques on the social construction of gender and sexuality have been effectively integrated into works on or with the MSM category, like the work of Young and Meyer (2005). However, critiques on the social construction of sex categorization has yet to be really taken into account, even though it may help us understand some of the limits and problems related to the use of the MSM category. For example, if the sex binary itself regularly faces definitional crises, it is only logical that the MSM category would face similar issues regarding its own definition. In fact, we would like to argue that MSM's instability and inaccuracy is largely inherited from the sex categories upon which it is built. If the ability to know what 'male' is constitutes a challenge for modern science, it is no wonder that the ability to know whom 'men who have sex with men' are appears equally challenging.

This difficulty to define accurately what a 'man' is appears clearly in the way trans feminine individuals[†] have been included – or not – within the MSM category. Though excluded from the category at first, trans feminine people have been included because of what Boellstorff calls a 'biologized understanding of maleness' (2011, p. 296). Activists and scholars argued that 'MSM' didn't accurately describe trans feminine individuals for, though they were 'genetically male' (Kammerer et al, 2001), they did not live as men but as women (Hawkes,

[†]Here we use the term 'trans feminine individual' to refer to people whose gender identity, expression, or behavior is different from those typically associated with their binary sex of male assigned at birth. By using 'trans feminine individual' rather than 'trans woman' or 'transgender woman,' we aim to broaden the meaning of trans experiences and not restrict our usage to any specific form of gender embodiment or identification.

2008). Including them within the MSM category not only negates their identity but also obscures specific issues, especially regarding the role of gender-based violence in HIV risk.

But the problem with defining trans feminine people as ‘men’ or ‘males’ does not only concern the social dimensions of HIV transmission and prevention. It is also about the very physicality and biology of HIV transmission and prevention. To include trans feminine individuals in the MSM category, one does not simply have to adopt a ‘biologized understanding of maleness’, as Boellstorff puts it. Whether we adopt a hormonal, genetic, or gonadic definition of sex – or a combination of these three criterion as it is often the case when it comes to assigning a sex to individuals who do not fit clearly in the sex binary – trans feminine people may, or may not, be considered male. In its 2006 Global Report, UNAIDS (2006, p. 110) defines ‘men who have sex with men’ as people engaging in male-male sex, including trans feminine individuals or, as they put it, ‘transgendered males’. However, what is the definition of ‘male’ adopted here? Could a trans feminine person still be considered ‘biologically male’ while being on hormone replacement therapy? Could a trans feminine person still be considered ‘biologically male’ after an orchiectomy (the surgical ablation of testicles) or a vaginoplasty (the surgical construction of a vulva)? When does one begin or cease to be ‘biologically male’? How does the erasure of surgically modified trans bodies prevent us from having access to accurate evaluation of HIV transmission post genital surgery?

These questions have particularly important implications when it comes to evaluating HIV transmission risk, developing HIV prevention programs, and implementing appropriate prevention tools. By subsuming vastly different bodies under the MSM category, we risk erasing important sexual practices and routes of HIV transmission. For example, by conflating MSM and trans feminine people, it becomes difficult to consider penile-vaginal penetration, thus erasing experiences of some post-operative trans feminine individuals. Similarly, how can we account for penile-vaginal penetration between trans masculine people and nontransgender men within gay settings while acknowledging the fact that the MSM category implies, not only anal intercourse as Patton and other scholars have stated, but also a specific form of bodies labelled as male?

As specificities of the HIV epidemics within trans communities have become more and more apparent, a shift has appeared in the conflation of MSM and trans feminine people. Examining the more recent UNAIDS Global Reports offers interesting insight on this evolution. While the 2006 Global Report included trans feminine individuals in the MSM category, as they were considered ‘biologically male,’ the 2010 Global Report used the phrase ‘men who have sex with men and transgender people’ (UNAIDS, 2010). Another shift appears in the 2013 Global Report as transgender women and MSM constitute two distinct categories. As a result, this report extensively addresses challenges faced by transgender women and emphasizes that gender inequalities and gender-based violence play an important role in the increased vulnerability of this population regarding HIV transmission. The ‘Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations’ further differentiate risk categories that honour differences in the specification of ‘transgender women or transgender men who have receptive anal sex with men’ (World Health Organization, 2014).

Even though these changes mark an extremely important shift in light of the disproportionate risk of HIV/AIDS among trans feminine people across the globe (Baral et al, 2013), it is essential to remember previous critiques on the use of categories in epidemiological research. Just as ‘gay,’ ‘man,’ and ‘male’ have raised definitional challenges and epistemological questions, ‘trans woman’ is a specific identity category, situated contextually and culturally in a particular place and time. The term ‘trans woman’ may refer to very different experiences, identities, or forms of embodiment and excludes trans feminine individuals who do not identify as women and/or do not embrace a binary definition of gender. While some people completely identify with the term, others may reject it altogether or use it strategically in order to make sense of their situation. In some non-Euro-Atlantic contexts, as well as some cultures within Euro-Atlantic environments, the category ‘trans woman’ may not make sense at all. Furthermore, attention should be given to the effects of using a category like ‘trans woman’ for the populations we want to reach. Do we – HIV researchers and scholars – effectively reach all parts of the trans community when using such a specific identity term? When we recruit ‘trans women’ as the target population, do we effectively reach trans populations most at risk for HIV, notably migrant trans feminine people engaged in sex work (Giami, 2011) who may not identify as ‘trans’ or as ‘trans women’? What realities, narratives, bodies, sexualities, and practices are implied and prioritized by this category? Which ones are excluded or erased? How can we properly address the HIV epidemics among trans women and other trans people assigned male at birth without erasing the experiences of trans men and other trans people assigned female at birth? Answers to these interrogations are unclear and deserve further investigation. Though the use of categories is often challenging and can suffer severe limitations, keeping those interrogations in mind may keep us from erasing the broad diversity of bodies, identities, practices, and sexualities within trans communities and thus enable us to reach people in need of appropriate information, materials, and services.

Throughout the world, the risk of HIV infection among trans feminine individuals is 49 times higher than that of members of the general population (Baral et al., 2013). This staggering figure requires action. However, how is it possible to prioritize and address the health needs of a population with appropriate specificity while at the same time seeking to maximize inclusion and avoid perpetuation of the sex and gender binary? Further, how can health professionals describe and measure risk without reducing individuals to their physical bodies through language and summary? Although we do not yet have answers to these difficult questions, we draw on examples from the field to illustrate these complexities through the lived experiences of individuals whose identities may not fit into the male/female binary or non-Euro-Atlantic constructs of HIV prevention categories.

Examples from the field

Trans feminine individuals in the Middle East and North Africa: Beirut, Lebanon

To illustrate the complex history of HIV prevention categories that we have outlined and discussed above, we provide examples from the field that highlight some of the challenges associated with existing constructs of definition, recruitment, and description. Challenges in our decisions about expressing HIV risk categories extend beyond a Euro-Atlantic context

and the English language. Until recently, HIV research among populations in the Middle East and North Africa (MENA) has often conflated trans feminine individuals and MSM (Mumtaz et al., 2010). In 2011, formative data were collected among a sample of ten trans feminine people in Beirut, Lebanon to understand their lived experiences and risk behaviour (Kaplan et al., 2015). Recruitment took place through referrals from an LGBT organization and from study participants. Interviews were then conducted by a social worker who was providing social support services to trans individuals. Unlike other contexts, such as India in which local terms approximate – to some degree – the North American usage of 'transgender' (Phillips et al., 2013), there is no equivalent term in Arabic that is used in Lebanon. Individuals use the term 'trans' due to a lack of local indigenous terminology; this gap has been identified as a need to be addressed within the trans community in Lebanon (El Khoury, 2014). In the above-described formative study, participants were recruited based on their understanding of the research team's use of the term 'transgender woman.' The participants used a range of words to express their identities including female, girl, woman, ladyboy, gay, transgender, and shemale transgender (Kaplan et al., 2015). The research team believed that the participants understood the usage of 'transgender woman,' but recruitment strategies, without the availability of a local term, had to rely on individuals' usage of terminology outside their first language. Further, although all participants indicated the preference for female pronouns to the interviewer (in Arabic the pronoun 'you' is gendered, therefore when speaking to or being spoken to directly, decisions about whether to use '*inteh*' for 'you' [feminine] or '*intah*' for 'you' [masculine], must be made), we cannot be certain that each individual necessarily agreed with or would identify herself with an identity of an individual who is assigned male at birth and has a female gender identity. In other words, participants were not asked if they agreed with the usage of the term 'transgender woman'; instead an open-ended question was used to allow participants to describe their gender identity without preconceived categories or identity labels. Thus as researchers, we impose our own definitions of the term 'trans' to recruit, define, and describe our target populations so that our audiences understand what we mean. However, is understanding actually taking place? What impact does this imposition have on individuals and communities with whom we work? How do these choices shape the way we attempt to approach important research questions?

The way in which the participants in the above-described study (Kaplan et al., 2015) defined their gender identity and comfort with it further elucidates the complexity of using terminology across different contexts and the problems with existing HIV risk categories. Participants were asked, 'How would you describe your gender identity? How comfortable are you with your gender identity?' and responded with a range of descriptions that speak to the diversity of gender experiences and expressions within and across times and places, as well as some of the motivational factors that are situated contextually. For example, some participants in the sample expressed frustration with existing labels and identity categories. One explained, 'I am a girl – a female. I don't like to identify as transsexual or transgender. I am not comfortable [with my gender identity] because I have a male sexual organ. I would prefer if I didn't have it. I would feel more comfortable with myself when I will do the sex change operation.'

Another participant expressed being ‘very comfortable’ with her gender identity and identified as ‘transgender,’ but said, ‘I don't like the definitions of transgender or gay or any of all this to define myself.’ Yet another participant seemed to view her identity as an unavoidable part of her: ‘Being transgender is something I feel deep inside me and I can't deny it. It is a reality I live in every day. I face a lot of problems because of it, but I try my best to overcome those problems.’ As mentioned, although participants all indicated the preference for the use of female pronouns, not all individuals wished to be perceived as women in all aspects of life.

The role of the family in overall health and well-being of trans feminine people was found to be integral in Lebanon (Kaplan et al., 2015). The importance of family support informed some participants’ decisions about gender expression, which impacted gender identity. Fluidly identifying as ‘ladyboy’ or ‘sometimes gay,’ one participant explained: ‘I would like to look very feminine and have a whole body hair removal, but I don't want to have breasts or have any operation to change sex. If I want to go to [see] my parents, I can't be dressed as a full woman. If my parents and family were not there, I would have nothing to lose.’ This participant cites her need to see her parents as motivation for not dressing ‘as a full woman.’ Implied in the participant's response is that while she might want to dress ‘as a full woman’ when she sees her parents, she chooses to compromise that desire for another: familial support. Her comments about not wanting to ‘have breasts’ or ‘any operation to change sex’ suggest the need for further inquiry to understand better the motivations and desires of this population regarding accessing medical transition providers and procedures. These motivations and desires – and what is both at stake and necessary for independence – must be interpreted within an individual's and community's context.

Within the non-Euro-Atlantic context of Lebanon as well as other collectivist cultures, dependence on and priority for positive familial relationships may impact an individual's desire and motivation to ‘transition’ either medically or socially or both. Again, even the term ‘transition’ and what is understood, imposed, and implied by the term may not translate well across different contexts. These factors likely inform an individual's HIV risk in addition to vulnerability to other adverse health outcomes. For example, without the support and acceptance from the family of origin, a trans feminine individual might be unstably housed due to a lack of infrastructure in the form of formal support within a context that relies on the informal support of family. Threats of violence impact safety, which can in turn impact mental and physical health (Kaplan et al., 2015). Cultures across the MENA region have been described as adhering to often rigidly defined binary gender roles; Beirut is an example of ‘hyperfemininity’ and ‘hypermasculinity’ (El Feki, 2013; Saleh & Qubaia, 2015). Within these contexts, the experiences of the participants raise questions about the intersections of culture and gender expectations. Do trans feminine people in Lebanon and other parts of the MENA region embrace the female/male gender binary? How do they see themselves fitting or not fitting in existing paradigms of sex and gender? Do Middle Eastern trans feminine individuals view the gender binary as an imposition, which results in their resistance?

Trans feminine individuals in the United States: San Francisco, California

San Francisco has long had a strong reputation for its liberal approach to self-expression and its political support of communities that have been historically marginalized, especially sexual and gender minorities. Recently, the context of living in San Francisco has changed due to the rising cost of living, an influx of high-profile tech companies, and decreasing diversity in its residents (Nevius, 2015).

However, San Francisco is currently leading the charge to increase access to transition-related health care for trans people, through innovative programs at the Department of Public Health (www.sfdph.org/dph/comupg/oprograms/THS/default2.asp) and at UCSF's Center of Excellence for Transgender Health (www.transhealth.ucsf.edu). While many trans people choose not to undergo surgery, some people who would historically not have had access to expensive transition-related surgeries that require specialists are now gaining access and realizing their life-long dreams through programs such as these. With increased access to transition-related health care, trans feminine people can pursue hormones (and sometimes puberty blockers) from a young age, enabling some to avoid gender dysphoric experiences of puberty and young adulthood, and achieve a gender expression aligned with their identity without necessarily needing to have access to tremendous financial resources. In light of this shifting landscape of access to care for trans feminine individuals, options for various forms of gender expression and embodiment become possible. Not all trans people desire surgeries, and among those who do, many do not desire complete reconstruction of the appearance and function of the genitalia. Having choices about how one embodies and expresses gender identity allows for a myriad of possibilities that lie, both biologically and socially, outside of the gender binary. When we approach sexual health research using a binary lens that erases trans feminine individual's bodies and the sociocultural context of their experiences, it is no wonder that the data, the programs, and the outcomes so obviously miss the mark. In a qualitative study of the role of gender affirmation in sexual risk behaviour, 22 trans feminine people of colour described the unique cultural context of their experiences at the intersection of race and gender (Sevelius, 2013). Many participants discussed the safety that ‘passing’ as a non-trans woman affords, and while most did not feel that fully passing was accessible to them, it also was not a guarantee of protection: ‘Even if you have the operation, you're still going to always be classified as male, no matter what...That's the problem I have [even though I pass]. Once you get a sex change, you're still living a lie. And hopefully you don't get killed. A guy who finds out might forgive you, or he might just leave you. Or he might just set you up and have you killed (African American, 35).’

So while some trans feminine people aspire to achieve a binary-based gender expression and embodiment, whether for safety or as an authentic expression of their identity, the societal lens imposed upon them continues to negate their experience and contributes to their sense of vulnerability. Those who felt they did not pass described the pain of facing stigma and rejection on an almost daily basis, and when they did receive some social affirmation of their gender it was often grounded in sexual objectification from men. The objectification experiences were described as affirming in the sense that they felt validated through these experiences, but validation came with the price of feeling that they were not being valued as

unique human beings with something beyond sex to offer the world. How can trans feminine individuals be true to themselves through expression and embodiment that is aligned with their authentic gender identity, when that very identity is largely not acknowledged as valuable or even possible? When their very existence is mostly erased or derided outside of sexual contexts, how is mental and sexual health possible for trans feminine people, especially trans feminine individuals of colour? ‘You walk down the street after you done turned the trick and you feel like you're the grand diva ‘cause somebody stopped ‘cause you're pretty. But see what I realize is that it's not the beauty on the inside that they see. All they see you for is a piece of ass...All they think that transgenders are good for is sex and drugs (African American, 23).’

The sociocultural framework of trans feminine individual's lives cannot be completely understood using a binary lens of inquiry. The nuances of embodiment and expression, as well as intersections of gender with race, class, and other situating life contexts such as access to transition-related health care are readily erased when trans feminine people are defined by their birth sex, their genitalia, or their sexual practices. The conflation of trans feminine individuals with MSM has stymied progress in halting the epidemic and has categorically contributed to the disparities experienced by trans feminine people by erasing, marginalizing, and misunderstanding the sociocultural context of their risk.

Conclusion

In this paper we have reviewed the troubled history of the MSM category and the problematic conflation of trans feminine individuals and MSM in much of the existing HIV literature. We have drawn examples from two settings in the field, Beirut and San Francisco, to illustrate how this practice has stymied progress in slowing the HIV epidemic in some of the most at-risk groups, including those who do not fit neatly into binary and Euro-Atlantic notions of gender and sex. Taking into account the sociocultural contexts of the individuals who are among the most at risk for HIV infection and other negative health sequelae will improve our abilities to recruit, measure, and report more effectively, accurately, and respectfully.

Here we have raised questions more than we have provided answers. We have established some of the problematic challenges with current approaches within cultural contexts in which we have expertise, but the best way forward remains murky. How might we proceed and strive to achieve both specificity and contextual relevance? Should we opt for referring to genitalia when describing risk categories and thereby prioritize bodies over cultures and contexts? Important shifts are taking place. What we used to consider highly specific risk categories are being challenged and/or becoming obsolete. The term ‘*unprotected* receptive anal intercourse’ has recently been swapped out by some in favour of ‘*condomless* receptive anal intercourse’ in light of strides in viral suppression and the protection that it affords. However, embedded in these terms are assumptions that still persist. The term ‘receptive anal intercourse’ tells us nothing about the penis – or other object – that is being inserted. Thus, even if we were to refer to types of sex that introduce higher risk profiles with purportedly more specificity, such as ‘penile-anal sex,’ this terminology still erases individuals’ experiences and sociocultural contexts including gender-based violence among

trans women and what are likely to be different risk profiles among trans men who have had genital surgery.

Although we have struggled to construct the way forward and instead have deconstructed existing hegemony, we include the following concrete recommendations for health professionals, researchers, and scholars.

1. Do not conflate trans women with MSM. For studies that include trans, non-trans, and gender nonconforming participants, analyse data gathered from these groups separately and in meaningful ways.
2. When reporting sample demographics, include gender categories beyond the gender and sex binary.
3. When collecting data, use the two-step question for assessing gender categories (Tate, Ledbetter, & Youssef, 2013) to ensure that trans people are counted.

As researchers, we must make decisions about participation criteria that both includes and excludes people. However, when doing so, it is important to consider whether our terminology actually captures and reflects our intended meaning and that it encompasses our intended target population. With such staggering HIV risk and rates among trans feminine individuals, these decisions cannot be made lightly. We must ask ourselves whether we are perpetuating binaries through these decisions. Are we making assumptions about what it means to ‘transition,’ to ‘pass,’ and to use certain pronouns? Are we imposing Euro-Atlantic constructs of what it means to be trans on contexts that may or may not function in similar ways? Promising advances have been made in terms of both terminology and health care access; it is important to continue to query existing constructs and categories of HIV risk.

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