FTM Rapid HIV Risks Needs Assessment 2008
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San Francisco is at an epicenter of HIV transmission among at-risk populations and is at the leading edge of research and prevention for these at-risk populations. Researchers and providers have generated a wealth of data in order to implement effective prevention programs as well as care for those who are HIV positive. Nonetheless, gaps exist, particularly with respect to transgender populations, and the Female-to-Male (FTM) transgender (TG) population specifically.[1] This rapid needs assessment explores the HIV risk behaviors and the contexts of risk taking among Female-to-Male transgender men in San Francisco.

Currently there is little published data in the U.S. on the FTM population and one local study conducted over ten years ago that surveyed 123 FTMs and conducted one FTM focus group (Clements-Nolle et al 2001). It found that 66% of its FTM sample was abstaining from sex or only had one partner. The most recent meta-analysis of risk behaviors among transgender persons in the U.S. found that "prevalence rates of HIV and risk behaviors were low among FTMs." (Herbst et al 2007). This conclusion is based on a very limited amount of research, some of which actually shows that FTMs are engaging in high-risk behaviors at high rates (Kenagy 2002).

Prevalence rates have been estimated at 1-3% in the literature, but low prevalence rates may reflect the lack of effective data collection on FTMs rather than accurate rates of infection. For example, if a testing site does not probe for TG status or sex assigned at birth, it is possible an FTM will be classified as an MSM without any understanding that his sex assigned at birth was not male. While California, and San Francisco in particular, has begun to expand the gender categories of data collection tools, it's not clear that providers always use those tools effectively. When providers do explicitly probe for gender identity, it's not always the case that an FTM client will say or check off 'FTM' rather than 'male.' Because of the current data collection limitations with tracking transgender populations, local providers' reports of anecdotal evidence, like increasing aggressive sexually transmitted diseases (STDs) and HIV incidence, motivated the HIV Prevention Planning Council to prioritize a rapid HIV risks community needs assessment. This invisible population may be circulating among at least two high risk populations, men who have sex with men (MSMs) and MTFs; in 2006 the estimated prevalence of HIV among non-injecting Male-to-Female (MTF) women living in San Francisco was 23% while that of MSMs was 24% (San Francisco Department of Public Health 2006).

Although the RFP called for a rapid, qualitative needs assessment, this assessment was primarily qualitative with a quantitative component. Using a community-based participatory research (CBPR) approach, it was important to use mixed methods that each incorporated a range of community input and feedback.[2] This approach reduces the historical power differential between researchers of marginalized populations and

[1] Please consult Appendix ___ for a glossary of key terms and acronyms used in this report.
[2] Please consult Appendix ___ for the study's methodology, design, and recruitment and retention.

members of the population in question and aims to enhance trust as well as effectiveness in addressing health disparities. (Viswanathan, Rhodes et al, 2004).

The CBPR approach facilitated rapid data collection in that each member of the research team offered different areas of expertise and a set of professional networks, such as the Department of Public Health's Transgender Advisory Group (TAG), that enhanced community participation in the assessment as well as participation on the research design and analysis sides of the assessment. Our team collected the data between mid-June 2008 until early September 2008. We employed a community-based participatory research approach that used mixed methods—47 surveys, 3 focus groups and 10 key informant interviews--in order to triangulate the data, or reduce the bias built into each mode of inquiry by using another mode. Surveys were conducted first in order to capture descriptive data, and while all modes of collection focused on assessing behavioral risks, healthcare access, mental health as well as socioeconomic status and perspectives on community and social support, the focus groups and key informant interviews were instrumental to an in-depth analysis of these data points.

After final IRB approval, the assessment focused on the following areas:

- Demographics
- Socio-Economic Status
- Healthcare Access and Quality of Care
- Mental Health
- Sexual Behaviors and Partners
- STI/HIV Knowledge and Testing
- Community and Social Support

The assessment data shows that FTMs are engaging in risky sexual behaviors, particularly frontal receptive sex with males, with multiple partners.[3] The data also shows that the frontal region may undergo physiological changes with testosterone therapy that may make it more susceptible to HIV transmission than the female vagina. While the assessment found that some FTMs utilize a range of protective strategies to reduce risks for HIV, both risk-taking and risk-reduction behaviors occur within a context of vulnerabilities related to various transgender and gender-related stigmas; these vulnerabilities, or cofactors, include economic marginalization, low self-esteem and fear of rejection by sexual partners, regular drug and alcohol use, limited access to culturally competent testing, a lack of community and social support and histories of violence and abuse. These vulnerabilities, also referred to as syndemic effects, around HIV signify the conditions for a possible surge in HIV incidence among the FTM population without intervention. (Stall et al. 2003).

[3] Please consult appendix ___ for a Glossary of Terms and acronyms used in this report.

QUANTITATIVE AND QUALITATIVE FINDINGS

The following sections highlight the themes that emerged from the main topics of inquiry:

- Demographics
- HIV Knowledge and Sexual Risk Behaviors
- Mental Health: Depression, Substance Use, Histories of Violence
- Healthcare Coverage and Cultural Competence

This report's analysis will focus on sexual risk behaviors along with other risk factors and social determinants of health. Each section will present survey results first and then present qualitative data that may support and add depth to the survey data as well as qualitative data that diverges from the survey trends and highlights unique cases.

SURVEY, FOCUS GROUP AND KEY INFORMANT DEMOGRAPHICS

As a tool, surveys can capture rich demographic information that focus groups and key informant interviews are not designed to do. This section highlights a striking profile of transgender men in San Francisco based largely on survey data with minimal demographic data on the focus groups and interviews at the conclusion of the section.

Gender, Sexuality and Relationship Demographics

Finding 1: FTMs often live 'stealth'[4] and are not out as transgender in their work or daily lives; FTMs' gender identity and sexual orientations are multiple and may vary depending upon the social context.

Survey respondents could check off more than one gender identity, and 81% did. 'FTM' was the most commonly held gender identity followed by 'Trans Man.' Thirty-eight percent checked 'identity not listed;' some of these included, 'Two Spirit,' 'Intersexual,' 'Fluid,' 'Boi,' 'MTM,' 'Trannyfag,' 'Gender Variant,' 'Manqueer,' and 'Metamorph.'[5] In a follow-up question to gender identity, we asked if respondents primarily lived and worked stealth. Fifty-five percent responded affirmatively. This slide underscores the variability of gender identity and expression as well as the range of terms used to describe them within this population. Likewise, it highlights possible challenges around tracking transgender populations by the use of a new epidemiological gender category such as 'FTM.'

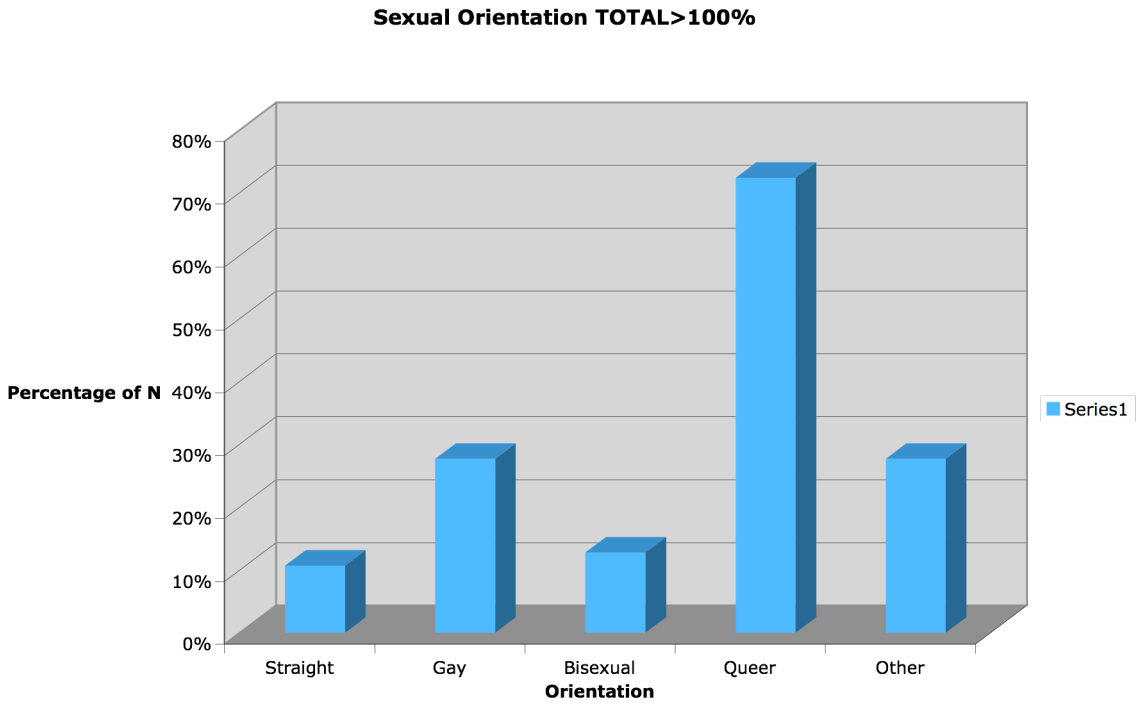
[4] See Appendix ___ for a Glossary of Terms.
[5] See Appendix ___ for a Glossary of Terms.

Slide 1

GENDER IDENTITY	
FTM	64%
Stealth	55%
Trans man	53%
Genderqueer	38%
ID not listed	38%
Man	28%
Transexual man	17%

Similarly, participants expressed a range of sexual orientations, but this time 55% of respondents chose only one orientation while the remaining 45% checked two or more orientations. While 'Queer' was the most common orientation, 'Straight' was the least common.[5] Thirty percent chose 'Other' and cited less commonly known orientations such as 'Pansexual,' 'Polyamorous,' 'Intersexual,' 'Anthrosexual,' and 'San Fransexual.'[5] Like the previous slide, this one highlights the complexity of sexual orientation and identity and suggests that the sample, as a whole, has fluid identities that are dynamic, changing and may vary depending upon the social context.

Slide 2



Slide 3

RELATIONSHIP STATUS	
Single and Cruising:	45%
Single, Not Dating/Cruising:	19%
Other Relationship:	19%
Monogamous Relationship:	15%
In Open Relationship:	13%

Finding 2: More FTMs are sexually active and have multiple partners than was reported 10 years ago.

Repeatedly, participants expressed having a range of intimate relationships (Slide 3). While fifteen different categories of relationships were listed and participants could check all that applied (e.g. one could check 'divorced,' as well as 'single and dating'), the most prevalent relationship category was 'Single and Dating/Cruising' at 45%. The second most common relationship, however, was 'Single and Not Dating/Cruising' at 19% along with 'Other Relationship' also at 19%. 'Other' included 'mostly monogamous,' 'boink buddies,' and 'long distance relationship' among others. The fourth most common relationship is 'Monogamous' at 15%, and the fifth is 'Open, non-monogamous or polyamorous relationship' at 13%.[6]

That 'single and dating' is the most common form of relationship signals that the FTMs commonly have multiple partners. Another 30% ('other' and 'open relationship') reported having sex with multiple partners for a total of 75%.

A mental health provider we interviewed was not surprised that 19% of FTMs reported 'single and not dating.' He said that many of his clients take a "sexual timeout" during transition. (Key Informant #3, Mental Health Provider). However, of these nine respondents, only one of them was in their first year of transition. Regardless of time since transition, the difference between this sample and the one surveyed over ten years ago is striking. The 1996 study found that 66% of FTMs were either abstaining from sex or in a monogamous relationship. (Clements-Nolle et al 2001). The 2008 survey reveals a more sexually active sample with 19% of participants reporting abstinence and 15% reporting monogamy for a total of 34%.

One of the survey participants (2% of the total, or 3% of TMSMs) reported being HIV positive. Only 64%, however, had been tested in the last six months. As we conducted this research, we learned about various HIV positive FTMs in the Bay Area, and we also heard from FTMs who are partnered with HIV positive gay men. The Department of Public Health clinics treated twelve HIV positive FTMs between January and June 2008; we do not know, however, if all twelve are unique cases or if some or all of the visits are

[6] See Appendix ___ for a Glossary of Terms.

duplicate cases. We do know from medical provider key informants that they treat HIV positive FTMs.

Socioeconomic Demographics

Finding 3: FTMs as a whole are well educated, economically marginalized, underemployed, and have experienced perceived discrimination in housing and employment.

Similar to Good Jobs NOW! (Transgender Law Center 2006), an economic needs assessment of San Francisco's transgender communities, the survey sample reported high levels of education and disproportionately low levels of income and employment status. Over half, or 53%, the sample had a college or graduate school degree versus 45% of the 2000 San Francisco County general population, while two percent had an eighth grade education or less. (www.bayareacensus.ca.gov)

Slide 4

HIGHEST LEVEL OF EDUCATION	
College Degree	28%
Grad Degree	19%
Some College	19%
H.S. Diploma/GED	11%
Some Graduate School	6%
Other Ed	6%
Associates	4%
Some H.S.	4%
8th Grade or Less	2%

Slide 5

CURRENT EMPLOYMENT STATUS	
Part-time	28%
Full-time with benefits	26%
Student	17%
Full-time no benefits	15%
Out of workforce	15%
Other (specify)*	15%
On disability	13%
Self-employed	11%
Non-traditional workforce	9%

*Includes internships with benefits, leave without pay, and between jobs.

Slide 6

Individual Annual Gross Income, N=38	
Range:	$0-65,000
Median:	$20,000
Believe annual income is where it should be at this point (N=47):	9%
Believe they have been denied a job or fired due to TG-status (N=47):	53%

Slide 7

CURRENT HOUSING	
Rent	55%
Marginally housed	19%
Homeless	15%
Student Housing	4%
Live with family of origin	4%
Own	2%

Next to such high levels of education, FTMs' housing, employment and income reflect disproportionately high levels of underemployment and economic marginalization. Over 30% of the sample reported homelessness or marginal housing such as SROs, shelters and couch surfing. Similarly, the sample's median annual gross income is $20,000, more than $45,000 less than the 2007 estimated San Francisco median household income $65,500 and $23,000 less than the estimated 2007 mean per capita income of $43,000. (www.bayareacensus.ca.gov). As for employment, 26% hold a full-time job with benefits; 26% of the sample also engaged in sex work in the last twelve months and 32% have done sex work since transitioning to male.

When asked if they had ever lost or been denied employment due to their transgender status, 53% answered in the affirmative. Thirty-two percent report having their housing negatively impacted due to their transgender status, and 37% reported having been homeless since transitioning from female to male.

Social inequalities such as poverty and economic marginalization are established co-factors of HIV risk behavior among many at-risk populations. (Farmer, P 1996 *Int Conf AIDS.* 1996 Jul 7-12; 11: 38 (abstract no. Tu.D.581) Harvard Medical School, Boston, MA. Fax: (617) 661-2669). A unique aspect of the FTM population is that it seems to have the education necessary to overcome economic marginalization; this paradox of high levels of education and low levels of income suggests that stigma around gender identity and expression may be underpinning this economic marginalization.

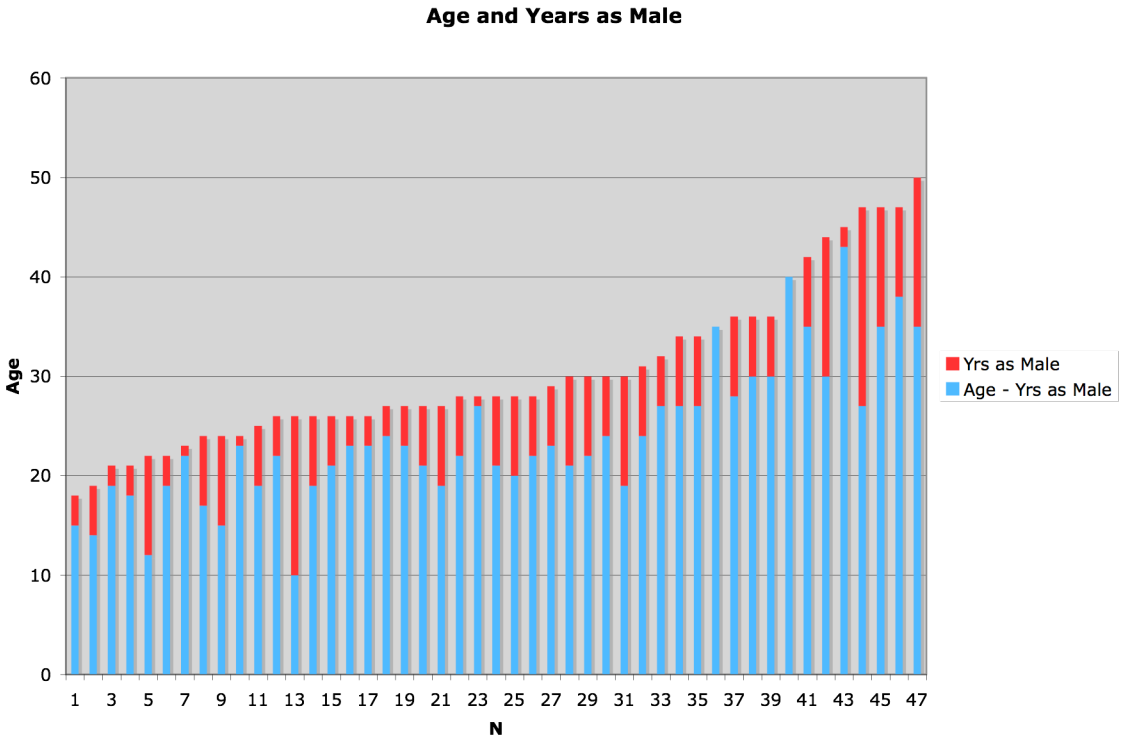
Age, Birthplace and Cultural Demographics

Survey participants ranged from ages 18 up to 50 years old (see Slides 8 and 9). The mean age was 30 and participants reported having identified and lived as male anywhere from one to sixteen years, with an average of eight years.

Slide 8

AGE
Age Range: 18-50
Mean: 30
Years living as Male: 1-16 years
Mean: 8

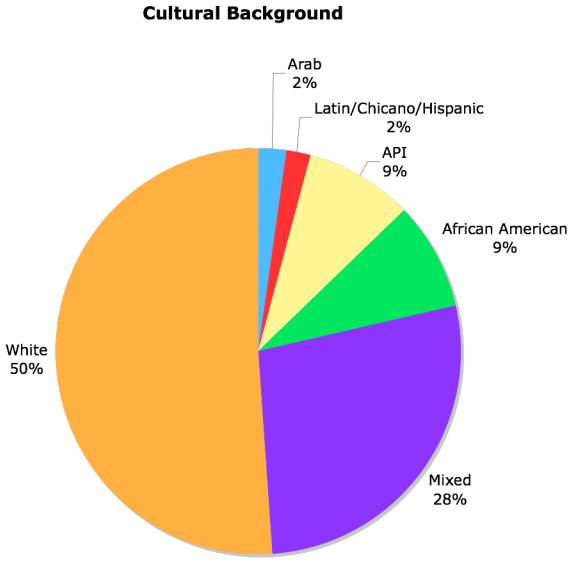
Slide 9 **Total Age (Red + Blue) and Years Living as Male (Red)**



Respondents were asked to choose the cultural identity with which they identified, and they could choose more than one category (see Slide 10). While 51% identified as Caucasian only, the remaining 49% identified as mixed or another cultural identity besides White; 28% identified as Mixed Race and chose more than one category, and much smaller numbers checked singular categories like African American (8.5%), Asian/Pacific Islander (API) (8.5%), Latino (2%) and Arab (2%).[7]

[7] See Appendix ____ to see the total breakouts of Cultural Identities; for example, 15% selected Latin/Chicano/Hispanic, but only 2% ID'd as only Latin/Hispanic. Similarly, 60% selected Caucasian but only 51% selected Caucasian only.

Slide 10



Slide 11

PLACE OF BIRTH/LEGAL STATUS	
Born in U.S.	85%
Born in CA	32%
Born in Bay Area	13%
Born in SF:	3%
Undocumented in U.S.	4%

As for place of birth, 85% of participants were born in the U.S., but only 3% were born in San Francisco. Of those born abroad, two out of seven are not documented to work in the United States. The general population of San Francisco consists of 37% foreign born and 63% born in the U.S. (www.bayareacensus.ca.gov). While we did not have the resources to outreach to foreign born FTMs, the small number of participants who reported San Francisco as their birth place may demonstrate the high levels of transgender migration to San Francisco from other parts of the state and country.

Country of birth aside, these demographics reflect a fairly diverse group in terms of age, cultural identity and place of birth. Although they do not mirror the city's overall demographics perfectly, the percentage of Caucasians, 51%, is consistent with the 2000 Census data where white San Francisco residents represent between 43%-50% of the population. (www.bayareacensus.ca.gov).

Focus Group and Key Informant Demographics

The focus groups had similar demographic characteristics as the survey at least along the few axes upon which they were polled. Among seventeen focus group participants, 45%

identified as Persons of Color (POC). Although we did not ask anyone directly, no one reported being HIV positive. Two focus group participants discussed having HIV positive partners currently and having had recent exposures. Similarly, some of our Key Informants discussed friends, clients and colleagues in the Bay Area who are HIV positive or are dating HIV positive men.

Table #1 FOCUS GROUP DEMOGRAPHICS, N=17

Focus Group	# FTMs	Age Range	% POC
#1	5	25-60+	80%
#2	7	22-40	14%
#3	5	21-26	40%

Table #2, on the other hand, shows a slightly different demographic in that 30% of the participants were not FTM. Persons of Color represented 30% of the key informants.

Table #2 KEY INFORMANT DEMOGRAPHICS, N=10

Realm of Expertise	#	% POC
Social Service Provider	3	33%
Medical Provider	3	33%
Community Leader	2	50%
HIV Positive FTM	1	0%
Partner of FTM (MSFTM)	1	0%

HIV KNOWLEDGE AND SEXUAL RISK BEHAVIORS

Finding 4: FTMs have HIV prevention knowledge and a low perception of risk; however, FTMs are engaging in high-risk sexual behaviors with high-risk partners and multiple partners.

The survey queried for several aspects of HIV knowledge and sexual behavioral risk-taking. Questions probed general knowledge around HIV risks as well as risks specific to them as FTMs. Additional questions covered a range of sexual practices, the contexts in which they occur, and the partners they have engaged with over the last twelve months. This discussion will focus only on questions around those sexual behaviors that put people at risk for acquiring HIV: 1) receptive anal sex, 2) receptive frontal sex (more traditionally understood as vaginal), and 3) receptive oral sex. Partners may include non-FTM males or MTF females (i.e. partners who were born with and still have what are traditionally understood as penises though they may identify as women or as transgender women).

As a cohort, the overwhelming majority (95%) believed their chances of having HIV at the time of survey were low to none. Similarly, 72% believe their chances of getting HIV are low to none, while 21% believe their chances are medium and 6% believe that their chances are high. Four respondents reported not knowing their current HIV status, while one reported positive status and the remaining 42 reported negative status. Sixty-four

percent had been tested in the last six months meaning that 36% may not know their true HIV status.

As a cohort, the sample scored very well on five of the nine true-false HIV knowledge questions (questions 95, 96, 99-101). There are four questions where the sample was more divided (questions 94, 97-98, 102). Twenty-three percent said that safer is sex is too difficult to practice all the time. Thirty-eight percent do not believe that unprotected oral sex with non-FTM males is very low risk for contracting HIV, and 32% do not believe that cleaning needles before sharing them can reduce chances of transmitting HIV. Finally, 11% said they don't know if FTMs who have sex with non-FTM males (TMSMs) are at much lower risk for HIV than MSMs, while 4% believed that statement to be true.

These results indicate a need for improved HIV and safer sex education as well as further research on the risks that are specific to TMSMs. While research has established that injection drug users who share needles can reduce one's chances of contracting HIV with a bleaching method, research has not been done around sharing and cleaning needles for hormone or silicon use. Similarly, research has not been done to establish the risks specific to TMSMs in relation to MSMs. More HIV education would improve FTMs self-efficacy around having safer sex as well as their knowledge around lower risk behaviors such as receptive oral sex with non-FTM males.

The most common source of HIV education among respondents is the Internet. More importantly, respondents reported that very little of available HIV information is specific to FTMs.

When asked directly, in an open-ended question, what respondents thought their greatest risks for HIV are, the most prevalent response was unprotected receptive sex, including anal and frontal. Others reported sharing needles in various contexts (e.g. during a relapse or getting a needle stick during BDSM piercing play), oral sex, casual sex, sex work, sex with non-FTM males, sex with multiple partners, and sexual assault as their greatest risks for contracting HIV. The survey followed this question by asking if and how respondents thought their risks were related to living as FTM. While sixteen respondents answered none or don't know, the next most prevalent answer had to do with low self-esteem and the inability to negotiate and assert oneself around safer sex with non-FTM male partners, who sometimes assume FTMs are at low risk for HIV because of their lack of a penis.

Also mentioned was a lack of FTM-specific information as well as having new partner choices post-transition (i.e. gay men in San Francisco where HIV prevalence among MSM is 24%). Two respondents named the effects of testosterone. One said that, having gone on and off testosterone, he was more likely to have unsafe sex while on testosterone due to his increased sex drive; the other respondent reported that testosterone makes him feel invincible with respect to STIs, HIV and pregnancy. Finally, one respondent answered that sexual violence was an HIV risk specific to living as FTM.

Slides 11 and 12 focus on the survey's questions around the riskiest sexual behaviors for HIV: 1) receptive anal sex, 2) receptive frontal sex (more traditionally understood as vaginal), and 3) receptive oral sex. Partners discussed include non-FTM males or MTF females; again, these two types of partners are discussed as the penetrating partner who have functioning penises that ejaculate such that if one has an MTF female partner who does not have a penis, the respondent would choose N/A for not applicable.

The data reveals that with non-FTM male partners, more respondents are engaging in frontal receptive sex than performing oral or receptive anal sex. While respondents are engaging in unprotected oral (51%), they are also engaging in unprotected frontal (33%) and unprotected anal (11%). Fifteen percent of the sample reported having eleven or more non-FTM male partners over the last twelve months with three persons reporting thirty or more partners.

Slide 11

RISK BEHAVIORS WITH MSTMs
OVER LAST 12 MONTHS
(N/A=Not Applicable)

Behavior	Always W/Barrier	No Barrier	N/A
Oral	6%	51%	43%
Frontal	26%	34%	40%
Anal	28%	11%	60%

Slide 12

HIGHER RISK PARTNERS
OVER THE LAST TWELVE MONTHS

Partner	Always w/Barrier	No Barrier	N/A
Male	11%	53%	36%
Paying Partner	9%	15%	75%
MTF	4%	13%	83%

Slide 13

NUMBER OF MALE (NON-FTM) PARTNERS
OVER THE LAST TWELVE MONTHS

Zero	32%
One	13%
2-5	30%
6-10	11%
11-19	9%
20-29	0%
30+	6%

The survey also asked where and how FTMs have found, or cruised for, their partners over the last twelve months (e.g. bars, sex clubs, parties, online, etc). By far, the most common mode of cruising among FTMs is online at 66%. The slide below shows that FTMs were as likely to be unsafe with those partners, presumably strangers, versus partners they have met through mutual friends, the second most common mode of cruising. These partners may reflect a range of genders.

Slide 14

MODE OF CRUISING
OVER THE LAST TWELVE MONTHS

Mode	Always w/Barrier	No Barrier	N/A
Online	28%	38%	34%
Via friend	13%	38%	49%

In an open-ended question, the survey asked respondents what factors keep them from using a barrier with male (non-FTM) partners. While some said they use barriers all the time for lower, receptive sex, others said being unprepared in the moment (including not being able to assert oneself) was the most common reason for not using barriers followed by the influence of drugs and alcohol, a driver of HIV transmission among all at-risk populations. (Colfax et al).

Focus group participants were not asked to disclose their personal sexual risk-taking behavior although some did. However, a number of themes consistent with the survey data emerged around why participants and their peers may be engaging in risky behaviors.

> **Finding 5: An overwhelming desire for acceptance, fears of rejection, and a negative body image while living amongst a body-centric gay culture, are perceptions that may propel FTMs to engage in risky sex.[8]**

Low Self Esteem and Fear of Rejection

Similar to Clements-Nolle's findings, all three focus groups emphasized a desire to be accepted among MSMs and how that desire drove them to engage in risky behaviors as a way to achieve that acceptance and avoid rejection. Some participants did not recognize that behavior as evidence of low self-esteem while others did. The following three quotes reflect some of these sentiments:

> "Just being in a place of low self-esteem you set yourself up to be self-destructive in lots of ways whether it's heavy drug and alcohol use, which of course is going to change your decision-making process or just kinda having an attitude like well, it doesn't matter--

[8] This finding, along with **Finding 6**, is more qualitative in nature in that it is a theme that emerged in the focus groups and key informant interviews.

> especially for guys who are like suicidal or really don't see too much hope in their future. There's just not a lot of reason to not take risks if you don't like your life anyways. (Focus Group #3 Participant)

> "When I moved to San Francisco, I had a boyfriend. And then when we broke up…he was like, "Well, I don't know if I can deal with your body…" So I felt like I had to validate my maleness and my masculinity, and my gayness. And I did that through having as much sex as I could possibly have. So it was like, every time somebody, every time I had sex with some guy, who like said, "I see you as male; I see you as gay; I see you as a sexual being; I see you as desirable," and those are all things that we all want and need…" (Focus Group #2 Participant)

> "I've been rejected multiple times because I don't have the right equipment…Um, but no I wouldn't do it without a condom if he outright said he was HIV positive. But if somebody told me he was HIV negative, and I know…that means shit. It does. I learned it in a really real way. So, um, so yeah, I would do it without a condom. I was going to do it a few times with this guy because I trusted him, and he was HIV positive. And he had the highest viral load ever because he contracted it less than a month before I met him." (Focus Group #1 Participant)

An overwhelming desire for acceptance, fears of rejection, and a negative body image while living amongst a body-centric gay culture, are all factors that propel FTMs to engage in risky sex. As with the Clements study, participants described a dissociative process from one's body parts perceived as female that may enable more risk-taking behavior. (Clements-Nolle et al 2001) Interventions may want to address more explicitly the meanings that TMSMs and MSMs attach to certain behaviors and body parts to destigmatize them.

Early Transition, Testosterone and Socialization

The focus groups and FTM key informants discussed the influence that testosterone has on FTM sex drives, particularly during early transition, and some acknowledged that it influences their risk behaviors. One said, "When I first started T, I didn't really care as much about--well, I wasn't as concerned about making sure I was safe as I was about making sure that I got sex because at that point that wasn't the biggest worry." (Focus Group #3 Participant)

Another participant likened early transition to puberty, a very vulnerable time for one's changing body and sense of self. He observed,

> "Everyone's got body issues [during transition]. Like, you might still feel really good about yourself, and your body may be like,

> almost how you want it, but…mixed with hormones, natural and like, shots or whatever, can make your shit crazy. And even if you think you feel great about yourself, like, the next second you can feel like shit. And if that second is when someone's about to fuck you, and that will make you feel better, then there's no real guarantee on how well you'll negotiate, even if you have all the skills—there is no guarantee on –if you'll even like ask someone what their status is, because they are going to make you feel a whole lot better about yourself at that moment." (Focus Group #2 Participant)

An FTM key informant also discussed how vulnerable FTMs are during the early stages of transition:

> "I think hormones contribute to risk taking. High levels of testosterone or early in the process of testosterone use when you're still learning to adjust to the feelings that brings on-- excitement, desire, opportunity and sometimes validation. You know, looking for validation, whether it's for a male or a female partner, it doesn't matter. You know, just the validation of being desirable." (Key Informant #7, Community Leader)

Another question raised, was what kind of impact testosterone has on the anatomy of FTM genitalia; that is, since testosterone changes the lubricating abilities in the genital region as well as a thinning of the vaginal walls, perhaps frontal receptive sex is riskier for FTMs on testosterone than has been established in the research regarding females. Given the relatively high number of urinary tract infections (UTIs) reported in the survey, more research is needed to determine increased susceptibility to infection. At least two of the medical providers discussed this susceptibility. One observed,

> "The reality is that after taking testosterone, the wall of their vagina is like a postmenopausal woman. So it's atrophic, which means that the lining becomes thin and smooth. There is less lubrication; so it's much more easy to damage. So, they're at greater risk for bleeding with penetration [and thus more susceptible to HIV if exposed]. In regards to thinking about HIV risk or other blood borne pathogens, it's a similar situation to the message we have been trying to get across to transgender women about their vaginas, in that you know you have to use a lot of lube and it's a very vulnerable area." (Key Informant #8, Medical Provider)

While focus group participants acknowledged a surge in sex drive and physical, sexual sensitivity during the early stages of their transition, at least two participants hesitated to attribute sexual risk-taking to testosterone. One participant explained that he wasn't a big risk-taker due to a significant amount of life experience:

> "I would imagine because I transitioned when I was older, relative to people I know…And so I think I had a pretty good understanding of myself, relatively speaking. I think when people are younger--this is what I see around me from very close friends, I think it kind of gets confused as to their orientation, what they want, what they don't want, what they're willing to do and not do for sex. And [testosterone] just kind of like enhances that for them. And I think for me it's a difference between wanting it versus acting on it. Finally I'm at a stage in life where it's a little bit easier to control. I don't have to act on everything I desire. Something I've learned." (Focus Group #1 Participant)

Another explained that many factors during early transition might contribute to risky behaviors that often are conflated with the powerful effects of testosterone:

> "There's a lot of other things happening too, and that's something I've really been looking at is when you say, "Oh it's because of the testosterone that I'm sexual or anxious or whatever it is," but there's all kinds of things happening at the same time we're starting testosterone. Our lives are changing, we're having to come out to the family, we're having to come out at work, we're having to make our way in the world differently. We're been seen differently for the very first time, and um, also we're starting to feel more in our bodies for the first time. So I think all those things contribute and we always just say the testosterone make these changes happen but there's so much happening when we are starting testosterone." (Focus Group #1 Participant)

While testosterone does increase sex drive, it is important to remember the many other pressures that come with early transition. These pressures may increase one's vulnerability to risk-taking: 1) rejection from or tension with family, intimate partners, friends, employers, work colleagues, 2) a changing relationship to one's body, and 3) being perceived in and moving through the world differently. Just as life experience is instrumental to building self-efficacy and assertiveness in general, resocialization is also instrumental to developing these skills as a man.

Youth, Invincibility and Survival

Besides the issue of resocialization, youth (ages 18-25 years) participants identified another trend that they have witnessed in their work with peers—a low perception of risk combined with a lack of information. One participant reported that many youth do not practice safer sex because they do not believe safer sex is commonly practiced. The youth participant himself attributes that commonly held belief to a lack of knowledge and information reaching them. (Focus Group #2 Participant) Another youth participant who works with peers said "There's no sense that [unsafe sex] will kill you, or that it's

dangerous…they're completely disconnected and just sort of wild and adolescent." (Focus Group #2 Participant)

Like young gay men, young FTMs may believe that they are more invincible to infection, and if they do seroconvert that access to medications will protect them from harm (Dilley et al 1997; Suarez et al 2001). Some youth who participated in our survey and focus groups differentiated themselves from their peers on the street, saying that those youth could not participate in this assessment because of their inability to meet their most immediate needs such as shelter, food and perhaps drugs or alcohol.

Our third focus group, which was made up of FTMs from 18-26 years of age, mainly echoed the first two focus groups and spoke of how they engaged in much more risk earlier in their transitions but did not articulate specific sentiments around invincibility. One spoke of actively using drugs and engaging in unsafe sex early in his transition and before he became sober. Another said his low self-esteem and high sex drive drove him on self-destructive paths, while others cited friends who used drugs and alcohol excessively and then put themselves at risk.

HIV Positive FTM on Unsafe Sex Behaviors

Although he no longer considers himself in his early stages of transition and lives stealth, the HIV positive FTM Key Informant discussed these vulnerabilities in relation to his seroconversion as a youth. He offered an analysis that de-emphasizes the lack of HIV information or lack of socialization and self-efficacy in gay culture; rather his testimony points to the vulnerabilities around the desire for acceptance among a community of gay men, in this case, HIV positive men:

> "I grew up helping my mother with the chicken soup brigade…and… picking out educational films for her because she taught medics in the military. I knew this shit from birth. It's like the worst thing that could have happened to me. I'd never had an STD before that in my life--like ever. I dated some positive people who were sometimes iffy about condom usage. I'd stop seeing them, go get tested, freak out. It was a slow, you know, de-evolution to not using condoms or being less scared about not using them." (Key Informant #10, HIV Positive FTM)

In fact, this key informant noted that he seroconverted as a youth via his HIV positive partner, an older HIV positive gay man with whom he was living at the time. Prior to living together, this FTM struggled to gain housing. He expressed the challenges around earning and saving money while living in the Bay Area:

> "There was nothing I could do to sort of get over debt. Every time I saved up money to move out of the North Bay…I would have like, the axel on my car blew. So I dropped a thousand dollars into that. Then the transmission blew, and I just said screw it, I've got

> a piece of shit car that I lived in for awhile…I saved up about a month's worth [of rent] and then my car died, just as I moved to Concord…and yeah, that's kind of been my story." (Key Informant #10, HIV Positive Youth)

Although he is no longer with his partner, the informant observed that he continues to struggle with safer sex behaviors.

> "It's like a coping thing. Here I am—lonely, horny, sad and HIV positive. Here's somebody else who is HIV positive and wants to have a really, really hot time and they don't like condoms, and they get tested and they have a partner and they don't play very often. You do all these things to justify it." (Key Informant #10, HIV Positive FTM)

This struggle may stem from persisting low self-esteem but is also situated firmly within a culture of HIV positive men who do not use condoms. While serosorting is good practice, this informant observed that serosorting with condoms is preferable as he is still very healthy, not on meds, and would like to resist new infections and HIV super-infection.

Lack of Community and Social Support

> **Finding 6: Social isolation is prevalent. FTMs have benefited from a sense of FTM community and peer-based support, such as mentorship, transgender clinic nights, and support groups, during early transition. Transitioned FTMs express wanting community outside trans-specific communities.[9]**

The survey did not focus on community and social support, but it was a topic discussed in the focus groups and among key informants. Social isolation was a major theme that emerged in the discussions. Focus group participants discussed how transitioning brought new forms of social isolation, alienation and racism. Participants expressed feeling alienated from the cultures with which they identify as men and how that alienation made them more willing to take risks in order to feel a part of that culture, even if it was a marginalized part of a culture, such as the barebacking or party-and-play gay subcultures. Key informants echoed focus group sentiments and observed that MSM organizations have not been very receptive to integrating TMSMs or MSTMs components into their programming despite many of the shared HIV risks.

It may make practical sense to integrate TMSM and MSTM issues and risk factors into MSM HIV prevention programming given several factors: 1) TMSM fit the behavior profile in that they are men having sex with other men, 2) the relatively small number of TMSMs relative to the total MSM population in San Francisco, and 3) many of the risks

[9] **Finding 6** is qualitative in nature and is a theme that emerged in focus group discussions and key informant interviews.

for HIV are parallel or directly linked due to the sexual relations between FTMs and MSMs.

One provider noted the difficulty in recruiting and retaining FTMs at transgender-focused organizations and said, "I kinda think that some of the gay organizations should start trans [inclusive] (sic) programs for men. Because…part of why we have a hard time is that some FTMs who have sex with men are more interested in finding a gay community than like finding a trans community." (Key Informant #1, Social Service Provider). One gay-identified FTM, who does not identify as trans openly, explained,

> "I'm not afraid of trans guys; I'm just not really focused in the trans culture. I'm not like genderqueer and queer-identified and going to queer youth groups and going to the tranny conventions and the tranny marches and the "Oh, look at me! I'm trans!" I've transitioned. Like, I'm done with it. It happens to be part of my life, but it's kind of like having a wart on your ass. I'm not going to join a wart-on-your-ass group…like it's just part of my body now and I've dealt with it and I've moved on." (Key Informant #10, HIV Positive FTM)

While FTMs expressed having some initially limited perceptions of gay community—for example, that having unprotected anal sex meant being a truly gay man--there are misperceptions that gay men have around TMSM and MSTMs.

> "There's this perception that FTMs aren't having sex with men in the gay community. So there's all these gay men that are like, "I don't know what you're talking about." But they're also the same guys who [FTMs] are having sex with. They're just not telling their friends…So it's a secret from our friends, and then it's a secret from our partner's community, and we don't have a community that supports us. So everything gets done secretly…It becomes more dangerous because you can't support somebody around it…" (Focus Group #2 Participant)

The MSTMs key informant also discussed a similar phenomenon where MSM organizations do not address the ways in which FTMs participate in sexual relations and risk behaviors with MSM/MSTMs. He noted,

> "There is a lot of fear. I still hear this; a lot of fear if we open up to that part [TMSM] of the community, then we're going to lose our identity as gay men…I bring up trans stuff every other meeting…You talk about diversity and that's not what [gay men] are thinking. But it's weird. I know other gay men around the table that play with trans guys--they're not shooting me down, thank god, but they're not…encouraging me to speak." (Key Informant #4, MSTMs)

The lack of social support with respect to TMSMs' participation in gay male culture reinforces less effective prevention efforts, and participants suggest that this lack of support actually encourages risktaking among FTMs in order to be more readily accepted as gay men. Research suggests that community-building efforts (i.e. that address and reduce stigma around MSTMs and TMSMs) may provide the extra support and stability that is needed to achieve behavior change that reduces one's risks for HIV (Hansen et al 2006).

Strategies for Safer Sex Practice

In addition to life experience as male, or more intentional resocialization, participants noted that having a primary partner was key to their reigning in testosterone's effects on their sex drive and early transition's influence on risk-taking. Participants even expressed gratitude for having been in committed relationships, both open and monogamous ones, during their first few months on testosterone as well as long after their transition.

> "I'm lucky that I was in a relationship during that first six to eight months. Yeah, because I wasn't really thinking about 'Oh, I got to go get another person.' I knew I'd be with her at least a couple times a week and I would take care of myself the rest of the time. If I had not had that, I might have been out of my mind to get that horny and not have an emotional connection at home or love. It's just a blessing that in the first years I was in a relationship." (Focus Group #1 Participant)

> "I realized that I'm in a partnership with somebody and part of being in a partnership is--I think if I wasn't in a primary partnership with somebody, I can imagine taking more risks." (Focus Group #3 Participant)

Focus groups discussed online cruising as the other major strategy for promoting safer sex behaviors. Although engaging in sex with strangers may seem inherently riskier, meeting them online first is a way to navigate disclosure of one's FTM status, establish HIV status, as well as negotiate safer sex practices without having to engage face-to-face and therefore avoid a more personal rejection.

Online cruising is also one method of socialization for FTMs especially given the difficulties in accessing gay culture. Participants discussed cruising the internet's gay sites such as Craigslist's MSM, Adam for Adam, Gay.com, and Manhunt as a means for finding MSTMs, and it's also a way for FTMs to access gay culture without immediately feeling self-conscious about their bodies or about not feeling accepted. Besides minimizing FTM stigma and MSTM stigmas, TMSMs' resocialization in the ways and means of MSM communities and cultures are the most effective way to improve self-esteem and self-efficacy around HIV prevention; online cruising reflects one readily available mode of resocialization and increased visibility despite being mediated via a computer.

DEPRESSION, SUBSTANCE USE AND HISTORIES OF VIOLENCE

> **Finding 7: FTMs may be experiencing significant levels of depression and are also using alcohol and marijuana and other drugs at high frequencies compared to the general population. Further research may be needed to investigate relationships between histories of violence, depression, and regular drug and alcohol use.**

The mental health section probed respondents for levels of depression, drug and alcohol use and histories of violence. According to CDC research, a number of factors contribute to high rates of infection among MSMs, including psychosocial problems like depression and illicit drug use (http://www.cdc.gov/media/pressrel/r020710.htm). While it is difficult to make any definitive conclusions on FTM participants' current mental health status, analysis of the data reveals that FTMs are less depressed than pre-transition. Nonetheless, high rates of depression, chronic substance use and histories of violence may persist and warrant further investigation.

Depression

The first part consisted largely of an abbreviated depression scale (see partial results on Slide 16) with six questions adapted from the Beck Depression Inventory, plus three new questions related to changes in outlooks/attitudes since transitioning. As Slide 16 indicates, as many as 30-50% of respondents may have mild to moderate levels of depression. However, it is also clear that over 75% of the sample say their outlook on life and comfort with their bodies have improved since transitioning (roughly the same percentage of respondents currently taking testosterone—70%). So, although significant levels of depression may be present among survey respondents, the depression seems to be less severe than pre-transition.

Slide 15

MENTAL HEALTH: DEPRESSION
"In the past two weeks I…"

Felt tired and had little energy
- 32% most of the time
- 43% occasionally

Had trouble staying focused on what I was doing
- 21% most of the time
- 55% occasionally

Felt uneasy, restless and irritable
- 30% most of the time
- 53% occasionally

Did not enjoy activities usually enjoyed
- 19% most of the time
- 30% occasionally

Felt sad, blue or down in the dumps
- 19% most of the time
- 53% occasionally

Felt like a failure
- 19% most of the time
- 51% occasionally

Slide 16

MENTAL HEALTH: DEPRESSION
"Since transitioning…"
79% say energy level has improved
83% say outlook on life has improved
83% say they feel more comfortable with their bodies

This data warrants further investigation into the relationships between depression, physical transition (including testosterone therapy and surgeries), non-physical/non-medical transition, as well as drug and alcohol use and histories of abuse. Major depressive disorder is associated with considerable morbidity, disability, and risk for suicide. Treatments for depression most commonly include antidepressants, psychotherapy, or the combination. Little is known about predictors of treatment response for depression for the FTM community. In a recent study of major depression among a general population, results suggest "psychotherapy may be an essential element in the treatment of patients with chronic forms of major depression and a history of childhood trauma." (Nemeroff, Heim, et al. 2003).

Providers are clear that high levels of depression are present. One observed, "…Lots of mental health issues. Um but if anything they get somewhat alleviated when they go on T and get worse when they go off. That's what [clients] say." (Key Informant #1, Social Service Provider) This provider also expressed concerns about a client who has tried to seroconvert by advertising online for sex with positive men.

> "I have one client who was trying to get HIV for awhile and he's like, um, he's very in the gay world and drug world and like everyone he knows has HIV, and it's really depressing because all his friends are dying…At one point…I know he was posting ads on Craisglist looking for barebacking from pos guys and having luck finding guys." (Key Informant #1, Social Service Provider)

It's not altogether clear that FTMs are reporting these kinds of symptoms to medical or mental health providers, however. A medical provider explained reasons why underreporting of symptoms may occur:

> "The other issue with trans men, as with men in general, is that there is tremendous underreporting of mental health problems, especially mood disorders, depression and anxiety…and part of it is, a lot of guys say, "I don't want to process," or people will tell me, "I didn't want to tell you because I thought you would take me off my hormones." But transition is hard for everyone." (Key Informant #8)

Parallel to resisting the reporting of physical complaints, FTMs may fear that their depression will become a reason for their providers to deny them testosterone or to take them off testosterone. At least one organization, Dimensions Youth Clinic, has considered this fear or mistrust around reporting mental health issues. The clinic explicitly offers individual and group psychotherapy, but therapy is not required to obtain care at this organization. While clients do not usually utilize the mental health services upon intake, they often do once they feel comfortable with the organization and have established trusting relationships with providers at the clinic.

Drug and Alcohol Use

The next part of the survey's mental health section asked respondents to list, if any, their top three current drugs of choice, including alcohol. This recreational drug matrix also asked respondents to list age at first use, frequency, amount consumed on average, and whether or not that drug had lowered their sexual inhibitions during consumption. Overall, alcohol and marijuana are the top two drugs of choice by far with 70% currently using the former and 51% currently using the latter on a regular basis. These numbers appear significantly higher than 2007 national averages established by SAMHSA (see Slide 17).

Slide 17

2007 SAMHSA National Averages vs. Survey Sample
Current Use of Select Drugs

	ALCOHOL	MARIJUANA
Age 18-25	62%	16%
Age 26-50	60%	4% (ages 26+)
	vs.	
FTM Sample (Ages 18-50)	70%	51%

'None' placed third, followed by a number of other drugs such as ecstasy, speed, cocaine, poppers, LSD, mushrooms, heroine and various prescription drugs (as well as caffeine and nicotine although we do not consider these recreational drugs).

It is important to note that the survey did not ask if the respondent was currently clean and sober, and the prevalence of 'none' along with 'caffeine' and 'cigarettes' may reflect men in recovery. For example, two survey participants informed us during our meetings that they were currently in residential treatment. A focus group participant also observed important relationships between drug and alcohol dependence, recovery and risk-taking behaviors:

> "I'm in recovery, and so most of my friends are also in recovery. And, so occasionally--well, actually, quite often--somebody will relapse, and so you'll have somebody out there who often times is like drinking and using excessively and then having unsafe sex

> along with it, you know? And a lot of them, that's the reason they chose to stop using, and then they go out and continue the behaviors once they start using again." (Focus Group #2 Participant)

Similarly, another participant discussed the vulnerabilities that emerge when chemical dependency replaces mental health treatment and services:

> "I have a friend who seems to not really take care of themselves and does really compulsive things--and uses excessively and drinks excessively and then will meet people really drunk and not disclose the information that they're trans and then go home with them and then sometimes experiences, um, a lot of transphobia. One time he went with a cop in his cruiser without telling him…that he's trans, and when the cop brought him to the motel room and took his clothes off and was like, "What the fuck?!" And, apparently, he was really angry." (Focus Group #3 Participant)

Likewise, drinking is a way to enable dissociation from one's body and the stigma regarding oneself as FTM. Another participant explained, "I've seen a lot of drinking but I'm not so much sure about other stuff. I think a lot of parties are sort of pre-parties where [FTMs] sort of drink to the point where they either have the confidence or enough distance from themselves. And then things can happen." (Focus Group #3 Participant) Key informant #5, a medical provider, also confirmed that his HIV positive FTMs have reported that drug and alcohol use contributed to their having unprotected sex.

One participant noted that issues of substance abuse, mental health and risk behaviors may disproportionately impact Communities of Color due to lack of services available or appropriate to them. He said, "I live in a neighborhood where I see people sexually active that are affected by mental illnesses and affected by, and these are People of Color, affected by mental illness, substance abuse, you know, um, lack of services, lack of resources, you know, who basically play Russian roulette every time they have sex." (Focus Group #1 Participant) While this phenomenon in some ways parallels the experiences of FTMs, transgender Men of Color may feel the impact of both trends.

Histories of Violence

Similar to the Virginia Statewide Needs Assessment, survey respondents revealed extraordinarily high rates of sexual and physical violence in their past:

Slide 18

HISTORY OF VIOLENCE
68% have been physically assaulted
66% pre- transition, or pre- and post- transition
2% post- only
62% have been sexually assaulted
60% pre- transition or pre- and post- transition
2% post- only

Two providers noted that they think queer youth are more likely to be targeted by sexual predators. One attributed that pattern to the fact that trans youth are somewhat titillating as gender non-conforming. (Key Informant #8, Medical Provider) Another sees the phenomenon as evidence of abuse of power differentials,

> "…I think that queer people are definitely targeted or queer children targeted by older folks who know that they are queer already and target them specifically because of that. So I think that there are large numbers of adults like trans and queer adults who have been survivors of sexual abuse because they were targeted as queer children." (Key Informant #9, Social Service Provider)

Besides being targeted by predators, queer kids do not always receive the affirmation they seek at home with their primary caregivers and may suffer abuse by their primary caregivers. This lack of affirmation may motivate them to seek affirmation from less trustworthy adults.

According to the CDC, sexual violence is linked to many negative health behaviors such as drug and alcohol abuse and risky sexual behaviors (CDC.gov, Sexual Violence Fact Sheet 2007). Focus group participants spoke very openly about the impact that sexual abuse has had on their behaviors and their becoming men. They discussed the various approaches in which they have dealt with the presence of low self-esteem, PTSD, dissociation, hyper vigilance and concerns about identifying with the gender of their perpetrator (although in at least one case, a participant's mother was the perpetrator). Approaches included compulsive sex and drug and alcohol use as well as less destructive ones such as therapy, processing with mentors, and using BDSM techniques in their sex practices and relations. One participant summed up the relationship between abuse and negative health and sexually risky behaviors:

> "…I definitely--I used to have a really terrible, shall we say, addiction to having sex with guys knowing that it was going to be unsafe and knowing they were likely to be positive. And that was like a big secret I wouldn't tell anyone about. And obviously there's like a community of that. And I definitely learned with therapy, through use of therapy, there was a connection to abuse." (Focus Group #2 Participant)

Another participant discussed how transition and reconnecting with his body also increased his vulnerability to risk taking. Prior to transition he was not as connected to his genitalia, and so he did not use it in many ways, but transition changed that. He explained:

> "I'm somebody who's been abused, but my body started opening up after transitioning. Of course that's going to make me be more prone to be engaging in "risky behaviors" with guys…right? …Because I'm now in the world so differently, and I'm opening

> my body up in a new way, it's going to make me want to open it up more, you know? There's some kind of letting go and that letting go can involve risk." (Focus Group #1 Participant)

FTM survivors of abuse may rediscover their sexuality after transitioning in unexpected ways and are perhaps unprepared to keep themselves safe. Participants discussed how as a survivor one might not have a strong sense of boundaries, self-esteem or assertiveness. One participant observed the impacts he sees sexual and physical violence having on his peers:

> "With sexual abuse, it's weird because reactions are unpredictable. Some people are going to be more self-destructive, or the issue of boundaries isn't there for a lot of folks in the sense of needing or having boundaries. Um, so just that alone makes it really easy to give in if the partner wants to have unprotected sex, or like having compulsive sex as a way of dealing with that…I definitely know a guy who for awhile, especially right after he was assaulted, who was really, really promiscuous and not super safe." (Focus Group #3 Participant)

While histories of violence do not necessarily translate into adult depression, anxiety, promiscuity, and drug and alcohol dependence, the high levels reflected in the survey data combined with the focus groups' discussion of the interdependences warrant further investigation and perhaps intervention.

HEALTHCARE COVERAGE AND ACCESS TO QUALITY CARE

Finding 8: Overall, local FTMs have healthcare coverage at levels somewhat comparable to the general population, but FTMs are accessing hormones without medical supervision and are sharing hormone needles and syringes.

Despite economic marginalization, FTMs are accessing healthcare. Most have access through either public or private forms of insurance, while 30% report having no coverage (see Slide 11). Similarly, 28% had not seen a primary care doctor in the last year.

Slide 19

HEALTHCARE COVERAGE	
Private Insurance:	36%
Public Insurance:	32%
No Coverage:	30%

More respondents are currently taking testosterone (79%), the primary mode of physical transition (vis-à-vis gender reconstructive surgeries) among the sample, than currently have medical coverage (68%). One explanation for this gap is that two of the transgender clinics, St. James Infirmary and Lyon-Martin, are not fully funded by the city and accept uninsured persons without requiring enrollment into Healthy San Francisco. Some

uninsured are accessing city-funded clinic services but may not have enrolled in Healthy San Francisco, the city's public coverage, at that point.

Among those currently taking testosterone, 41% report accessing testosterone without a prescription at some point, fourteen of whom reported accessing it from friends and the other three reported accessing it in Mexico. Three of the respondents also reported having shared needles or syringes in order to take their testosterone.

Slide 20

TESTOSTERONE THERAPY	
Testosterone (T) Ever	85%
Ever Obtained T without a prescription	41%
Ever shared hormone needles/syringes	8%
T Current	79%

All but one of the focus group participants had never been on testosterone and, like the survey participants, noted accessing it through their providers at the transgender clinics and their private providers. The focus groups, however, mainly discussed the ways in which testosterone contributes to changes in risk behaviors as well as the possible anatomical changes that increase vulnerability to transmission.

San Francisco is remarkable in its capacity to offer a range of transgender-related medical care and cover more and more procedures and medications for those who do not have private insurance. There are at least four clinics that offer primary care, including hormone therapy, for transgender persons—Lyon-Martin, Tom Waddell, Dimensions, and St. James Infirmary. Depending on one's income, each offer programs to help cover the costs of services, tests, and medications at a sliding scale or at no charge.

> **Finding 9: Providers, both public and private, and FTM consumers need to develop more effective mechanisms and tools to discuss as well as address sensitive issues around primary care, particularly sexual health.[10]**

While levels of coverage are encouraging overall, participants expressed various concerns around access to culturally competent providers. On the survey cultural competence is primarily defined as knowledgeable about and sensitive to transgender persons and transgender-related healthcare. Not surprisingly, 89% of survey respondents agreed that discussing their TG status and TG-specific healthcare needs with their provider was important. However, only 68% said they were comfortable doing so, and the same percentage thinks that their provider is knowledgeable about the subject.

[10] This finding stems from the qualitative focus group and key informant interview data where providers and FTM participants alike expressed some frustration around very inconsistent treatment experiences due to a lack of mechanisms (e.g. appropriate intake forms, language and training to make care and treatment more effective).

Similarly, focus group participants discussed having to shop around for culturally competent providers within the systems of care, especially private systems. "I remember when I first started going to Kaiser, before I found my miracle doctor. I really missed going to Tom Waddell like crazy…because you don't have to advocate and explain everything." (Focus Group #1 Participant)

In contrast, participants expressed the relative comfort they feel when utilizing the public clinics that offer transgender services and some of them on nights specific to transgender clients only. "I like going to Dimensions and like, you know, being able to do everything at once and no one cares." (Focus Group #2 Participant) Similarly, one said, "I had good experiences at Lyon-Martin. Transguys are one of their specialties." (Focus Group #1 Participant)

Another participant explained how he has been fortunate to have his pediatrician continue to see him for primary care while he also uses Dimensions for hormone therapy since his pediatrician did not feel comfortable managing it:

> "I've been pretty lucky with my doctors. I still see the doctor who was my pediatrician. So, he knows about the whole process and I've gone to Dimensions for hormones and gyno things. I just had a consultation with a surgeon for top (surgery) today. And, um, because of my family history, I'll probably be able to get it covered by insurance. And she said she'd advocate for me and write to the insurance company." (Focus Group #3 Participant)

Although this participant's experiences with his private provider in the East Bay are positive, the lack of cultural competence and efficacy with regard to transgender-related healthcare among Bay Area private providers may be adding stress to the public health system in San Francisco.

Although they feel comfortable utilizing the city's TG clinics, participants observed that the clinics often seem overwhelmed with clients. One noted,

> "I had a doctor who was sort of like, she just seemed so overburdened by me. I was like, it's time for my annual and she was like, "Can't do it today. Can you come back in? No, I will reschedule you," and like I kept on going and going and she could like never see me." (Focus Group #2 Participant)

Another participant added that not only is the system stressed by volume, it also occasionally shows signs of needing more regular staff cultural competency training.

> "One thing that sounds really familiar to me about Tom Waddell is the feeling that they are overwhelmed…And that they feel like it's up to them to prioritize between you and the five million other

> people outside…In addition to that, my experiences were wrong pronoun all the time." (Focus Group #2 Participant)

Besides the pronoun issues, other participants as well as medical providers emphasize that FTM patients' concerns or complaints are sometimes dismissed by medical providers as "due to your being trans." One focus group participant reported:

> "I was having this weird headache, a chronic headache, and she… gave me the whole, 'Oh it's because your trans line.' It was like, 'Lets adjust your testosterone dose and see if that helps.' I was like, 'No we tried that last time, and it didn't make a difference. I still have this headache,' and she was like 'Well I don't know, maybe you're stressed out,' and I was like, 'Actually I'm pretty relaxed, unless I come here.' Anytime I have a headache it's because I am trans, and that's why I was like, I'm out of here, but then when I went to [another provider], who I love, he was like, 'Oh, that sounds disturbing, lets get you a CT scan, lets get you an MRI,' and that's when they were like, 'You have this cyst on your brain.'" (Focus Group #2 Participant)

Two key informant medical providers echoed some of these concerns around medical providers tendency to dismiss FTMs' medical complaints as due to their transgender hormone therapy or the simply the stress of living as transgender. One observed,

> "I think, you know, [FTMs] get a lot of, 'You're having these problems because of your testosterone.' I had a patient who was traumatized by a cardiologist who kept taking him off his testosterone because his cholesterol was high, instead of treat your cholesterol, you know? Testosterone is not likely doing it. You know, I think medical providers tend to see someone on testosterone, they're not used to seeing trans people. They freak out, and they say it's because of your testosterone." (Key Informant #8, Medical Provider)

Besides providers' tendency to attribute health problems to hormone therapy, key informant providers and focus group participants identified communication barriers that may arise between FTMs and their primary care providers. This barrier emerges for at least two reasons. First, newly transitioning FTMs are encountering an entirely new set of experiences and do not necessarily have the language or self-efficacy yet to navigate and discuss them. Second, providers want to respect their FTM patients' privacy, and they too may experience a discomfort with available language. A provider noted:

> "I think we're reluctant to ask too many details about people's sexual activity because, I think people are overly respectful in terms of not wanting to embarrass people because you're talking about their genitals, and they might be uncomfortable with them,

> but they don't know what to call them…[Providers] don't know what to call them because everyone has [particular] names for their parts." (Key Informant #8, Medical Provider)

Another provider says he and his clients discuss their sexual health all the time. He says that a sense of humor often eases the discussion:

> "What I do is say, 'Well you know,' or even that ethos of 'Now I'm a gay man; I have to deal with this.' 'You're right and you know what gay men your age have now? I know you look like you're 14 but, you're in fact 32, and so gay men your age have figured out that they're worth negotiating condoms for.'" (Key Informant #5, Medical Provider)

This absence of language and efficacy around sexual health is a considerable barrier for anyone to experience, whether provider or consumer. However, for a newly transitioned FTM who possibly has little to no social or community support, marginal housing and income, and a very new sexual life as a transgender man, it is imperative that medical providers and FTM consumers develop effective ways to discuss and address sexual health. Research has shown that increases in STIs, particularly gonorrhea, may signal an increase in HIV seroconversions (Katz 2003). With 30% of the sample reporting STIs in the last year, more effective care as well as informational materials can help prevent STIs as well as the progression of untreated STIs, including UTIs. Untreated STIs compromise the immune system, increase one's susceptibility to HIV, and can be fatal.

Slide 21

STIs IN THE LAST 12 MONTHS	
69% had none	
30% had one or more STIs:	
UTIs	8 cases
Chlamydia	7 cases
Gonorrhea	3 cases
Herpes	3 cases
Hepatitis C	2 cases
Syphilis	2 cases
Warts	2 cases
Molluscum	1 case
BV	1 case

Another participant observed, beyond his good doctors, the shortcomings he's experienced at Kaiser around access, communication and sexual health:

> "I've had some weird--like I have good providers at Kaiser, like I have a really good doctor and I have a really good OBGYN person, but then it's everything else. It's the waiting room. It's the

> person who takes your blood and does your weight. The person you have to call--I had a UTI-- and they and every single person I talked to, from the nurse on the phone to the person who roomed me, to the person who took my blood, to the pharmacist, nobody believed I had a fucking UTI cause they were like you can't have a UTI with a dick. And I was like, I have a UTI, and they were like no you don't, and I'm like yes I do." (Focus Group #2 Participant)

While UTIs are not necessarily sexually transmitted, focus group participants agreed that, generally, UTIs and sexual activity both tend to increase with transition. Testosterone, and all the physiological changes that it brings may be a contributing factor to the increase in UTIs. Nonetheless, barriers exist around having UTIs tested and treated effectively.

Another participant related his story around UTI testing and the confusion that often emerges during the visit:

> "I went and got my test for a UTI and the provider was really great. She's really smart; we had a really nice time. And then I went back for my result and this jackass doctor runs in and asks me what I was there for and I was like, I don't know I'm getting my result. We talked about Non-Gonococcal Urethritis for a little bit, and then he ran out and ran back in and was like, "Wait! What do you have? And I was like I don't know, that's why I'm here; I need my result. "No, do you have a penis?" And I was like "Ah, you need to sit down. I am already sitting down; you can't talk to people like that." (Focus Group #2 Participant)

While the participant had both positive and negative interpersonal experiences with the two providers who worked with him, a lack of adequate documentation around the patient's particular case (i.e. that his anatomy differs from typical male genitalia) as well as a lack of training around appropriate and respectful communication may have made the difference.

Similarly, guys reported facing confused providers when seeking standard STI/HIV testing at local clinics. One said,

> "And when I went the provider was like, "Why are you here?" And I said I am having sex with a partner, who is having symptoms today, and so we're both here, you know, getting tested. And she was like, "Alright. Well," and she started asking me questions about my balls and stuff like that, and I was like, "Nope, no balls." I was like "I'm trans. It says so in my chart. I also wrote it on the intake form before I came in, and talked to the receptionist. So, you should know." She was like, "Oh-I-I-um-I do pediatrics," I

> was like, "Okay." She was like, "I've never been at this clinic. I've never met a transperson." (Focus Group #2 Participant)

Another discussed how the invisibility of FTMs at the gay men's clinic kept him from accessing services following an exposure to HIV:

> **"…**With my HIV scare I ended up going to Magnet, and I've gone to City Clinic a few times but they weren't very cool…but I lied at Magnet actually. Usually I'm out, but I didn't feel right at Magnet saying FTM. I told them I was a bio guy because when I started filling out their form, they have transgender but it's totally MTF. I was like, 'Fuck this!' I'm not going to start out explaining--I'm already scared shitless that I'm HIV positive." (Focus Group #1 Participant)

An intake form that makes room for treating all MSMs, including TMSMs and MSTMs, allows providers and clients to dialogue more openly and clearly. A more nuanced intake form makes testing, diagnosing and treating more effective, and beyond directly improving access to testing, the simple presence of this acknowledgment raises awareness around the diversity of MSMs that seek testing; this increased visibility among and inclusion with other MSMs may help lessen the perceived stigma associated with FTM bodies among MSMs.

Focus group participants cited problems beyond communication barriers with their providers. A common complaint concerns the all-female waiting rooms at Kaiser and San Francisco General when seeking routine, gynecological care. One explained, "It's a terrifying thing when you walk into a gynecologist's office, and they call your name." (Focus Group #1 Participant). Another participant elaborated:

> "It stops me from going to get a pap smear, which I need. And it stops me from doing the health stuff that I really need to do because physically I really need to have those things done and not have to feel shame about it." (Focus Group #1 Participant)

Many focus group participants related stressful interactions occurring at the intake desk of gynecological departments where staff often does not believe they have appointments for exams. As a result, unwelcome attention is drawn to the unnecessarily prolonged interaction. Following this interaction is the very uncomfortable wait amongst babies, pregnant women and females who, after hearing the prolonged interaction at the intake desk, are wondering why a man is waiting to see their provider. This barrier to access basic primary care and essential preventive procedures like pap smears poses a great health risk to FTMs. Regular pap smears, according to one medical provider, as part of routine primary care has been instrumental in reducing rates of cervical cancer which, by and large, is caused by the human papillomavirus (HPV), a sexually transmitted infection that, when diagnosed internally, signals a possible exposure to HIV as well via unprotected sex.

The last significant complaint participants voiced pertains to doctor and provider visits beyond the scope of primary care—often doctors who are much farther from cultural competency than their primary care providers. For example one participant related feeling like a transgender guinea pig when seeking physical therapy:

> "One time I was going to a physical therapist to get work on my knee and being FTM came up, and so they were like, "We have some residents here who like [it] if they came in and asked you questions," and I was like, "Sure." So they came in, you know? Sometimes it's like that, where it's random and you're put up for random education." (Focus Group #3 Participant)

Another participant noted that what typically determines whether or not he will see a doctor outside primary care, is whether or not he'll have to remove his clothing. (Focus Group #1 Participant) Having to confront providers' discomforts and do education under these circumstances induces much anxiety and deters him from seeking care.

Some participants expressed fear around having to go to the emergency room where everyone, including the FTM seeking care, is somewhat unprepared for the stressful interaction. One participant felt like the persistent lack of awareness and knowledge of FTMs, and the fact that the hospital had two different records for him, confused all the providers and staff and made the visit very chaotic:

> "My sex partner is HIV positive. And so what happened was we started having sex with a condom on and the condom slid off and both me and him thought maybe it might have, but neither of us stopped to actually check. You know, it was in the middle of things, and so I went in to the Emergency Room to get Post Exposure Prolaxis (PEP) after that happened. And so they kept switching doctors and each doctor that I went to I would have to explain that--eventually they'd be like "Wait are you transgender?" and I'd be like "yeah." and they'd be like "Ok," and they'd just assume that I was male-to-female. So, that was creating some interesting questions and some interesting confusion. And they were wondering why my insurance through Healthy Families wasn't like covered, and it's because it wasn't like matching up with what they had on file." (Focus Group #3 Participant)

Limited access to culturally competent care often correlates with a higher risk for HIV as well as other costly and preventable factors like emergency room visits. From primary care at the transgender clinics to the emergency rooms at local hospitals, some structural mechanisms, like improved intake forms, more trainings, an FTM-oriented lexicon and set of protocols around sexual health, may greatly reduce some of the barriers to treatment that emerge while seeking services. While FTMs may not be engaging in unsafe sex in the same ways or with the same frequencies as MTFs or MSMs, they are

engaging in unsafe sex practices with multiple high risk partners. Limitations around current modes of data collection, however, prevent us from knowing accurate rates of HIV prevalence among TMSMs and FTMs in general. More broadly, the data paints a picture of a set of syndemic effects, such as economic marginalization, high risk sexual behaviors, high rates of substance use, lack of culturally competent testing sites and a lack of community and social support, that could result in a surge in seroconversions (Stall et al. 2003).

LIMITATIONS

A drawback of a rapid assessment is that it limits the recruitment of the "hardest-to-reach." For example, our recruitment and survey was conducted only in English; with more time and money, we would definitely conduct Spanish and/or Tagolog and Cantonese versions and provide appropriate translations. Another factor impacting the assessment data and findings was our decision to seek institutional research board (IRB) approval. Given the time-consuming nature of the approval process, we had to eliminate the possibility of recruiting from vulnerable populations such as youth under age eighteen, incarcerated FTMs, among other hard-to-reach FTMs, as such research can take months for approval.

The HIV positive segment of the FTM population may be more difficult to reach within the assessment's rapid time constraints due to stigma around HIV positive status, distrust of research, or not identifying as FTM. Moreover, the reliance on participants' self-report of HIV status rather than a survey/trial design that incorporated HIV testing of participants also limits the data. For example, 36% of the survey sample had not had an HIV test in the last six months and may not actually know their true HIV status.

RECOMMENDATIONS: FTM HIV PREVENTION AND EARLY INTERVENTIONS

In order to intervene and address these cofactors, or syndemic effects, this assessment recommends a strategy of HIV prevention and early intervention that focuses on the greatest area of risks observed in our assessment, TMSMs. The following recommendations address these risks from various levels—individual, community, structural and organizational-- and from various perspectives—TMSMs, MSTMs, and related providers.

1) Integrate TMSM and MSTM HIV prevention counseling, testing and prevention protocols into MSM programs. With over 60% of the sample having sex with men and multiple partners in the last year and over 55% living and working as stealth FTMs—i.e. living as men and not "out" as FTM, prevention programming should target the sources of risk behaviors directly and in ways that affirm and make visible the risk behaviors and cofactors occurring with and between TMSMs.

   Several providers suggested that having unprotected sex with men was the greatest risk engaged, combined with stressful cofactors such as low self-esteem, economic marginalization, and lack of knowledge among providers concerning gender identity, specific risks and sexual behaviors. These issues may best be addressed openly and visibly in provider settings accessed by both FTMs and

MSMs and raise awareness around specific risks. Focus group and key informant participants expressed that the lack of public, transgender visibility at the sites of or awareness on the part of MSM providers and among MSM in general directly impacts their ability to feel safe and respected when seeking services but also impacts their self-esteem in that this invisibility carries over and is reinforced by a broader invisibility in gay culture.

Specifically:

A) Establish a committee of TMSM and MSMs/MSTM providers who can establish, oversee and consult on the following processes.
B) Deliver regular cultural competency trainings (perhaps via computer module followed by live trainings) at testing clinics, particularly Magnet and City Clinic, although AHP and Kaiser were also named as places where testing was difficult to access. More transgender staff may also improve care.
C) Revise intake forms and counseling and testing protocols to address TMSM issues and risks (see also #3).
D) Develop provider-client sexual behavior lexicon for aforementioned providers as well as transgender clinics. Both providers and FTMs expressed having difficulties and challenges discussing sex, sex work and sexual behavior with FTM clients.
E) Develop HIV prevention interventions that openly address TMSMs within MSM HIV prevention interventions. These interventions, like those for MSM, should be sex positive, emphasize wellness and other assets, address body issues and associated risks, and emphasize the development of safer sex negotiation skills, such as assertiveness, and self-care skills. These interventions should also address the limitations of sero-sorting with casual partners and associated risks with sero-discordant coupling.
F) Develop HIV prevention interventions with positives that incorporate TMSM issues and risks into the intervention.
G) Develop HIV prevention interventions that address stigma around TMSM and MSM—locating a common ground and addressing different kinds of stigma at once (e.g. social marketing print/video/youtube campaigns).
H) Develop and disseminate safer sex information and materials at testing sites and transgender clinics as well as other establishments where TMSMs and MSMs congregate.

2) FTM youth from 18-25 need additional social support beyond increased capacity and recognition among MSM providers.
    A) Increase/expand linkages to GED programs and City College.
    B) Increase job-training programs.
    C) Increase mechanisms for informal and formal peer mentoring.
    D) Increase safe and affordable housing options.
    E) Increase access culturally competent mental health and substance use/recovery providers
    F) Develop HIV prevention interventions that stress wellness, self-care, self-efficacy, skills building around communication, assertiveness and safer

sex negotiations (at Dimensions for example). These interventions should also address the risks around sex work too.

G) Develop community-driven social marketing campaigns that raise awareness and address stigma around FTM/transgender issues and risks particular to youth.

H) Increase youth representation on the SF DPH Transgender Advisory Group

3) Address the data/epidemiology conundrum perhaps with more research/trials around HIV and STD testing; SF DPH is not unique in its challenges around tracking or collecting data on this population and therefore cannot establish HIV incidence or prevalence rates or STD incidence or prevalence rates. SF DPH in conjunction with community members can lead the way in establishing a consistent, safe and explicit way for providers to collect this data with greater effectiveness. The survey sample reported the need to have culturally competent HIV testing providers and establishing FTM presence on the intake and data collection forms is a fundamental step toward achieving that.
4) Conduct further research around mental health, depression, substance use low self-esteem and how they may be impacting risks for HIV.
5) Consider coverage of transgender-related surgeries under Healthy San Francisco. Providers emphasized how much self-esteem and quality of life improves after clients, who want it, have top surgery. Participants emphasized the kinds of risks they took in order to save enough money to finance the procedures. Homelessness, sex work, and foregoing expensive education costs were all named as ways FTMs managed to save enough money for surgery.
6) Consider coverage (further research may be needed) of mental health services under Healthy San Francisco. Participants named low self-esteem, a negative body image as well as histories of violence as reasons for engaging in risks such as sex work, promiscuous/anonymous sex, and regular drug and alcohol use.