mental health comorbidities such as depression, anxiety, and PTSD [352]; and social determinants that may present barriers to care [7]. Sexual and gender identity and sexual behaviors should be discussed in a nonjudgmental manner in order to understand sexual risk and diminish stigma [364]. Multidisciplinary teams that simultaneously address biological and psychosocial issues are critical in optimizing outcomes, including early initiation of therapy and adherence support to maximize immune recovery and health and minimize transmission risk [365, 366]. ART should be prescribed according to established adult and adolescent treatment guidelines [7] (see also Section 1: Optimizing Care).

The transition of adolescents from pediatric to adult care usually occurs between the ages of 18 and 25 years and is impacted by variable factors, from patient preference to availability of providers and system/clinic rules. Youths are at high risk of falling out of care and experiencing poor clinical outcomes during this transition period [367, 368]. The transition of care from pediatric or adolescent providers to adult providers should be a deliberate, comprehensive, and coordinated multidisciplinary youth-friendly process that involves the healthcare team and the patient [369–371]. Care must be given to synergistically attend to the diverse needs of the adolescent that extend beyond medical care, including employment, independent living, and intimate relationships. Over time, youths must learn to negotiate the healthcare system and assume increasing responsibility for their healthcare. There are several resources on best practices for transitioning youths with HIV to adult care [7, 372–375].

SECTION 11: CONSIDERATIONS FOR TRANSGENDER AND GENDER-DIVERSE ADULTS

Recommendations

- Transgender and gender-diverse persons with HIV should have access to care that is gender-affirming, nondiscriminatory, nonstigmatizing, and culturally sensitive.
- Intake forms, medical records, and other documentation should include gender identity options in addition to sex assigned at birth, chosen name and pronouns, and legal name.
- Transgender persons should be offered medically necessary gender-affirming interventions in accordance with national guidelines.
- HIV care providers should be familiar with gender-affirming hormone treatment and necessary clinical and laboratory monitoring or provide referral to a clinician or endocrinologist experienced in transgender care.

Evidence Summary

Transgender people identify with a gender that differs from their sex assigned at birth. Recent data estimate that approximately 1.3 million adults in the United States identify as transgender or gender diverse [376]. It is important to use the appropriate terminology when talking with and about transgender persons. Many terms are used and often are confused with each other or used incorrectly (Table 8). Gender dysphoria refers to the discomfort that some transgender people may experience due to the discrepancy between their gender identity and sex assigned at birth. Some individuals opt for medical interventions, such as the use of gender-affirming hormones and surgeries, to align their physical characteristics with their gender identity.

Stigma and discrimination are serious issues that threaten the quality of care for transgender and gender-diverse persons, regardless of HIV status. Nearly half of transgender persons face family rejection, 40% report a history of attempted suicide, 29% live in poverty, 30% have experienced homelessness, 33% have experienced discrimination within the healthcare system, and 23% avoid the healthcare system due to fear of discrimination [377]. Global estimates show a pooled HIV prevalence of 19.9% (95% CI, 14.7%–25.1%) among transgender women, with 66-fold higher odds of HIV prevalence than the general population [378]. Data among transgender men are limited, but estimated HIV prevalence is 2.56% (95% CI, .0%–5.9%) [378]. Given the disproportionate impact of HIV on transgender individuals and the psychosocial barriers they face, health systems and healthcare providers should strive to create more

Table 8. Terminology Associated With Gender Identity and Hormonal Therapy

Gender identity: An individual's sense of being male, female, nonbinary, agender, etc.
Transgender, trans, nonbinary, gender diverse: Adjectives used to refer to persons whose gender identity does not align with their sex recorded at birth (the latter primarily based on visible physical anatomy)
Nonbinary: An adjective used to refer to persons whose gender identity is outside the gender binary, that is, do not identify exclusively as a man or a woman; some nonbinary persons may not identify with any gender (agender)
Cisgender: An adjective used to refer to people whose gender identity corresponds to the sex they were assigned at birth
Gender expression: How a person communicates their gender through appearance, dress, name, pronouns, mannerisms, and speech
Gender-affirming hormone treatment and surgeries: Broad categories of medical interventions that transgender persons might consider to align their appearance and their gender identity
Gender affirmation: An overall process of alignment of physical characteristics and/or gender expression with gender identity
Gender dysphoria: Discomfort felt by some persons due to lack of alignment between gender identity and the sex recorded at birth; not all transgender persons have dysphoria, but many US insurance companies require this diagnosis for payment for gender-affirming medical and surgical interventions
Feminizing hormone therapy: The use of estrogens and often androgen blockers with the objective of inducing changes in physical characteristics to better match patient gender identity
Masculinizing hormone therapy: The use of testosterone with the objective of inducing changes in physical characteristics to better match patient gender identity
Sex assigned at birth: Refers to a person's status as male, female, or intersex based on physical characteristics at birth