LGBT Health
Volume 3, Number 2, 2016
© Mary Ann Liebert, Inc.
DOI: 10.1089/lgbt.2015.0133

Documentation Status as a Contextual Determinant of HIV Risk Among Young Transgender Latinas

Sarah L. Palazzolo, BA,[1] Thespina J. Yamanis, PhD, MPH,[1] Maria De Jesus, PhD,[1] Molly Maguire-Marshall, MA,[1] and Suyanna L. Barker, DrSC, MA[2]

Abstract

Purpose: The purpose of this study was to explore the contextual factors that determine or mitigate vulnerability to HIV among Latina transgender women. Documentation status (legal authorization to live in the United States) has been cited by other studies as a barrier to recruitment or engagement in HIV-related care among immigrant Latinos, but not explored as a determinant of HIV risk for transgender immigrant Latinas.
Methods: We collaborated with a community-based organization to explore these contextual, including social and structural, factors. In-depth interviews in Spanish captured life histories of eight 18- to 29-year-old transgender Latinas, who collectively self-identify as *chicas trans*. Codes were assigned deductively from the interview guide, and emerging themes were identified throughout data collection.
Results: Most participants migrated to the United States from Central America after experiencing discrimination and violence in their countries of origin. Participants emphasized documentation status as a critical factor in three areas related to social and structural determinants of HIV risk: gender identity expression, access to services, and relationship power dynamics. *Chicas trans* who gained legal asylum reported greater control over sexual relationships, improved access to services, and less risky employment.
Conclusions: Documentation status emerged as a key HIV risk factor for this population. For undocumented transgender Latinas, legal asylum appears to be a promising HIV-related protective factor. Further research could assess whether legal assistance combined with wraparound support services affects HIV prevention for this population.

Key words: access to care, HIV, public policy and advocacy, transgender.

Introduction

A systematic review estimated that 27.7% of male to female transgender individuals in the United States are living with HIV.[1] African American and Latina transgender women (TW) have accounted for the largest proportions of HIV cases in several studies.[1–4] Among young transgender women of color (ages 15–24 years), self-reported HIV prevalence has ranged from 19% to 22% across various U.S. cities.[5,6] Condomless anal intercourse, sex with multiple partners, illicit drug use, and involvement in commercial sex work (CSW) are demonstrated behavioral risk factors for HIV among transgender women of color (TWOC).[4,7–9] Some suggest that these behaviors are determined by the co-occurrence of poor mental health and substance use linked to social inequality,[8,10–12] also referred to as a syndemic,[13] among TWOC. Thus, there has been a call for interventions focusing on contextual, including social and structural, determinants of the HIV-related syndemic for TWOC.[11]

Studies on HIV-related contextual determinants for TW have focused on the role of employment, living situations, and access to health services. Unemployment was an sexually transmitted infection risk factor among TWOC in New York City.[4] TW living in marginal housing situations were more likely to use illicit drugs and hormones, increasing their HIV risk.[14] TW are often uninsured for healthcare[15] and have reported a lack of nonjudgmental, transfriendly care environments.[16–18] Lack of health insurance and stable employment were key reasons cited by some TW for engaging in CSW to pay for gender transition therapies or basic survival needs.[4]

Studies have also linked racial and gender-based discrimination with stress and depression among TWOC.[15,19] The

[1]School of International Service, American University, Washington, District of Columbia.
[2]Community Health Action Department, La Clínica del Pueblo, Washington, District of Columbia.

effects of discrimination on mental health contribute to low negotiation power and lack of consistent condom use for TW in commercial as well as personal sexual relationships, increasing their HIV risk.[14,20] Furthermore, finding gender affirmation in a sexual partner is very important for transgender women's mental health.[21]

Although studies have included African American and Latina TW in their samples,[2,15,22,23] few have assessed contextual determinants of HIV specific to these groups.[24,25] Documentation status (legal authorization to live in the United States) is sometimes mentioned as a limitation for recruiting or retaining immigrant (noncitizen who lives in the United States) Latino/a sexual minorities in prevention and treatment,[26–29] but not as a contextual determinant of the HIV-related syndemic among transgender immigrant Latinas. For example, a prior study showed higher depressive symptoms and needs for social support among transgender Latinas compared to African Americans and Whites.[25] The authors speculated that their finding may be explained by transgender Latinas' loss of extended family due to immigration.[25] However, the effects of participants' immigration experiences and/or documentation status remained unexplored.

Studies with nontransgender Latinos, including men who have sex with men, show that those who are undocumented experience delays in HIV diagnosis[30] and have lower CD4 cell counts during treatment initiation, compared to legally documented Latinos, African Americans, and Whites.[31] The stress generated by a combination of documentation status, racial and gender discrimination, and barriers to social services likely adversely affects mental health and HIV risk for undocumented Latino/a sexual minorities, although the exact causal relationships remain unclear.[32–34] Conversely, the security provided by having legal documentation to live and work in the United States may have positive effects on mental health and HIV risk for this group. To our knowledge, this is the first study to explore these associations among transgender immigrant Latinas.

As a result of nearly two decades of immigration case law that recognizes sexual minorities as members of a ''particular social group'' who have credible fear of past and/or future persecution in their countries of origin, asylum is an option for some undocumented TW.[35–37] Asylum protects the right to live and work in the United States and as such is one of the best outcomes of very few legal options for undocumented immigrants fleeing persecution. However, the asylum process requires an applicant to meet several stringent conditions. These conditions include applying for asylum within 1 year of arrival to the United States and proving that the applicant's life or freedom would be threatened in his or her country of origin on account of race, religion, nationality, political opinion, or membership in a particular social group (see 8 U.S. Code § 1158 for other conditions and limits on eligibility for asylum).[38] Exceptions to the 1-year filing deadline can be made if major changes have occurred in country conditions or personal life circumstances, such as undergoing a gender transition. Six months after submitting an asylum application, if the applicant does not experience any delays in his or her case, he or she is cleared to apply for work authorization. After 1 year, asylees may apply for legal permanent residency; after 5 years of continuous permanent residency in the United States, they become eligible for naturalization.[38]

Methods

Setting

Washington, District of Columbia (DC), is among the five cities with the highest number of reported AIDS cases.[39] In 2012, 2.5% of the DC population was living with HIV.[40] DC had the highest rate of Latinos living with HIV in 2010 (1830.2 per 100,000); a rate more than four times the national rate for Latinos (432.4).[41] TW of color in DC are particularly at risk for HIV; a 2005 study found a 32% HIV prevalence among TWOC in DC.[42]

The DC metropolitan area is home to over 500,000 undocumented immigrants, most of whom are Latino/a.[43] It also has one of the largest shares of undocumented immigrants in the country and this share has grown recently, in contrast to a declining national rate.[43] The majority of these undocumented immigrants are from El Salvador, followed by other Central American countries.[43]

Data collection

We conducted an in-depth qualitative study to identify salient contextual determinants of HIV and mental health for transgender Latinas living in the DC metro area. We partnered with a community-based organization (CBO) that houses a center for Latino sexual minorities. The young transgender Latinas who attended the CBO's center collectively identified themselves as *chicas trans*; thus, we will use this term to identify the population.

In 2013, a bilingual and bicultural research team conducted in-depth life history interviews with eight *chicas trans*. Eligibility criteria included being between the ages of 18 and 29 years and self-identifying as Latina or Hispanic and transgender male to female. Ethical approval for this study was obtained from American University's Institutional Review Board in Washington, DC.

Participants were recruited through advertisements at the CBO's center for Latino sexual minorities and on their Facebook page. All interviews were conducted in Spanish in a private room at the CBO. Each interviewer reviewed the consent form in Spanish with participants. Participants were permitted to sign with an ''X'' to avoid disclosing their names. Consent to digitally record the interview was obtained verbally. Participants were asked to describe their life and sexual histories in detail. Table 1 describes the interview domains and example questions.

Data analysis

Analysis began during data collection. Topics for further exploration were noted and incorporated into ongoing fieldwork. Using ATLAS.ti version 7,[44] two research assistants coded the interviews in Spanish. Codes were assigned deductively from the interview guide and then emerging codes were identified from the data. The codes were reviewed by the lead investigator. Once the data were categorized, comparisons were made between participants. After several rounds of data analysis, data saturation was reached. The researchers identified themes and explained the data's core meanings, relationships among themes, and identified areas of further research. All quotes were translated from Spanish to English after data analysis was complete.

Table 1. Life and Sexual History Interview Domains and Example Questions for Study Among Eight Transgender Latinas in Washington, DC

Domains	*Example questions*
Day-to-day life	How do you earn income Where do you live and with whom
Social support	Social networks and support Places where you socialize Services used
Migration history	Reasons for leaving country of origin Length of time in the United States
Social discrimination	Legal status to remain in the United States Experiences of discrimination
Service providers	Experiences with services Examples of when helped/not helped
Health	HIV status History of mental health Frequency of accessing medical care
Sexual history	Characteristics of three most recent sexual partners, including where you met, where you had sex, HIV status, and condom use Types of sexual activities (receptive vs. insertive anal intercourse) Violence by sex partners Drug and alcohol use with partners Ideal romantic/sexual partner
Commercial sex work	History of experiences in sex work Venues where you met sexual partners

Results

Demographics

Table 2 describes participants' demographics. Seven participants were non-U.S. citizens from Central America, and one participant was born in Puerto Rico. Participants lived in the United States for an average of 9.5 years. All were employed. Four participants graduated from high school, one of whom went on to study at the university level. Three performed CSW in the past. At the time of the interview, one participant was living with HIV.

Context of migration

All of the non-U.S. citizen participants experienced and/or witnessed extreme violence in their countries of origin. Four participants migrated to the United States from a small rural town in Central America. Their families suffered economic hardships. Five participants reported suffering direct violence in their countries of origin, including kidnapping, rape, and abuse by family members. The other two noncitizen participants felt afraid and unable to express their female gender identities in what they described as transphobic and risky environments, where gangs routinely targeted sexual minorities. As one of our participants stated, she received death threats from local gangs related to her feminine gender expression:

> When I began to express my feminine sexual orientation, that made it a lot more difficult for me. Because they [the gangs] don't look at you like a person. They'll start to discriminate against you, screaming at you, saying really vulgar words at you in the street. In my country we've always had words like *maricón*, *puto*, *joto* [derogatory sexual slurs]…so I started to feel bad for my dad and my mom. It started to get ugly…

All of our Central American participants left their families to move to the United States because of the violence and discrimination they experienced related to their gender expression.

Documentation status

Six study participants self-reported that they had been undocumented at some time while in the United States. Two of the six participants had been granted asylum and two were in the process of applying for asylum. One participant born outside of the United States did not discuss her status. One participant was born a U.S. citizen in Puerto Rico. Documentation

Table 2. Demographic Characteristics of Eight Transgender Latina Participants in Washington, DC

Characteristic	*Measure*	n	*Statistic (mean or %)*
Age	Mean years	8	25.9
Highest level of education completed	Some university	1	12.5%
	Completed high school	3	37.5%
	Some high school	1	12.5%
	Some primary school	3	37.5%
Country of origin	El Salvador	6	75.0%
	Guatemala	1	12.5%
	USA (Puerto Rico)	1	12.5%
Time in the United States among participants born outside the United States	Mean years	7	9.5
Number of sex partners	Mean reported number in the last month	8	4.1
Documentation status of participants born outside the United States ($n=7$)	Reported being undocumented at some point in time (%)	6	85.7%
	Unknown	1	14.3%

status emerged consistently as a theme from our interviews, particularly in relation to three HIV-related risk factors among *chicas trans*: gender identity, access to services, and relationship power dynamics.

Gender identity

Participants described the importance of being supported in their female identity for their self-esteem and mental health. When asked about their ideal sexual and/or romantic partner, participants identified gender identity affirmation as a key trait. The ideal partner would also be publicly open about his or her relationship with a transgender woman.

The participants reported that when they were called by their male names, they felt shame, humiliation, and a loss of dignity. As one woman explained, an ID card that conflicts with the identity presented by a transgender woman contributes to contextual HIV risk:

> It's really hard for transgender women, when you look like Veronica, and your papers say José. And so then the apartment rejects you, jobs, and everything, and they don't have any other options but to go into sex work.

Participants reported that they felt vulnerable and discriminated against in public spaces where identification is required for entry, such as government agencies, service providers, health clinics, and social venues. They commonly cited that they would leave home only for a necessary outing to avoid encounters with the police. One participant described what she perceived as a discriminatory experience when she was not admitted to a popular social venue because the name on her ID card did not match her feminine gender. Another participant expressed frustration and humiliation that service organizations would call her to the appointment window by her male name.

All participants agreed that changing their names was important to affirm their identity and would prevent discrimination. Asylum offered an opportunity to change participants' legal identity documents. One participant reported that after winning her asylum case, she updated her legal name. The name change prompted her to start gender-affirming hormone therapy and, ultimately, increased her confidence to express her feminine gender:

> I applied for asylum and things were more like how I wanted them to be. Before, I didn't know what it felt like to take a pill to make changes in my body. But now, since I've been taking them, I feel much more sure of myself, and I feel like I've found myself.

Access to services

The six participants who reported being undocumented reported that they accessed health services through emergency care or at community clinics and that these services were primarily focused on HIV testing and prevention. About half of the participants had a regular doctor whom they visited for HIV tests and/or hormone treatment. The other half did not have a regular doctor. Nevertheless, all participants had previously tested for HIV. Two participants reported testing every 3 months when they received regular hormone treatment and others reported testing after having unprotected sex. However, from the perspective of some *chicas trans*, receiving mostly HIV testing and prevention services stigmatized them and provided substandard care by not attending to their health holistically. Participants expressed interest in receiving general healthcare checkups.

At the same time, lack of financial means compelled undocumented *chicas trans* to rely on dangerous and illegally imported intravenous hormone injections that may place them at greater risk for HIV. As one participant put it: ''There are a lot of people that I know who sometimes look for pirated hormones …they use them because they can't go to the doctor and pay $100 for just one injection.'' Lack of access to comprehensive gender-inclusive healthcare, therefore, contributes to contextual HIV risk.

In addition to limited access to health services, undocumented participants reported challenges finding well-paying jobs and securing safe affordable housing. Five participants reported engaging in CSW at some point while in the United States and two reported relying on someone they called a ''patrocinador,'' a sexual partner who supplied basic necessities such as food and shelter. One participant explained the necessity of engaging in CSW to survive: ''You could be in this country legally [one day] but you still don't have your ID or a work permit. You don't have anything…You're going to die of hunger.'' Since finding authorized employment in restaurants or other service sector industries, two participants were no longer in CSW or transactional sexual relationships and had reduced their number of sexual partners, thereby reducing their risk for HIV.

Chicas trans who were granted legal asylum described important changes in accessing social services and employment. One participant reported that after receiving asylum and being issued a social security number, her immigration lawyer encouraged her to enroll in school and get a better job. Asylum removed her fear of deportation in the workplace by authorizing her to work, and she decided to pursue employment other than CSW:

> Well, I'd say my life [after asylum] changed 180 degrees. Because that was why I didn't go to school, I wasn't working, and after they approved my asylum case, they sent me a work permit, and even though I didn't know how to speak English, I went to work, because now they see that my social security number is good. My life changed completely.

Relationship power

Five participants reported that they were in a serious relationship with at least one main sexual partner and three of those reported additional occasional casual sexual partners. When asked if they ever felt afraid of a partner, several women recounted direct physical abuse and controlling behavior by sexual partners. One woman described being afraid of a partner who was using drugs; another recounted how her partner forced her to have oral sex without a condom. Another participant described how after one year her partner suddenly changed his behavior: ''He started to humiliate me and he hit me, treated me badly physically. He told me he wasn't going to do it again. I forgave him, and nothing changed.''

Lack of legal documentation to live in the United States created a barrier for *chicas trans* to leave relationships

with controlling or abusive partners, as one formerly undocumented participant described:

> I didn't really know him. I went to live with him to try to have a roof to stay under, and he was *really* possessive… if I wanted to leave, I couldn't leave. He almost just wanted to have me there for him, and I had to serve him as a sexual object. But I didn't have another alternative at that time. I didn't feel good, to be honest; I was with him to stay off the street.

This same participant reported that being granted legal asylum changed her situation. After asylum, she applied for food stamps and cash benefits. She moved out of the home she shared with the controlling partner and found her own apartment. Thus, attaining legal permission to live in the United States resulted in access to social services, which facilitated her leaving her unequal relationship.

The Puerto Rican participant, born a U.S. citizen, felt that she was more independent and secure compared to her undocumented peers and reported feeling confident speaking up about her rights. The benefits of legal status, including a social security number that allows citizens and permanent residents to work, gave her the ability to provide food, housing, and money for herself. As she explained:

> ''Me, for example. I have my own apartment, I have my own job; I don't count on anyone for anything. When there are other people providing for you, they are the ones who have the power to say yes or no.''

Discussion

This study provides important new evidence to suggest that legal protection can act as a protective factor for the HIV-related syndemic among undocumented transgender Latinas. Lack of documentation to live in the United States prohibited affirmation of gender identity for *chicas trans*; it also acted as a barrier to obtaining housing, employment, and other social services that may have diminished the need to engage in transactional or ''survival'' sex. Asylum enabled previously undocumented *chicas trans* to leave situations that produced violence and/or HIV risk, such as CSW, abusive relationships, and marginal housing.

Asylum also provided a foundation from which previously undocumented *chicas trans* were able to access services and work authorization. While certain services are available to undocumented immigrants, such as public education and emergency medical care, asylum protects them from deportation, making social spaces they might have once avoided more accessible. While the finding that lack of documentation status acts a barrier to healthcare is represented in other literature with immigrant Latinos,[33,45] ours is the first study that we know of to report the positive effects of legal asylum. Our study thus answers the call for research focused on protective factors to mitigate determinants of HIV risk for lesbian, gay, bisexual, transgender (LGBT) populations, rather than exclusively focusing on factors that accentuate vulnerability.[46]

All undocumented immigrants face significant barriers to healthcare and other social services. However, the intensified trauma of violence, discrimination, and stigma raises the stakes for undocumented sexual minorities. Organizations such as Immigration Equality in New York City and others have demonstrated success with helping LGBT asylum seekers win their cases.[47,48] Despite this organization and others' apparent success, exactly how many LGBT asylees there are in the United States is unknown. The United States Citizenship and Immigration Services (USCIS) do not provide public data on how many TW have made successful asylum claims.

It is important to note that there may be adverse consequences for *chicas trans* going through the asylum process. There may be profound disappointment if the process is unsuccessful. Furthermore, applicants must demonstrate credible fear of persecution.[49] Divulging experiences of persecution in front of a legal audience can be retraumatizing. Therefore, it is important to provide emotional social support for *chicas trans* during the asylum legal process. Organizations and lawyers providing immigration-related legal aid must also be trained in cultural and transgender sensitivity.

Our study is limited in its ability to generalize or test the association between documentation status and HIV risk. Because our eligibility criteria focused on transgender Latinas between 18- and 29-years-old, our findings are limited in their application to older adults, who experience different barriers to seeking healthcare and social support.[50] Nevertheless, these detailed life and sexual histories inform our understanding of social and structural HIV risk and protective factors among young immigrant *chicas trans*. Of course, documentation status cannot remove all the risk factors that TWOC face. As others have shown, transgender Latinas with limited employment opportunities and marginal housing situations, regardless of documentation status, can have difficulty leaving high-risk situations for HIV transmission, such as CSW and sex with occasional ''exchange partners.''[14] Others have also demonstrated increased HIV risk among TWOC, regardless of documentation status, due to intravenous drug use and needle sharing.[14,51] We echo earlier calls for holistic interventions that include wraparound services such as preventative case management, education, and job training and placement services for transgender Latinas likely to enter CSW.[15] Medical interventions should also include mental health support.[15]

Conclusion

We find that obtaining legal documentation to live in the United States can protect against HIV risk among undocumented transgender Latinas by affirming their identity, making it easier to avoid controlling sexual partners, and providing access to greater employment opportunities and public services. Because asylum grantees are eligible for work authorization, a social security number, and eventual permanent residence, *chicas trans* who obtain asylum are more likely to avoid CSW and its associated health risks. Future research should investigate these associations quantitatively. Research should also explore whether providing legal aid in the context of an HIV-related intervention might increase undocumented sexual minorities' use of health and HIV-related services, mitigate behavioral risk factors and fear of deportation, or link them to and retain them in care. Providing legal services within a healthcare setting is a structural intervention approach that has demonstrated effectiveness for improving access to healthcare and well-being for low-income children.[52,53] It is worth testing whether legal services could add value to a holistic HIV-related intervention for transgender immigrant Latinas.

Acknowledgments

Funding for this project was provided by American University's School of International Service Collaborative Research Awards. The work of the second author was enabled, in part, by a CFAR ADELANTE grant (AI050409). The authors are grateful to the study participants who generously gave their time and shared their stories. They also thank study interviewers A.J. Doty, Rosa Covarrubias, Javier Morla, and Esther Spindler for their excellent skills and the time and effort they devoted to gathering data from the participants.

Author Disclosure Statement

No competing financial interests exist.

References

1. Herbst JH, Jacobs ED, Finlayson TJ, et al.: Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. AIDS Behav 2008;12:1–17.
2. Rapues J, Wilson EC, Packer T, et al.: Correlates of HIV infection among transfemales, San Francisco, 2010: Results from a respondent-driven sampling study. Am J Public Health 2013;103:1485–1492.
3. San Francisco Department of Public Health. HIV/AIDS Epidemiology Annual Report. 2012. San Francisco, CA, San Francisco Department of Public Health.
4. Nuttbrock L, Hwahng S, Bockting W, et al.: Lifetime risk factors for HIV/sexually transmitted infections among male-to-female transgender persons. J Acquir Immune Defic Syndr 2009;52:417–421.
5. Garofalo R, Deleon J, Osmer E, et al.: Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. J Adolesc Health 2006;38:230–236.
6. Wilson EC, Garofalo R, Harris RD, et al.: Transgender female youth and sex work: HIV risk and a comparison of life factors related to engagement in sex work. AIDS Behav 2009;13:902–913.
7. De Santis JP: HIV infection risk factors among male-to-female transgender persons: A review of the literature. J Assoc Nurses AIDS Care 2009;20:362–372.
8. Kosenko K: Contextual influences on sexual risk-taking in the transgender community. J Sex Res 2011;48:285–296.
9. Baral SD, Poteat T, Strömdahl S, et al.: Worldwide burden of HIV in transgender women: A systematic review and meta-analysis. Lancet Infect Dis 2013;13:214–222.
10. Nemoto T, Operario D, Keatley J, Villegas D: Social context of HIV risk behaviours among male-to-female transgenders of colour. AIDS Care 2004;16:724–736.
11. Operario D, Nemoto T: HIV in transgender communities: Syndemic dynamics and a need for multicomponent interventions. J Acquir Immune Defic Syndr 2010;55:S91–S93.
12. Poteat T, Wirtz AL, Radix A, et al.: HIV risk and preventive interventions in transgender women sex workers. Lancet 2014;385:274–286.
13. Singer M, Clair S: Syndemics and public health: Reconceptualizing disease in bio-social context. Med Anthropol Q 2003;17:423–441.
14. Fletcher JB, Kisler KA, Reback CJ: Housing status and HIV risk behaviors among transgender women in Los Angeles. Arch Sex Behav 2014;43:1651–1661.
15. Clements-Nolle K, Marx R: HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. Am J Public Health 2001;91:915–921.
16. Bauer GR, Hammond R, Travers R, et al.: ''I don't think this is theoretical; this is our lives'': How erasure impacts health care for transgender people. J Assoc Nurses AIDS Care 2009;20:348–361.
17. Melendez RM, Pinto RM: HIV prevention and primary care for transgender women in a community-based clinic. J Assoc Nurses AIDS Care 2009;20:387–397.
18. Sanchez NF, Sanchez JP, Danoff A: Health care utilization, barriers to care, and hormone usage among male-to-female transgender persons in New York City. Am J Public Health 2009;99:713–719.
19. Rhodes SD, Martinez O, Song E-Y, et al.: Depressive symptoms among immigrant Latino sexual minorities. Am J Health Behav 2013;37:404–413.
20. Nemoto T, Operario D, Keatley J, et al.: HIV risk behaviors among male-to-female transgender persons of color in San Francisco. Am J Public Health 2004;94:1193–1199.
21. Sevelius JM: Gender affirmation: A framework for conceptualizing risk behavior among transgender women of color. Sex Roles 2013;68:675–689.
22. Wilson EC, Chen Y-H, Arayasirikul S, et al.: Connecting the dots: Examining transgender women's utilization of transition-related medical care and associations with mental health, substance use, and HIV. J Urban Health 2015;92:182–192.
23. Wilson E, Rapues J, Jin H, Raymond HF: The use and correlates of illicit silicone or ''fillers'' in a population-based sample of transwomen, San Francisco, 2013. J Sex Med 2014;11:1717–1724.
24. Wilson EC, Chen Y-H, Arayasirikul S, et al.: Differential HIV risk for racial/ethnic minority trans*female youths and socioeconomic disparities in housing, residential stability, and education. Am J Public Health 2015;105 Suppl 3:e41–e47.
25. Nemoto T, Bödeker B, Iwamoto M: Social support, exposure to violence and transphobia, and correlates of depression among male-to-female transgender women with a history of sex work. Am J Public Health 2011;101:1980–1988.
26. Vega MY, Spieldenner AR, DeLeon D, et al.: SOMOS: Evaluation of an HIV prevention intervention for Latino gay men. Health Educ Res 2011;26:407–418.
27. O'Donnell L, Stueve A, Joseph HA, Flores S: Adapting the VOICES HIV behavioral intervention for Latino men who have sex with men. AIDS Behav 2014;18:767–775.
28. Reisen C, Iracheta M, Zea MC, et al.: Sex in public and private settings among Latino MSM. AIDS Care 2010;22:697–704.
29. Rhodes SD, Hergenrather KC, Montaño J, et al.: Using community-based participatory research to develop an intervention to reduce HIV and STD infections among Latino men. AIDS Educ Prev 2006;18:375–389.
30. Dang BN, Giordano TP, Kim JH: Sociocultural and structural barriers to care among undocumented Latino immigrants with HIV infection. J Immigr Minor Health 2012;14:124–131.
31. Poon KK, Dang BN, Davila JA, et al.: Treatment outcomes in undocumented Hispanic immigrants with HIV infection. PLoS One 2013;8:e60022.
32. Rhodes SD, Mann L, Simán FM, et al.: The impact of local immigration enforcement policies on the health of immigrant Hispanics/Latinos in the United States. Am J Public Health 2015;105:329–337.

33. Martinez O, Wu E, Sandfort T, et al.: Evaluating the impact of immigration policies on health status among undocumented immigrants: A systematic review. J Immigr Minor Health 2015;17:947–970.
34. Quiroga SS, Medina DM, Glick J: In the belly of the beast: Effects of anti-immigration policy on Latino community members. Am Behav Sci 2014;58:1723–1742.
35. Matter of Toboso-Alfonso. Board of Immigration Appeals Interim Decision no. 3222. 1990.
36. Reyes-Reyes v. Ashcroft. CA 9th, No. 03-72100. 2004.
37. Boer-Sedano v. Gonzales. CA 9th, No. 03-73154. 2005.
38. United States Citizenship and Immigration Services. Asylum. 2015. Available at www.uscis.gov/humanitarian/refugees-asylum/asylum Accessed April 27, 2015.
39. Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 2007. Vol. 19. Atlanta, US Department of Health and Human Services, Centers for Disease Control and Prevention. 2009. Available at www.cdc.gov/hiv/pdf/statistics_2007_HIV_Surveillance_Report_vol_19.pdf Accessed March 30, 2015.
40. District of Columbia Department of Health, HIV/AIDS, Hepatitis, STDs and TB Administration. Annual Epidemiology & Surveillance Report. Government of the District of Columbia, Department of Health: Washington, DC. 2013. Available at http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2013%20Annual%20Report%20FINAL-2.pdf Accessed August 6, 2015.
41. Centers for Disease Control and Prevention. HIV among Latinos. 2011. Available at www.cdc.gov/hiv/resources/factsheets/pdf/latino.pdf Accessed March 30, 2015.
42. Xavier J, Bobbin M, Singer B, Budd E: A needs assessment of transgendered people of color living in Washington, DC. Int J Transgenderism 2008;8:31–47.
43. Passell JS, Cohn D. Unauthorized Immigrant Totals Rise in 7 States, Fall in 14. Washington, DC. 2014. Pew Research Center. Available at http://www.pewhispanic.org/2014/11/18/unauthorized-immigrant-totals-rise-in-7-states-fall-in-14/. Accessed December 2, 2015.
44. ATLAS.ti. Berlin: Scientific Software Development GmbH, 2013.
45. Rhodes SD, Hergenrather KC, Aronson RE, et al.: Latino men who have sex with men and HIV in the rural south-eastern USA: Findings from ethnographic in-depth interviews. Cult Health Sex 2010;12:797–812.
46. Mustanski BS, Newcomb ME, Nicholas S, et al.: HIV in young men who have sex with men: A review of epidemiology, risk, and protector factors, and interventions. J Sex Res 2011;48:218–253.
47. Immigration Equality. Immigration equality—Legal services. 2015. Available at www.immigrationequality.org/our-work/#legal-services Accessed March 21, 2015.
48. Millman J: The battle for gay asylum: Why sexual minorities have an inside track to a U.S. Green Card. Wall Street J. Updated June 13, 2014. Available at www.wsj.com/articles/why-sexual-minorities-have-an-inside-track-to-a-u-s-green-card-1402676258 Accessed March 23, 2015.
49. Heller P: Challenges facing LGBT asylum-seekers: The role of social work in correcting oppressive immigration processes. J Gay Lesbian Soc Serv 2009;21:294–308.
50. Fredriksen-Goldsen KI, Cook-Daniels L, Kim HJ, et al.: Physical and mental health of transgender older adults: An at-risk and underserved population. Gerontologist 2014;54: 488–500.
51. Reback CJ, Fletcher JB: HIV prevalence, substance use, and sexual risk behaviors among transgender women recruited through outreach. AIDS Behav 2014;18:1359–1367.
52. Beeson T, McAllister BD, Regenstein M: White paper—Making the case for medical-legal partnerships: A review of the evidence. Washington, DC; 2013. Available at http://medical-legalpartnership.org/medical-legal-partnership-literature-review/ Accessed March 21, 2015.
53. Weintraub D, Rodgers M, Botcheva L, et al.: Pilot study of medical-legal partnership to address social and legal needs of patients. J Health Care Poor Underserved 2010;21(2 Suppl):157–168.

Address correspondence to:
Thespina J. Yamanis, PhD, MPH
School of International Service
American University
4400 Massachusetts Avenue NW
Washington, DC 20016

E-mail: yamanis@american.edu