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Sexual HIV risk among gay, bisexual, and queer transgender men: Findings from interviews in Vancouver, Canada

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Abstract

Gay, bisexual, queer and other men who have sex with men are disproportionately affected by HIV in Canada. While up to two-thirds of transgender men identify as gay, bisexual or queer and report a variety of HIV sexual risk behaviours, transgender men are often overlooked within epidemiological HIV surveillance and research. While a growing body of research has begun to examine sexual risk for transgender gay, bisexual and queer men, most studies have been conducted in the USA. This study explored sexual HIV risk for this population in the Canadian context, specifically in British Columbia in an environment of publically funded universal access to healthcare including HIV testing and treatment. We conducted interviews with 11 gay, bisexual and queer transgender men. Participant narratives suggest that HIV risk for these transgender men is shaped by a diversity of sexual behaviours including inconsistent condom use, seeking partners online for greater safety, and accessing HIV/STI testing and other healthcare services despite facing transition-related barriers. Public health prevention and health education must recognise the presence of transgender men and ensure health services and broader population health promotion meet the unique sexual health needs of this sub-population of gay, bisexual and queer men.

Keywords

Transgender; trans men; gay men; HIV; sexual risk; Canada

Introduction

Initially created to combat stigma associated with homosexuality and HIV and AIDS (Young and Meyer 2005), and illuminate the incongruence of behaviour and sexual identity (Bauer

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and Jairam 2008), the epidemiological concept men who have sex with men includes a broad yet diverse population in HIV/AIDS discourse. Despite this seemingly inclusive term, transgender (trans) men (i.e. people whose gender identity does not conform with sex assigned at birth) are often excluded from epidemiological surveillance and research due to small sample size, eligibility criteria, or limited research design (Bauer 2012). Additionally, these factors, and the misconception that trans men are predominantly heterosexual or otherwise not at risk for HIV, have contributed to the historical absence of trans men in the HIV literature and policy response.

Of the limited available literature on HIV among trans men HIV prevalence appears low, with some studies finding no infections and others up to 10.0% by self-report in a recent review of HIV/STI risk among trans men globally (Reisner and Murchison 2016). Laboratory confirmed HIV serostatus ranged from 0%–4.3% in the same 2016 review (Reisner and Murchison 2016). HIV prevalence among the subgroup of trans men who have sex with men ranges from 1.2% to 2.2% by self-report in US based studies (Feldman, Romine, and Bockting 2014; Scheim et al. 2016; Sevelius 2009). Up to two-thirds of trans men identify as gay, bisexual or queer in Canada and US studies (Clements-Nolle et al. 2001; Iantaffi and Bockting 2011; Bauer et al. 2013), and gay, bisexual or queer trans men report non-transgender male sex partners across a number of studies (Chen et al. 2011; Bauer et al. 2013; Sevelius 2009; Reisner, Perkovich, and Mimiaga 2010; Clements-Nolle et al. 2001). Gay, bisexual and queer trans men report a variety of sexual risk behaviours including receptive anal and genital sex, inconsistent condom use (Chen et al. 2011; Clements-Nolle et al. 2001; Rowniak et al. 2011), anonymous partners (Reisner et al. 2014), and sex work (Sevelius 2009; Bauer et al. 2013). This subset of trans men are included within the behavioural population of men who have sex with men, a population that is disproportionately affected by HIV/STIs in Canada. Specifically in British Columbia, Men who have sex with men comprise both the greatest proportion of prevalent HIV infections, 54% in 2011, and a majority of all new HIV diagnoses, 57.5% in 2014 (BC Centre for Disease Control 2015).

While a growing body of research has begun to examine sexual risk for gay, bisexual and queer trans men, most studies have been conducted in the U.S. (Herbst et al. 2008), where healthcare systems, and sexual and gender minority related public policy are substantially different from Canada. As such, evidence of the experiences of U.S. based gay, bisexual and queer trans men may not be representative of the same population in Canada. This study sought to explore sexual HIV risk and risk factors for gay, bisexual and queer trans men in the Canadian context. We used qualitative data collected from trans men in a larger cohort study of gay, bisexual and queer men in British Columbia to achieve this goal. Data were collected in British Columbia, in an environment of publicly funded universal access to healthcare including HIV testing and treatment.

Methods

We conducted a qualitative study (n=11) of trans men recruited from a larger longitudinal cohort study, the Momentum Health Study. In-depth qualitative interviews explored HIV

sexual risk and risk factors for gay, bisexual and queer trans men. The Momentum cohort provided descriptive demographic statistics for interview participants.

Participants and procedures

Cohort participants were recruited via respondent driven sampling between February 2012 and February 2014 (Forrest et al. 2014), and enrolled in the Momentum Health Study after providing written informed consent. Initial participants or ‘seeds’ were recruited in-person via gay men’s health and social organisations as well as online via mobile sexual hook-up websites and apps and social media. Eligible participants were 16 years of age or older, identified as a man, able to complete a self-administered questionnaire in English, lived in the Metro Vancouver area, and reported having sex with a man in the 6 months prior to baseline. Ethical approval for this study was obtained from the University of British Columbia, Simon Fraser University and the University of Victoria.

Sex and gender were recorded in the behavioural survey using a two-part multiple choice question: 1) ‘What was your sex at birth?’ responses included ‘Male’, ‘Female’, ‘Intersex’, and ‘Prefer not to answer’, and 2) ‘How would you currently identify your gender?’ response options included ‘Male’, ‘Female’, ‘Trans-man (F to M)’, ‘Trans-woman (M to F)’ and ‘Intersex’. All participants who reported female sex assigned at birth identified their current gender identity as a ‘Trans-man (F to M)’. We included descriptive statistics and qualitative data from the 11 of the 14 transgender cohort participants who agreed to be interviewed.

We conducted a community-engaged qualitative study informed by HIV risk related major aims of the larger Momentum Health Study, exploring HIV sexual risk among the small sample of gay, bisexual and queer trans men in the cohort. To this end, we recruited a local community representative to advise this study as a member of the larger study Community Advisory Board and hired and trained a peer interviewer to conduct interviews and assist with data analysis. Based on a review of the literature on the sexual health of gay, bisexual and queer trans men, an interview guide was developed consisting of broad domains related to the HIV sexual risk and risk factors. Results presented here relate predominantly to the sex and dating and HIV/STI testing and healthcare domains. Interview questions included for example, “How do you usually meet guys for sex or dating?” and “Can you talk about a time you were worried about HIV?”. Interview questions on participant’s sexual experiences distinguished between trans and non-transgender partners.

Between November and December 2014, semi-structured in-depth interviews (S. L. Schensul, Schensul, and LeCompte 1999) were conducted with the 11 of the 14 trans participants in the cohort study who consented to the qualitative study. Interviews were facilitated through use of an interview guide, took place in a private closed-door office one-on-one with a trained interviewer and lasted between 45 and 97 minutes, with an average completion time of 62 minutes. Interviews were audio recorded and transcribed verbatim. Each participant received either \$50 in cash or prize draw tickets worth an equivalent amount for their participation at each phase of the study, survey and qualitative interview.

Data analysis

Demographics—Descriptive statistics were used to describe the demographic characteristics of the 11 interview participants.

Interviews—Data were analysed using thematic content analysis (Green and Thorogood 2009), employing the interview guide as a framework to identify *a priori* themes significant to the project's primary research focus. Constant comparative method (Glaser 1965) was used to identify dominant and recurring sub-themes as they emerged. The interview team began discussion of interview data while interviews were being conducted to inform minor shifts in interview guide wording reflecting participants' language about their bodies and experiences. Interview transcripts were manually catalogued in the qualitative analysis software NVIVO (QSR International Pty Ltd. 2014) and systematically reviewed to identify emergent themes. Individual accounts were grouped into discrete categories describing common themes of experience and organised into a thematic map. Research team members AJR and KS compared themes and coding hierarchies to resolve inconsistencies and support validity. During data analysis memos recorded observations and interpretations of common concepts and overarching themes. These were then organised to create broad themes directly related to the central research question of this study: namely, what are Vancouver gay, bisexual and queer trans men's experiences of HIV risk?, specifically sexual behaviour and dating, and HIV/STIs and healthcare access.

Findings

Demographics

Of 719 total participants in the cohort study, one participant reported being assigned intersex at birth and another identified as a trans woman; both were excluded from this analysis. Of the remaining 717 eligible participants, 14 (1.7%) trans men were identified via the two-step sex and gender questions. Table 1 presents demographic characteristics for the 11 of these 14 gay, bisexual and queer trans men that agreed to participate in interviews. All participants self-reported HIV-negative serostatus, consistent with baseline biological point-of-care HIV testing. They had a median age of 26 (IQR:25–28), 64% identified as queer while 36% identified as gay, most lived in Vancouver outside of downtown (73%), identified as White (91%), had attained education beyond high school (91%), and earned less than \$30,000 CAD in annual income (73%).

Sexual behaviour & dating

Sexual behaviours and risk reduction strategies—Participants described engaging in a diversity of sexual behaviours, including inconsistent condom use and receptive and insertive anal and genital sex, with both trans and non-transgender men partners. Participants described regular partners, as well as sex with casual and anonymous partners, some of unknown or discordant HIV serostatus. As one participant commented,

One of my regular partners is HIV-positive but we are both really open with each other and we take precautions and like I said, I don't really bottom. (Participant 1)

Participants described personal sexual risk reduction strategies calculating risk based on types of sexual behaviours engaged in, serostatus of partners, relationship to partners, risk negotiation conversations and condom use. Risk assessment based on the gender identity of participants' partners also impacted sexual decision making, meaning less frequent barrier use during genital and oral sex for some who had trans partners. Most participants used condoms as their main risk reduction tool; elaborating on a variety of condom use strategies, some using condoms for all penetrative sexual activities with any partners, some only for anal or genital sex, others only with non-primary partners. Trust and open communication was an important factor in negotiation of condomless or barrier-less sex. As one participant commented,

Usually my normal procedure for guys that I don't know, it's always like condom sex. I do have a couple of partners that I play bare with, so I've got a rapport with them and I trust that they're telling me the truth when they're getting tested and so forth. (Participant 4)

Participants were highly concerned about their sexual risk not only in terms of HIV, but also other STIs, bacterial vaginosis, and in some cases unplanned pregnancy. As one participant explained,

Pregnancy, any sort of STI or potential HIV transmission, you know? I just don't want any fluid [exchanged during sex]. (Participant 5)

Gay, bisexual and queer trans men in this study described extensive safer sex plans for the range of sexual behaviours they engaged in with a variety of partners. A high level of caution characterised participant sexual decision-making. Participants articulated a sophisticated understanding of HIV/STI sexual risk and associated prevention strategies both generally as well as specifically within accounts of their sexual encounters with partners.

I have not been super into oral sex unless we've been together for quite a while, and I know about their – we both know about each other's like testing and STIs and things like that. For cis [cisgender, i.e. people whose gender identity is consistent with sex assigned at birth] guys, that means condoms. I guess for sex tools or toys that means condoms as well. And I think I'm pretty careful about making sure I have like a pretty strong foundation in a relationship with people before I move beyond any of that and I trust that they're getting tested regularly and telling me about their other interactions. (Participant 9)

Seeking sexual partners online—While most respondents had experiences meeting sexual partners through a variety of venues including physical venues such as bars and clubs, socially through friends, and at bathhouses, participants overwhelmingly described seeking male sexual partners online. Respondents were motivated by the ability to control disclosure of trans status and ease experiences of rejection and misperception by a potential sexual partner.

I remember meeting this one guy at a friend's party and we were flirting the whole time. He was like, 'oh we should totally go for a beer' and so we connected and then I told him I was trans and he was like, 'oh I'm not looking for anything'. So,

the couple of times that I have, I have got rejection so I don't usually put myself out there anymore... Yeah, so I just, yeah I don't usually; at this point, it's like, if somebody is interested then they have to, like I usually put myself right away now which I think is kind of shitty that I have to do. Just doing the online stuff is safe. If somebody doesn't want to contact me, they just don't contact me. I don't have to deal with it. (Participant 5)

Seeking sex partners online also meant greater control in the negotiation of safer sex.

And what I really like about them [online dating websites and apps] is one of their primary questions that shows up on every body's profile is are you into safer sex or not? So, they have that right off the bat that I can choose whether to engage in people who aren't into safer sex or I can find people who are into safer sex. (Participant 9)

Connecting with sexual partners via the Internet also brought up concerns for physical and sexual safety that were carefully navigated. As the same participant elaborated,

Like, having someone know where I'm at when I go meet up with someone for the first time. Making sure that I meet them in public before we go to either of our houses or somewhere else, and stuff like that can be pretty important. Or hooking up in like a sex-positive space where there are other people around that can make sure that if either of us aren't into it, that it's ended. (Participant 9)

Experiences of alcohol and drug use—Most participants reported drinking alcohol and some used marijuana and poppers during sexual encounters to facilitate connection with partners, bolster self-esteem, and increase social enjoyment and physical pleasure. At the same time, some participants also expressed wariness about their own and partners' impaired decision-making during sex under the influence of alcohol, or other substances. Moreover, substance use conflicted with a strong desire to control negotiation of safer sex, sometimes presenting a barrier to fulfilling connections with sexual partners, and sexual satisfaction. This complex perspective on sex under the influence of alcohol is described by one participant,

It's tricky, I think that alcohol is good, because it kind of relaxes you, but it also lowers your pain tolerance, makes decision-making harder, sometimes it can lead to, you know, unsafe situations. I mean it's good to be present when you're having sex and sometimes alcohol can help you stay present or help you disassociate. So it's really like dependent on the situation and the person and where I'm at too... Alcohol is pretty necessary when I'm having someone come over, cause it's really, it's scary, you know, and usually there are poppers involved, because they're fun. Yeah it just kinda, it makes it easier, it makes me less scared. You know it's hard not to tremble when you're sitting beside a stranger about to have sex with them. (Participant 8)

HIV/STIs and healthcare access

Perceived HIV risk—None of the participants were HIV-positive and only 2 of the 11 interviewees knew another gay, bisexual and queer trans man who was HIV-positive. Many participants perceived their risk of HIV, and to some extent other STIs, to be relatively low.

I would say that nobody in my social circle that I know of is having any kind of present fears or concerns around their HIV status or their risk to contract it.
(Participant 1)

Access to trans-competent sexual healthcare and HIV/STI testing—All participants described regular access to testing for HIV and other STIs. A connection to healthcare through routine testosterone therapy monitoring and transition-related care provided an access point to integrating regular HIV/STI testing into participants' personal healthcare plans.

When I've been sexually active with multiple partners, I get tested every few months. With the blood work through HRT and testosterone, my doctor usually just does the blood-screening test as well for me... Yeah, oh, I'm already getting blood drawn. I probably need to get tested, let's just draw two more vials for HIV and syphilis. (Participant 11)

Some participants described seeking regular testing despite challenges in accessing culturally-competent trans and gay men's healthcare services including clinic staff using birth names, insisting on undesired pap testing, and lack of understanding of the sexual practices of and corresponding health risks for gay, bisexual and queer trans men. The complexity of navigating non-anonymous testing, interprovincial migration for higher education, and surgical waitlists within provincial healthcare systems presented an additional challenge for one participant. Participants expressed both an appreciation for local trans-specific healthcare services and a desire for integration of trans-competent care into services for the general public and those targeted for gay men.

I've been pretty lucky in my experiences, but people have tried to talk me out of testing for saying I was low risk behaviour, that they didn't understand my behaviour really, or things like that. I've had practitioners as well just say they don't know what to do; they don't know what to look for. I've had some health problems and they've been examining me while saying they don't what to do and they don't know if I should worry about cancer or things like that while they're doing internal exams. (Participant 9)

Generally, participants described testing frequently for HIV and other STIs, sometimes regardless of the level of sexual risk identified in their lives.

I like to get HIV testing every time [I go to the clinic], even if I know my risk is low. (Participant 1)

While for some frequent testing was a casual part of their healthcare routine, for others it was motivated by anxiety about HIV/STI acquisition, personal and partner STI history, as well as unwanted pregnancy in some cases.

Well, I get really anxious and paranoid so I try to get tested a lot because I get scared. (Participant 2)

Participants described lack of general and sexual health information specific to their needs as gay, bisexual and queer trans men. Living in urban areas and being well networked within trans communities facilitated better access to relevant health information and trans-competent healthcare services. As one participant explained,

I just really worry about trans folks that are more isolated than me because I had people to go to. I had people to recommend those doctors and to tell me about some of their limitations beforehand. I think in Vancouver we can be pretty lucky as long as you're well connected but outside of Vancouver, outside of the lower mainland, it can be a real challenge to find the resources that I've had access to for years. And if you don't find them online or if you give them bad information online that can really lead you down some fairly vulnerable paths...I think especially outside of cities and especially outside of communities we're at risk. (Participant 8)

Participants described the need to advocate for their own health (e.g. appropriate testing) and non-health (e.g. correct name, pronoun) needs when accessing primary healthcare and HIV/STI testing, as well as transition-related care services. Participants reported a range of barriers to health care access including having to conduct research independently on their health care needs and diagnostic and treatment options to be able to inform a health care provider, and the need to advocate for chosen name and pronoun use with health clinic staff. This led many to avoid clinics where they had had these experiences, and to favour attending health care centres specialising in trans health care. As one participant elaborated,

I have tried just going to walk in clinics and stuff like that to ask questions or request tests and stuff like that and I just found the doctors were generally confused about me and my body. And I had to go into great detail. That made me not so comfortable talking to them about it because they were just kind of sitting there confused and it made me feel awkward. So, yeah, when it comes to those tests I will go to special groups rather than just, like, everyday healthcare. (Participant 3)

Discussion

To our knowledge, this is the first study in Western Canada to assess sexual HIV risk and related risk factors among gay, bisexual and queer trans men and the only with a sample recruited from within a larger bio-behavioural study of gay, bisexual and queer men. Gay, bisexual and queer trans men in this sample had a range of trans and non-transgender sexual partners, including regular, casual, and anonymous, some of unknown or discordant HIV serostatus. Gay, bisexual and queer trans men engaged in a range of sexual behaviours including receptive genital and anal sex and inconsistent condom use. Contrary to common assumption, gay, bisexual and queer trans men may be at elevated risk for HIV and other STIs (Chen et al. 2011; Bauer et al. 2013; Sevelius 2009; Reisner, Perkovich, and Mimiaga 2010; Clements-Nolle et al. 2001), compared to the general population.

Narratives suggest a disjuncture between the sexual health education participants had received, access to information and health services, and evaluation of their own sexual

practices and risks. Despite a paucity of trans-specific information available, participants talked about sharing known sexual health information among their communities of other gay, bisexual and queer trans men, contributing to the sophisticated understanding of the mechanisms of HIV/STI transmission demonstrated in these interviews. The apparent disconnect between low stated perception of personal HIV risk coupled with a high-level of conscious preoccupation with risk and sexual risk prevention practices that may put participants at low risk of HIV acquisition is consistent with findings from a Massachusetts clinic-based mixed methods study of gay, bisexual and queer trans men (Reisner, Perkovich, and Mimiaga 2010) and may be explained partly by concern for other sexual health risks, including other STIs, pregnancy, and sexual assault. This apparent contradiction between perception and practice may be further explained by the unique complexities of navigating sex and sexual health for gay, bisexual and queer trans men, including gender-related stigma and discrimination, the need for gender-affirmation from peers and partners, and changes in self-comfort with the body over the course of transition.

A dominant theme was the exclusion and invisibility of gay, bisexual and queer trans men within existing health promotion and health services, both general and specific to the sexual health needs of gay men. Gay, bisexual and queer trans men have reported a number of structural drivers of HIV risk related to healthcare access in the literature, including low proportions of recent HIV testing (Bauer et al. 2013) and lack of access to culturally appropriate health services and information (Sevelius 2009). Participants in this study described a number of barriers to accessing healthcare including service provider misperception of their gender-identities and bodies, lack of provider training in trans-competent healthcare and language, and the need to self-advocate and educate as patients. There is a need for provider respect for gay, bisexual and queer trans men as experts on their bodies and needs, while being better trained on trans-inclusive language and healthcare to avoid requiring gay, bisexual and queer trans men be educators in the provider-client/patient relationship (Lim, Brown, and Kim 2014). Findings indicate that participants face multiple barriers when accessing sexual health information and services, both trans-specific and those shared with non-transgender men. These findings demonstrate the need for both trans-inclusion in general services for gay men as well as trans-specific education and care within services targeted to gay men.

Under the British Columbia Treatment as Prevention strategy, British Columbia has dedicated significant resources to expand dramatically HIV testing outreach and support services and engagement of HIV-positive individuals in healthcare and antiretroviral treatment (Montaner et al. 2006; Montaner et al. 2010; Montaner et al. 2014). This study also provides context for local barriers and facilitators of accessing this programme for gay, bisexual and queer trans men, indicating this population may face a number of barriers related to lack of trans-competency from frontline staff and clinicians when accessing HIV testing.

In addition to structural or ‘institutional erasure’ (Bauer et al. 2009) in healthcare access, participants also described experiences of social erasure driving sexual health vulnerability, through seeking sex online. Specifically, meeting partners online has been associated with increased engagement in HIV sexual risk behaviour (e.g. condomless sex) (Lewnard and

Berrang-Ford 2014). Current findings highlight the importance of the Internet for gay, bisexual and queer trans men in meeting partners for sex and dating, potentially maximising physical and sexual safety, and mediating rejection and misperception, consistent with recent studies among this population in San Francisco (Sevelius 2009) and Boston (Reisner, Perkovich, and Mimiaga 2010). The ability to control trans-status disclosure encouraged seeking sexual partners online; and misperception or rejection by a potential sexual partner was easier when moderated by an online interaction rather than an in-person experience. Concerns about physical or sexual violence as a result of disclosure were also minimised by seeking partners online or via mobile phone applications for meeting gay men. Encountering male sexual partners online was motivated by the facility for negotiating safer sex and establishing boundaries around desired sexual activities. Similarly, a recent qualitative study of young gay men found the Internet offered benefits including finding and filtering partners, sexual facilitation, relationship development and maintenance, improved communication and identity development (McKie, Lachowsky, and Milhausen 2015). Partners met online were sometimes anonymous and of unknown or discordant serostatus, and alcohol or other substances facilitated online-initiated encounters for some participants. These findings highlight the tension between seeking sex online as simultaneously protective and risky for gay, bisexual and queer trans men; suggesting online encounters may provide an important target for interventions to reduce sexual HIV risk.

Importantly, participants used a heterogeneity of language to talk about themselves and their bodies, describing binary and non-binary gender identities on the trans-masculine spectrum, and sexualities ranging from exclusively gay to queer, with men, women, and gender-variant sex partners. Such diversity within this small sample of gay, bisexual and queer trans men is consistent with findings from recent studies of trans men in Canada (Bauer et al. 2013; Scheim and Bauer 2015), and highlights the limitations of language and the ways it is often operationalised in research. Gay, bisexual and queer trans men, particularly those who are gender-variant and identify outside the gender binary, may be further excluded from research by existing divisional population definitions such as men who have sex with men.

While population-based HIV research approaches may necessitate categorising gay, bisexual and queer trans men as a homogenous group for data collection, it is important to ensure studies acknowledge the diversity of this population. Furthermore, health promotion and healthcare for gay, bisexual and queer trans men must recognise the heterogeneity of their lived experiences and needs in the context of service delivery, community-building and the mitigation of social stigma.

Limitations

The experiences of this small sample of gay, bisexual and queer trans men are wide-ranging with certain common themes, although they may not be representative of all gay, bisexual and queer trans men in Vancouver. Although this study produced a unique sample of gay, bisexual and queer trans men recruited from within a larger respondent driven sampling study of gay, bisexual and queer men, it represents an exploration of HIV sexual risk and the context of HIV vulnerability for a small sample of peer-recruited largely White, HIV-negative, sexually active trans men with a relatively high level of access to resources such as

employment, stable housing, and healthcare. Findings from this study may not be applicable to trans men who differ demographically, in terms of social determinants of health, or in other geographic contexts. As one Canadian-based study of trans persons found, experiences of racism were associated with greater odds of engaging in high risk sexual behaviours (Marcellin, Bauer, and Scheim 2013), indicating a need for more research with ethnographically diverse trans people. This study was conducted in British Columbia, Canada where there is a publicly funded healthcare system including access to hormone treatment and some gender affirming surgeries (e.g. mastectomy and hysterectomy), as well legal protections on the basis of gender identity (Mamela v Vancouver Lesbian Connection 1999) and a level of social acceptance for the lesbian, gay, bisexual, queer community and specifically trans persons. Readers should be cautious in applying findings from this study to gay, bisexual and queer trans men in other contexts without these social, legal, and medical resources.

Implications

This study contributes novel data from gay, bisexual and queer trans men recruited from within a larger non trans-specific bio-behavioural respondent driven sampling recruited cohort study of gay, bisexual and queer men. In addition to confirming findings in the largely U.S.-based literature regarding HIV sexual risk and risk factors for gay, bisexual and queer trans men, this study contributes to the limited knowledge of HIV risk for this population in the Canadian context. Specifically, this study analysed data from British Columbia, where there is publicly funded universal access to healthcare including HIV testing. Confirming findings in the U.S.-based literature, our results indicate that sexual HIV risk and the factors that shape it for gay, bisexual and queer trans men may be similar across the U.S. and Canada, despite the substantially different healthcare systems and policy environments. This may suggest that healthcare systems and public policy could play less of a role in shaping HIV risk for this population than non-country specific socio-cultural factors such as cissexism (the assumption that all people are non-transgender) (Bauer et al. 2009). This is an important area for further research.

Importantly, a number of findings may represent areas for action for healthcare policy and practice. Participant narratives in this study indicate routine transition-related medical care engagement may be an access point for incorporating regular HIV testing into a personal health routine for gay, bisexual and queer trans men. Health professional education could prime health providers to take advantage of such routine care to engage gay, bisexual and queer trans men not recently tested into a regular HIV/STI testing routine. Many participants described trans-specific negative experiences interacting with care providers as well as systems when accessing sexual healthcare services, consistent with other Canadian literature (Bauer et al. 2015). This points to the need for health professional education in trans-competency and care, as well as the incorporation of trans-inclusive administrative systems. There are some existing resources for health professionals that may be useful in improving healthcare access experiences for gay, bisexual and queer trans men. Specifically, major medical and public health professional organizations such as the Canadian Medical Association (Canadian Medical Association 2015) and World Professional Association for Transgender Health (Coleman et al. 2012) have recommended transgender care guidelines,

and Deutsch and Buchholz (2015) have provided resources for creating inclusive electronic health records systems, as others have pointed to (Bauer et al. 2015).

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Table 1

Demographic profile of gay, bisexual and queer trans men interview participants

	Participants (n=11)
	n(%)
HIV status	
HIV–	11(100)
HIV+	–
Age, median(IQR)	26(25–28)
Area of residence	
Downtown/West End (excludes DTES)	1(9)
Rest of Vancouver	8(73)
Outside Vancouver	2(18)
Sexual Identity	
Gay	4(36)
Bisexual	–
Queer	7(64)
Ethnicity	
White	10(91)
Asian	–
Aboriginal	–
Other	1(9)
Education	
<High School	–
Completed High School	–
>High School	10(91)
Other	1(9)
Annual income	
< \$30,000	8(73)
\$20,000 – \$44,999	2(18)
\$45,000 – \$74,999	1(9)