

The Washington, DC Transgender Needs Assessment Survey

Final Report for Phase Two:

Tabulation of the survey questionnaires;
Presentation of Findings and
Analysis of the Survey Results;
and Recommendations

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*In memory of Tina Teasley, Pat Hamilton, Jean Robinson-Bay, Sparkle Maharis,
Jeffrey Pendleton, Tyra Hunter and many others no longer with us,
who dared to express a different gender in the District of Columbia*

II. Executive Summary

The Washington, DC Transgender Needs Assessment Survey (WTNAS) is a project implemented by US Helping Us – People Into Living, Inc. and funded by the Administration for HIV/AIDS, Department of Health of the District of Columbia Government. It was conducted during the period September 1998 to May 2000 in two phases: design and development of the data collection instrument; and administration of the survey and analysis of the data.

The primary goal of the Washington Transgender Needs Assessment Survey (WTNAS) is to provide the first quantitative evaluation of the health and housing needs and concerns of the transgendered residents of the District to Columbia. This analysis will allow the District Government, community-based social service organizations, and AIDS Service Organizations to specifically target and thus better allocate intervention services for transgendered people in need. The survey evaluates self-reported HIV prevalence, knowledge, testing and sexual risk behaviors. It also examines what services are currently being accessed by transgendered people, the quality of those services, the sensitivity of service delivery staff to transgendered clients, what barriers exist to accessing existing services and what services are still needed.

The WTNAS employed a snowball sampling technique with an added financial incentive. Key members of individual transgender subpopulations were asked to become Survey Administrators. All participants were known to the Survey Administrators through their work in HIV/STD outreach efforts conducted by several different ASOs or CBOs located in the District, their memberships in individual transgender support groups, and their social networks. Eligibility for participation in the survey was open to anyone who was visibly Gender Variant, a resident of the District of Columbia, and willing to sign Informed Consent. Gender Variant was defined to include those who live or want to live full-time in a gender opposite their birth or physical sex; those who have or want to physically modify their bodies to match their internal gender identity; and those who wear the clothing of the opposite sex in order to fully express an inner, cross-gender identity.

A total of 263 questionnaires were collected from September 11, 1999 to January 31, 2000. Duplication was prevented by the use of an acrostic as a unique identifier for each participant. Subtraction of duplicated and incomplete/inconsistent questionnaires produced a final n of 252.

Participants range in age from 13 to 61, with nearly 80% 36 years and under. Seventy-five percent report being born anatomically male, 24% female and 1% intersexed. Over 94% are of color, with nearly 70% African-American and 22% Latino/a. Eighty-four percent are U.S. citizens, and 20% have immigrated to the U.S., mostly from Latin American countries. The majority of the participants self-report their sexual orientation as Gay (65%), their gender identity as Transgender (69%) and their relationship status as single (69%).

Forty percent have not finished high school, and only 58% are employed in paid positions. Twenty-nine percent report no source of income, and another 31% report annual incomes under \$10,000. Fifteen percent report losing a job due to discrimination from being transgendered. Forty-three percent of the participants have been a victim of violence or crime, with 75% attributing a motive of either transphobia or homophobia to it.

Almost half of the participants (47%) do not have health insurance, and 39% do not have a doctor whom they see for routine health care. Ratings of accessed regular health care services with regard to their quality and sensitivity to the participants as transgendered individuals range from Good to Excellent, but the numbers reporting indicate a low level of overall access. The most common barriers to accessing regular medical care reported are lack of insurance (64%), inability to pay (46%), provider insensitivity or hostility to transgendered people (32%), and fear of transgender status being revealed (32%).

With regard to transgender-related care, 52% have taken hormones at some point in their lives, and 36% are currently taking hormones. Only 34% report that a doctor monitored their blood levels while they were taking hormones, and 58% have acquired hormones from friends or on the street. Over 90% of those currently taking hormones state they plan to continue taking them for the rest of their lives. Quality and sensitivity ratings of accessed transgender care services are also good to excellent, but again indicate low overall access. The most common barriers cited are inability to pay (48%), not knowing where to obtain service(s) (37%), health insurance not covering the service(s) and provider insensitivity or hostility to transgendered people. Knowledge of the Benjamin *Standards of Care* for hormonal and surgical sex reassignment is very low for participants (less than 10%) and also low for their doctors (42%).

Thirty-four percent of the participants feel their drinking is a problem for them, but only 36% actually sought treatment for it. Thirty-six percent feel they have a drug problem, but only 53% sought treatment for it. Thirty-five percent report experiencing suicidal ideation, and 64% of them attribute it to their gender issues. Of those with suicidal ideation, 47% report they have actually made attempts to kill themselves – 16% of the entire sample.

The most commonly-reported sources of information about HIV and AIDS for all participants are HIV seminars, workshops and focus groups (22) doctor's offices (12%) gay and lesbian bars or nightclubs (11%) and schools (11%). Of those who are not HIV positive or who do not know their HIV status, nearly forty percent report being tested within the last six months, and a third report a testing frequency of every six months. However, 18% report never being tested.

Twenty-five percent of all participants report being HIV positive, with 53% report being negative and 22% who do not know their HIV status. Thirty-two percent of the Male-to-Females (MTFs) report being HIV positive. Seventy percent of the seropositive participants were diagnosed more than two years ago, and two-thirds believe they became infected with HIV through unprotected sex with non-transgendered males. Only 8% of the seropositive participants report encountering barriers to receiving HIV/AIDS services. The most common inaccessible service is hospitalization (3 cases), and the most common barrier cited is provider insensitivity or hostility to transgendered people (3 cases). Quality and sensitivity ratings of accessed transgender care services are also good to excellent, with somewhat higher overall access levels than regular or transgender-related medical care.

In the sexual risk behaviors assessment, the highest rates on a lifetime basis ("have you ever...") are in the risk categories of Unprotected Oral-Genital Contact (77%), Unprotected Genital-Genital Contact (67%), Unprotected Oral-Anal Contact (43%) and Unprotected Genital-Anal Contact (42%). In some categories, the rates also remain high on more recent time scales (i.e., Within the Last Year or Within the Last Month). The top three reasons given by those who admit to unsafe behaviors are they trusted their sex partner (41%), their partner(s) appeared to be healthy (36%) and they didn't know there was a risk associated with the behavior (25%).

In the housing assessment, 81% have their own living space, and 75% feel safe in their living spaces, but 13% did not feel safe. The most common barriers cited by those who lack housing are economic situation (38%), housing staff insensitivity or hostility to transgendered people (29%), estrangement from birth family (27%) and lack of employment (23%). In the participant's self-perceived needs assessment, the top three most important and immediate needs are housing, employment, and HIV-related care.

In evaluating the findings, the following conclusions are most significant:

The transgender population is radically different from MSM communities, due to such factors as the negative impact of per capita rates of discrimination and violence on educational, employment and housing opportunities; the negative impact of transphobia and trans-ignorance on health care access; the urgent need of transgendered people for access to transgender care; and the impact of gender identity issues on education and prevention. The latter includes the invisibility of transsexual men; negative body issues; the influence of self-perception of sexual anatomy through gender identity; and the impact of changing sexual anatomy over time.

Many socioeconomic factors in the transgender population negatively impact access to all forms of health care and housing. Unemployment rate is 42%; 40% have not finished high school; 29% have no income and 31% have incomes of under \$10,000/year; 47% lack health insurance; and 43% report being victims of violence or crime. The most common barriers to all care types are economic situation, lack of insurance, failure of insurance to cover care, caregiver insensitivity or hostility to transgendered people, and fear of their transgendered status being revealed. Only 26% of the participants are satisfied with their current living situation, with employment, hostility and insensitivity of housing staff and other residents as the most common barriers to housing.

The high overall HIV prevalence rate of 25% (32% in MTFs), along with the high numbers who report unsafe sexual behaviors, demonstrate a population at a significantly high, immediate risk for HIV/AIDS and other STDs. According to the HIV Prevention Community Planning Committee's *Three Year Plan for 1999-2002*, only Black Male IDUs show a higher overall prevalence rate (27%) amongst District at-risk populations. Twelve percent of the WTNAS participants report unprotected sex while doing sex work as a reason for having unsafe sex, and of those 72% were HIV positive. Two-thirds of the seropositive participants believe they became infected with HIV by having unprotected sex with non-transgendered men. It is likely that the MTF seropositive participants represent a significant HIV vector for men who have sex with MTF transgendered people (note that these men should not be considered "MSMs").

With regard to alcohol and drug abuse co-factors, 46% of the participants report having sex while drunk or high (on a lifetime basis), and 22% admit to drug use as a reason for having unsafe sex, along with 9% who had unsafe sex to obtain drugs. These figures correspond to the 34% and 36% who admit a problem with their alcohol use or their drug use, respectively. However, only 36% of those with alcohol problems and 53% of those with drug problems have sought treatment for substance abuse.

A desperate population, which may be seen in its high suicidal ideation rate of 35%. Of those with suicidal ideation, 64% attribute it to their gender issues and 47% report they had actually made attempts to kill themselves – 16% of the entire sample.

Intervention services are not only appropriate but urgently needed. Accordingly, the Principal Investigator makes the following recommendations:

A paradigm shift is strongly recommended, in order to facilitate effective prevention methods specifically targeted at transgender subpopulations. **The establishment of a Gender Variant (GV) category separate from MSMs must** be carefully considered.

The development of HIV/STD education and prevention materials specifically targeted at transgendered people is an immediate and pressing need. As with other populations, effective prevention materials must be culturally-appropriate and sensitive to transgender subpopulations.

Transgender outreach efforts must be continued and should be expanded to include additional transgender subpopulations, especially Latino/a and FTM groups.

Creative solutions to housing difficulties of transgender people should be explored, including the establishment of transgender-only housing units, floors in existing housing facilities, lockable rest-room or separate wash-room facilities if necessary, and additional training for staff of assisted housing agencies.

The development of a pilot program for transgendered people in the District's vocational rehabilitation system should be planned in conjunction with the appropriate DC Government agency, along with sensitivity training for its personnel.

The implementation of educational programs for medical providers about transgender care, and transgender sensitivity and awareness in-service programs for the staffs of ASOs, social service CBOs, substance abuse treatment facilities, and housing agencies should be made a permanent part of their regular in-service training.

The establishment of a local clinical program for hormonal sex reassignment and transgender-related care, with careful monitoring of blood levels during hormone administration, and provision of transgender-sensitive gynecological care for transsexual men and women.

The development of educational programs for transgendered people about transgender care. Health education plays a key role by empowering transgendered people to become informed consumers of transgender-related care. These programs would help transgendered people become more informed about their bodies and sexual anatomy, the risks involved in transgender-related care, the procedures and treatment options available to them, and their rights as consumers under the Benjamin *Standards of Care*. This would increase their likelihood to seek greater access to transgender care, which would impact positively on their overall health. Successful resolution of incongruent gender identity and somatic states should reduce the impact of negative body issues that lower self-esteem and create opportunities for high-risk sexual behaviors and substance abuse. Such in-reach programs also present excellent opportunities for additional efforts to raise awareness about HIV/AIDS and its prevention.

III. Overview

Washington, DC has the highest AIDS rate in the United States – 143.4 persons per 100,000 population, versus 17.1 nationally – a rate more than eight times the national average. Almost 9,000 people in the Washington metropolitan area are living with AIDS, and an estimated 14,000 to 17,000 others are infected with HIV. To their credit, the different communities of Washington, both straight and gay, have organized themselves to undertake the necessary steps of building public awareness through educational efforts to decrease transmission of HIV and other sexually-transmitted diseases.

As efforts towards fighting HIV/AIDS have increased, public resistance towards frank discussion of alternative sexual practices have decreased. Groups that were once socially stigmatized have become more visible, better organized, and also recognized by public and private funding sources formed to assist the struggle against HIV. However, one group remains a notable exception: the transgendered community of Washington.

Transgendered people represent perhaps the most heavily stigmatized, socially marginalized and with regard to HIV/AIDS, underserved at-risk population within the District of Columbia. Until recently, with the exception of some notable, courageous individuals like Tina Teasley and Jeffrey Pendleton (both deceased), there has been little in the way of organized effort by openly transgendered persons to advocate for research, education and prevention, cultural sensitivity training, and outreach efforts within the District of Columbia. The traditional way of dealing with transgendered people at risk or living with HIV/AIDS appears to be an approach which simply places them into the same educational and prevention categories and modalities as men having sex with men (MSM).

However, this report will document the significant ways in which the transgendered community of Washington is radically different from the various MSM communities. Previous prevention efforts targeted at male-to-female transgender populations that have been based upon the commonality of existing (birth) genitalia are inherently flawed and should be abandoned. In combating HIV/AIDS in other at risk populations, the importance of cultural competency and sensitivity of HIV/STD service providers and culturally-appropriate education and prevention materials have been repeatedly cited as determining factors for success.

Although the direct action group Transgender Nation – Washington has been active since 1994, protesting transphobia in the media and the negligence of the DC Fire Department in the death of transgendered resident Tyra Hunter in 1995, it was not until the 1996 formation of Transgenders Against Discrimination and Defamation (TADD) that the District was fully made aware of its transgendered living with AIDS population. Serving on the District's HIV Prevention Community Planning Committee, TADD co-founder Dee Curry educated the city government and its AIDS Service Organizations (ASOs) about the needs and concerns of transgendered people living with AIDS. Earline Budd of the HIV Community Coalition, as well as the Principal Investigator of this report, were both active in educating the various social service community-based organizations about the needs and concerns of transgendered people. However, advocacy for services to meet the needs of this largely underground community has proven to be a daunting task, for several reasons.

Transgendered residents of the District seem to comprise a somewhat small community. There is actually not one community, but a collection of different sub-populations, each with its own priorities and challenges. They are divided principally along the lines of race, class, gender

vector, gender transition status, and the degree of openness with regard to being transgendered – all factors which create obstacles to open, collective advocacy for HIV prevention and other health services.

Gender vector describes the direction of gender and/or physical sex change transpeople take, i.e., from female-to-male (FTM, or F2M) or from male-to-female (MTF, or M2F). Taken alone, the prior socialization experiences of the two gender vectors are, in varying degrees, sufficient to foster gendered differences which are not conducive to concerted activism, in a manner similar to those differences between non-transgendered men and women. *Gender transition* is the process by which transgendered people begin to live full-time in a gender different from their physical sex. It is vaguely analogous to coming out as gay, lesbian or bisexual, only much more complex, due to its unconcealable saliency, physical transformation requirements, and extensive psychosocial readjustment.

To non-transgendered people, the myriad terms and labels that transgendered people use to identify themselves can appear to be ill-defined, confusing, and sometimes contradictory. The term 'transgender' itself is a purposefully vague umbrella term for a diverse group of gender variant identities that includes transgender itself, transgenderist, transsexuals, crossdressers (the preferred term in lieu of 'transvestite'), intersexed people (formerly, hermaphrodites), Doms (dominant lesbians), passing women, some (but not all) drag queens and drag kings, and many others. *Gender Variant* refers to those who cannot or chose not to conform to rigid cultural norms for their gender, as based upon their physical sex. Transgendered people are usually visibly gender variant in the ways they express their gender, identify themselves and live their lives.

As with MSM populations, cultural differences along race, ethnic and class lines are to be expected, and there also are many visibly gender variant gay, lesbian and bisexual people who do not use the term transgender to describe themselves. Although self-identification is an important personal right, in many cases it has hampered efforts at local and national levels to build effective coalitions for social change from the various transgendered constituencies. It also can cause some researchers to omit significant members of transgender or transgender-appearing populations from their research efforts. In order to avoid this pitfall, the Principal Investigator has used *Gender Variant (GV)*, as a catch-all term analogous to MSM, which may become more popular in the future in describing these populations.

Regardless of their actual sexual orientation, transgendered people are almost always misperceived to be the gendered extremes of gay men and lesbians. Moreover, they are unfairly stigmatized by the media and public, and considered to be mentally-disordered, classified as such by the American Psychiatric Association in its *Diagnostic and Statistical Manual (DSM)*. Thus they face intense, societally-imposed, gender-based oppression in the form of discrimination in employment, housing, public accommodations and health care, as well as intimidation, harassment and violence, including physical and sexual assault, and murder.

Fear of this oppression and stigmatization, coupled with the societal marginalization from lack of employment and educational opportunities, drives most transgendered people underground. The closeted majority of transgendered people, mainly heterosexual male crossdressers, are episodic in their transgendered behaviors and pass as non-transgendered heterosexual men. Even the visible minority who live or want to live full-time in a gender different from their physical sex seek to gain passing privilege. Passing as a member of the non-transgendered majority affords transgendered people physical safety and relative freedom from gender-based oppression. Unlike other forms of privilege which are bestowed at birth,

passing privilege can be gained by successfully accessing the various medical technologies that many transgendered people use to modify their bodies to attain congruency between their internal gender identity and external somatic state. Once passing privilege is gained, most will assimilate into the non-transgendered population. But accessing these expensive technologies – which are typically excluded from most health insurance plans – often becomes a function of class and race, which may explain why transgendered people in the suburban support groups seem to access them far more frequently than the urban participants of this survey.

Those who live openly but lack passing privilege are extremely vulnerable to discrimination and violence. Denied traditional educational and employment opportunities, many transgendered people become socially marginalized and turn to crime to support themselves, or to substance abuse to ease their many hardships. While some transgendered activists decry them as stereotypes repeatedly used by the media to maintain stigmatization, transgendered sex workers do exist and are thought to be a significant though largely unmeasured vector for HIV and other STDs. Their means of survival makes them remote, underground and difficult if not impossible to study.

Perhaps the most significant barrier to the provision of health care and social services to transgendered people is the lack of research. The social stigma discourages both public and private funding of research into gender variance, thus maintaining the status quo of oppression. But another hidden factor greatly inhibits research about HIV education and prevention in transgendered populations. Many transgendered people exhibit a general reluctance to discuss having sex in any form, either alone or partnered. Unlike gays and lesbians, whose same-gender sexual relationships define them as both identities and as communities, the sexual practices of both MTF and FTM transgendered people remain largely unexplored. Frank discussion about sex is rare, especially within MTF transgender support groups, probably due to a combination of factors such as homophobia, internalized transphobia, still-resident competitive natures from prior male socializations, lingering shame issues with regard to the autoerotism and self-feminization fantasies inherent in male-to-female crossdressing, and persistent discomfort with and even hatred of their incongruent sexual anatomy. This reticence makes any study of transgendered sex practices very difficult.

Thus transgender residents of the District of Columbia constitute a difficult to define, heavily stigmatized, socially marginalized and multiply-divided population, that live under the aggregating oppressions of gender, race and class. The combined impact of all these factors has prevented not only successful advocacy for health care and social services but also any definitive research. Add the mortality and morbidity brought on by HIV/AIDS and other STDs, substance abuse, malnutrition, violence, homelessness, chronic mental health issues like depression and gender dysphoria – *and you see perhaps the single-most desperate population in the District*. With any other visibly-identifiable population, response by public and private health and social-service agencies would be immediate. However, the effectiveness of such a response is necessarily dependent upon hard data – which is the primary purpose of the survey and this report.

IV. Sampling Methodology

The primary goal of the Washington Transgender Needs Assessment Survey (WTNAS) is to provide the first in-depth analytic evaluation of the health and housing needs and concerns of the transgendered residents of the District to the District Government, community-based social service organizations, and AIDS Service Organizations. This analysis will allow them to

specifically target and thus better allocate intervention services for transgendered people in need. While some previous studies have focused on transgender sex workers, who represent a potentially significant HIV vector, it was deemed more important to do a survey that reflected the needs, issues and concerns of the transgender population of Washington as a whole. Moreover, socioeconomic concerns such as their lack of employment, educational and housing opportunities due to discrimination; barriers to accessing general and transgender-related health care; and the effects of violence are postulated as major factors impacting directly on their HIV status, safer sex practices and their access of both HIV education and prevention services and HIV-related care. Given the likelihood of all these interrelated, basic life issues, a comprehensive assessment was considered to be entirely appropriate.

Determination of eligibility presented a challenge, due to the diversity of self-definitional terminology used by gender variant people to identify themselves. Rather than limit participation to only those who identified themselves as transgender, it was decided to open eligibility to anyone who was visibly Gender Variant and a resident of the District of Columbia. Gender Variant was defined to include those who live or want to live full-time in a gender opposite their birth or physical sex; those who have or want to physically modify their bodies to match their internal gender identity; and those who wear the clothing of the opposite sex in order to fully express an inner, cross-gender identity. Signed informed consent to participate was the only other eligibility requirement.

The WTNAS was regarded by the members of the organized transgendered community of the District as a potent local community empowerment initiative. Accordingly, the Principal Investigator sought to involve as many transgendered residents of the District as possible, as both survey participants and also as Survey Administrators. Since transgendered people often are denied work at professional levels due to discrimination and stigmatization, the WTNAS presented a significant opportunity to improve the skills of its transgendered Survey Administrators and demonstrate their potential as social service workers.

The WTNAS used a snowball sampling technique with an added financial incentive. The Principal Investigator identified key members of individual transgender subpopulations and asked them to become Survey Administrators. All of the WTNAS Survey Participants were known to the Survey Administrators through their paid and volunteer work in HIV/STD outreach efforts conducted by several different ASOs and CBOs (community-based organizations) located in the District, their memberships in individual transgender support groups, and their social networks. Including the Principal Investigator, there were a dozen trained Survey Administrators. Ten identified themselves as transgendered, and seven were of color. All signed Confidentiality Statements assenting to their safeguarding of the privacy of all WTNAS participants. Ultimately, nine were involved in successful data collection.

After obtaining signed informed consent from each and every participant, the Survey Administrator coded the acrostic (a unique identifier for each participant, which was used to prevent duplication). Each participant would then complete the questions, either by having them read to them directly (in the majority of cases) or by filling it out themselves. If the participants completed the questionnaires themselves, the Survey Administrator would then perform quality control, which consisted of checking the questionnaire for omitted, ambiguous or inconsistent responses. Participants were paid \$10 for their participation in the WTNAS. The Principal Investigator then met with each Survey Administrator in person to receive the completed surveys, informed consent forms and *Participant Payment Records (PPRs)*. Omissions and lapses in Quality Control were brought to the immediate attention of the Survey Administrators

by the Principal Investigator, and any administration issues were discussed prior to the Survey Administrators receipt of payment. The Survey Administrators were paid \$15 for each completed questionnaire returned to the Principal Investigator. A separate *Financial Report* provides detailed accounting and documentation for all WTNAS expenditures.

V. WTNAS Chronology

Phase One of the project began in September 1998. The survey questionnaire was designed, circulated for review, pilot tested and revised. The final version of the questionnaire consisted of 57 questions divided into four sections on demographics; general and transgender-related health care; HIV/AIDS-related care, testing and sexual risk behaviors; and housing. To capture data on the sizeable numbers of gender variant people who were Hispanic, the survey questionnaire was translated into Spanish. Phase One was completed with the delivery of the final draft questionnaire in January, 1999. In Phase Two of the project, the questionnaires were distributed and the data compiled and analyzed, with the results presented in this report, along with recommendations.

Distribution and administration of the WTNAS questionnaires began on September 18, 1999 and ended January 15, 2000. Data collection for the WTNAS ended January 31, 2000, and all outstanding questionnaires were returned to the Principal Investigator within two days of that date. **A total of 263 questionnaires were collected** from September 11, 1999 to January 31, 2000. The total length of the data collection period was 20 _ weeks or 143 days. Data from the questionnaires were then entered into spreadsheet tables using Microsoft EXCEL during which a second round of intensive quality assurance was performed, in order to identify data inconsistencies, incorrectly coded acrostics, and duplicated questionnaires. A total of three (3) questionnaires were identified as having been completed by the same person (i.e., duplicated) and another eight (8) questionnaires were discarded because they were grossly incomplete, missing key fields, or contained inconsistent responses. Removing these eleven questionnaires left the WTNAS with **a final sample of 252 participants**. The EXCEL tables were imported into SPSS 6.1 for the Power Macintosh, which was used to produce the data tables for all variables. Note that the tables presented in the Findings below are composite aggregates of multiple variables. For tables representing all individual variables, or for data referenced but not presented in tabular form below, see the Appendix.

VI. FINDINGS

Demographics

The 252 participants of the sample population range in age from 13 to 61, with a median age of 27. (Youth participants were interviewed mostly at the Sexual Minority Youth Assistance League, with the full cooperation the agency). One hundred and eighty-eight (75%) were born anatomically male, 60 (24%) anatomically female, and four (1%) were intersexed. The predominant gender identity of the participants is Transgender (69%), while 65% self-report their sexual orientation as Gay (65%). The majority (69%) report their relationship status as single. Over 94% of the participants in the sample were of color (either African-American, Latin American, Native American, or biracial/multiracial) with nearly 7 out of 10 African-American (see Table 5). English is the most commonly-spoken language (76%), followed by Spanish (13%). Twenty-three of the participants (9%) are bilingual, with twenty (8%) bilingual in English and Spanish. Baptist is the most commonly-reported religion (45%), followed by Roman Catholic (23%). (See Table 1 for basic demography).

VARIABLE	RANGES OR RESPONSES	FREQUENCY	PERCENT
AGE RANGE	13 to 24	99	39.3
	25 to 36	102	40.4
	37 to 48	41	16.3
	49 to 61	10	4.0
GENDER IDENTITY	Transgender	174	69.0
	Woman	37	14.7
	Man	32	12.7
	Androgynous	2	0.8
	Questioning	1	0.4
	(other not listed)	6	2.4
PHYSICAL SEX AT BIRTH	Male	188	74.6
	female	60	23.8
	intersexed - assigned female	2	0.8
	intersexed - assigned male	1	0.4
	intersexed - not assigned	1	0.4
RACE	African American	175	69.4
	Hispanic-Latino/a	55	21.8
	White	11	4.4
	Native American	4	1.6
	Biracial	3	1.2
	Multiracial	1	0.4
	(other race not listed – not API)	3	1.2
LANGUAGE	English	192	77.1
	Spanish	32	12.9
	Bilingual	23	12.9
	Asian Language	2	0.8
SEXUAL ORIENTATION	Gay	164	65.1
	Bisexual	33	13.1
	Lesbian	29	11.5
	Heterosexual	11	4.4
	Don't Label	6	2.4
	(other not listed)	5	2.0
	Queer	3	1.2
	Asexual	1	0.4
RELATIONSHIP STATUS	Single	173	68.7
	Monogamous	54	21.4
	Married	22	8.7
	(other not listed)	2	0.8
	Polyamorous	1	0.4

Table 1: Age, Gender Identity, Physical Sex at Birth, Race, Language, Sexual Orientation and Relationship Status (n=252)

Forty percent of the participants report they have not finished high school. The educational levels of the other participants vary from 28% being High School Graduates or possessing a High School GED, to 6% being College Graduates and another 6% with Graduate or Professional Degrees. Only 58% of the sample report working in a paid position.

VARIABLE	RESPONSE	FREQUENCY	PERCENT
EDUCATION	Some High School	87	34.5
	High School Graduate	57	22.6
	Some College	40	15.9
	College Graduate	16	6.3
	Graduate or Professional Degree	15	6.0
	High School GED	14	5.6
	Elementary	13	5.2
	Tech Degree	5	2.0
	Some Grad School	4	1.6
	None	1	0.4
WORK STATUS	Working	145	57.5
	Not Working	99	39.3
	Unpaid Volunteer	7	2.8
	(no response)	1	0.4

Table 2: Education and Work Status (n=252)

Among those employed, 57% hold a Single Full-Time Job and 33% a Single Part-Time Job. The highest number of employed participants (38%) work in the service industry, followed by private sector office workers (15%), as shown in see Table 3.

VARIABLE	RESPONSE	FREQUENCY	PERCENT
EMPLOYMENT STATUS	Single Full-Time Job	83	57.2
	Single Part-Time Job	48	33.1
	1 Full-Time and 1 Part-Time Jobs	6	4.1
	Multiple Part-Time Jobs	3	2.1
	(no response)	5	3.5
JOB CLASSIFICATION	Service Industry Worker	55	37.9
	Private Sector Office Worker	21	14.5
	Non-Profit CBO Worker	14	9.7
	Artist	14	9.7
	Private Sector Professional	13	9.0
	Government Worker	8	5.5
	Sex Worker	8	5.5
	Factory/Manufacturing Worker	6	4.1
	Skilled Laborer	5	3.4
	Teacher	1	0.7
	(other job type not listed)	4	2.8

Table 3: Employment Status and Job Classifications (n = 145)

Forty-two percent are either unemployed or working only as an unpaid volunteer. The most common barriers to employment (Table 4) are being a Full-time Student (33%), Discrimination based upon Transgendered Status or Gender Variant Appearance (26%), and self-reported Disability (23%). Six of the eleven who report Other as a work barrier specify their lack of job skills as a barrier to employment. Of the 24 participants citing disability, 14 are receiving either SSI or SSDI while 5 have applied and are waiting to receive it.

WORK BARRIER	FREQUENCY	PERCENT
FT Student	35	33.0
Transgender/Gender Variance Discrimination	28	26.4
Disabled	24	22.6
(other work barrier not listed)	17	16.0
HIV-related Discrimination	3	2.8
Immigration Status	1	0.9
FT Homemaker	1	0.9

Table 4: Barriers to Employment (n=106)

Another measure of employment discrimination asked if participants had ever lost a job due to being transgendered. Fifteen percent respond that they had lost a job due to being transgendered, and another 8% were unsure. Underemployment and lack of employment are significantly reflected in the income question (Table 5). Twenty-nine percent report no source of income, and another 31% report annual incomes of under \$10,000. Thirteen participants report dependents, with a median number of two.

INCOME LEVEL	FREQUENCY	PERCENT
No Source of Income	73	29.0
\$1 to \$5,000	32	12.7
\$5,001 to \$7,499	37	14.7
\$7,500 to \$9,999	10	4.0
\$10,000 to \$12,499	12	4.8
\$12,500 to \$14,999	14	5.6
\$15,000 to \$19,999	16	6.3
\$20,000 to \$24,999	17	6.7
\$25,000 to \$29,999	19	7.5
\$30,000 to \$34,999	7	2.8
\$35,000 to \$39,999	4	1.6
\$40,000 or More	8	3.2
(no response)	3	1.2

Table 5: Income Levels (n=252)

Eighty-four percent (212) of the participants respond they are U.S. citizens. Twenty percent of the participants have immigrated to the U.S., mostly from Latin American countries, with the majority from El Salvador (18) and Mexico (9). The number of years spent in the U.S. varies from 1 year to 41 years, with a median of 10.5 years, and the majority (68%) are from urban areas in their native countries.

According to the Gender Public Advocacy Coalition, violence against transgendered people has reached pandemic levels. Accordingly, the WTNAS questionnaire contains a section patterned after the standard form used by the participating organizations of the National Coalition of Anti-Violence Programs (NCAVP) to report bias-related crimes committed against gay, lesbian, bisexual, and transgender persons, as well as Persons living With AIDS. However, not only bias-specific but all types of crimes and violence were included, and participants also were asked to ascribe motives to them. One hundred and nine participants (43%) report they have been a victim of violence or crime. Table 6 provides a breakdown by NCAVP type, with percentages of the entire sample shown. Note that most of the 109 participants experienced multiple incidents of different kinds.

VIOLENCE OR CRIME	FREQUENCY	PERCENT
Harassment	66	26.2
Intimidation	44	17.5
Assault with Weapon	43	17.1
Simple Assault	39	15.5
Robbery	35	13.9
Sexual Assault/Rape	34	13.5
Burglary/Theft	27	10.7
Vandalism	11	4.4
Police Entrapment	6	2.4
Police Sweep	5	2.0
Unjustified Arrest	5	2.0
Blackmail/Extortion	5	2.0
Abduction	4	1.6
(other violence/crime not listed)	2	0.8
Bombing	1	0.4

Table 6: Violence/Crime Classifications (n = 252)

Standard NCAVP categories for self-perceived motives also were used. The 109 participants who fell victim to violence or crime were instructed to check any and all categories of motives they thought applied to their experiences. Table 7 shows the motives and percentages of the total (109).

MOTIVES	FREQUENCY	PERCENT
Homophobia	45	41.3
Transphobia	37	33.9
Don't Know Motive	30	27.5
Economic Gain	22	20.2
Domestic Violence	11	10.1
Racism	9	8.3
(other motive not listed)	5	4.6
Civil War	3	2.8
HIV-related	2	1.8
Disability	0	0.0

Table 7: Perceived Motives Among Those Who Experienced Violence or Crime(s), (n = 109)

Regular Health Care

Almost half of the participants (47%) report that they do not have health insurance, and 39% report that they do not have a doctor whom they see for routine health care. Fifty-seven (43%) of the 132 participants with health insurance belong to a health maintenance organization (HMO). Table 8 shows the types of health insurance coverage of those who have it.

TYPE OF INSURANCE	FREQUENCY	PERCENT
Private Insurance Through Employer	51	38.6
MEDICAID	49	37.1
MEDICARE	17	12.9
Private Insurance - Self-Paid	12	9.1
(no response)	3	2.3

Table 8: Types of Insurance Coverage (n = 132)

Only 9% report they encountered barriers to accessing regular medical care, and the most common barriers they reported are No Insurance (64%), Couldn't Afford It (46%), Caregiver Insensitivity or Hostility to Transgendered People (32%), Fear of Transgender Status Being Revealed (32%), Insurance Failed to Cover It (23%) and Lack of Transportation (23%). The types of inaccessible regular medical care services are shown in Table 9.

TYPE OF CARE	FREQUENCY	PERCENT
Annual Phys Exam	12	54.5
Dental Care	8	36.4
Routine Hospitalization	6	27.3
Routine ER Visits	5	22.7
Routine Prescriptions	5	22.7
Vision Care	5	22.7
Routine Med Tests	4	18.2
Gynecological Care	3	13.6
(other routine care not listed)	3	13.6
DC EMS	1	4.5
Specialist Care	0	0.0

Table 9: Inaccessible Regular Medical Care Services Among Those Reporting Barriers to Accessing Them (n=22)

Those participants who accessed regular medical services were asked to rate them. The quality of the services and the provider(s) sensitivity to the participant as a transgendered person were both rated on scales from 1 (Extremely Poor) to 5 (Excellent). Only those who had actually received the specific type of care were instructed to rate it, and only those who rated the quality of care were instructed to rate the sensitivity of the provider. Those participants who had not disclosed their transgender status to their providers were instructed not to rate the sensitivity of the provider(s). Since this data was ordinal, median values are used as a means to rate the quality and sensitivity. The types of regular medical care services are listed in order of highest access in Table 10, along with the percentage of all participants who accessed each type of care or service. The ratings of quality and sensitivity by the participants all ranged from Good (4) to Excellent (5), indicating high levels of satisfaction by those who accessed them.

REGULAR MEDICAL SERVICE	RATING CATEGORY	FREQUENCY	PERCENT RESPONDING	MEDIAN RATING
Annual Physical Exam	Quality	137	54.4	4
	Sensitivity	118		4
Routine Prescriptions	Quality	109	43.3	4
	Sensitivity	93		4
Dental Care	Quality	100	39.7	4
	Sensitivity	80		4
Routine Tests	Quality	91	36.1	4
	Sensitivity	70		4
Routine ER Visits	Quality	78	31.0	4
	Sensitivity	63		4
DC EMS	Quality	69	27.4	4
	Sensitivity	56		4
Vision Care	Quality	59	23.4	4
	Sensitivity	44		5
Routine Hospitalization	Quality	55	21.8	4
	Sensitivity	48		4
Specialist Care	Quality	34	13.5	5
	Sensitivity	26		5
Gynecological Care	Quality	28	11.1	4
	Sensitivity	22		4.5
Other Routine Care	Quality	21	8.3	5
	Sensitivity	17		5

Table 10: Assessment of Accessed Regular Medical Services (n=252)

Anatomical Inventory

Since many transgendered persons seek to alter their bodies in varying degrees to achieve some measure of congruency with their internal gender identity, their sexual anatomy is often in flux. Consequently, a current anatomical inventory was included in the WTNAS to assess the degree to which the participants had accessed the various medical procedures used by transgendered people to achieve this physical congruency. For clarity, natal and altered anatomy are listed separately in Tables 11a and 11b, respectively. Please note that these figures are not exclusive of each other, and that in many cases some participants do not report gonadal genitalia, which accounts for smaller numbers of testicles, uteruses and ovaries.

NATAL ANATOMY TYPE	FREQUENCY	PERCENT
Natal Penis	183	72.6
Natal Testicles	144	57.1
Natal Vagina	60	23.8
Natal Clitoris	56	22.2
Natal Uterus	52	20.6
Natal Ovaries	49	19.4
Natal Breasts	53	21.0
Mixed Sex Characteristics	3	1.2

Table 11a: Natal Anatomy Inventory (n=252)

ALTERED ANATOMY TYPE	FREQUENCY	PERCENT
Breasts through Hormonal Therapy	90	35.7
Breasts through Silicone Injections	26	10.3
Hormonally-enlarged FTM Genitalia	8	3.2
Complete FTM Top Surgery	7	2.8
Breast with Surgical Implants	6	2.4
Surgically-constructed Vagina	4	1.6
Surgically-constructed Clitoris	3	1.2
Surgically-constructed Labia	2	0.8
Surgically-altered Clitoris	0	0.0
Breast Reduction	0	0.0
Clitoral Release Procedure	0	0.0
Vaginectomy	0	0.0
Testicular Implants	0	0.0
Metaoidioplasty	0	0.0
Phalloplasty	0	0.0

Table 11b: Altered Anatomy Inventory (n=252)

Transgender-related Health Care

The most common way that transgendered people alter their bodies is by the exogenous administration of opposite-birth sex hormones, clinically referred to as *Hormonal Sex Reassignment*. Fifty-two percent of the participants report that they had taken hormones at some point in their lives, and 36% are currently taking hormones.

However, only 34% report that a doctor was monitoring their blood levels while they were taking hormones, and 58% have acquired hormones from friends or on the street. Over 90% of those currently taking hormones state they plan to continue taking them for the rest of their lives. Of those who currently are not taking hormones and those had never taken them, 22% are planning to do so in the future, and another 36% are unsure.

The most common sources of information about transgender health care for the participants were Word of Mouth (73%), Transgender Support Groups (39%), Gay Newspapers (39%) and Transgender Newsletters or Magazines (31%), as shown in Table 12.

SOURCE OF INFORMATION ABOUT TRANSGENDER CARE	FREQUENCY	PERCENT
Word of Mouth	184	73.0
Transgender Support Group	98	38.9
Gay Newspaper	97	38.5
TG Newsletter	79	31.3
Doctor	21	8.3
Phone Book	20	7.9
Health Clinic	19	7.5
Psychotherapist	19	7.5
Internet	18	7.1
Difficulty Finding Any Information	11	4.4
(other source not listed)	5	2.0

Table 12: Sources of Information About Transgender Care (n=252)

Just 11% of the participants report they encountered barriers to accessing transgender health care. The types of inaccessible care and the barriers to access are shown in Table 13. The most common barriers cited are Inability to Pay (48%), Not Knowing Where to Obtain Service(s) (37%), Health Insurance Not Covering the Service(s) and Health Care Provider Insensitivity or Hostility to transgendered people.

VARIABLE	RESPONSE	FREQUENCY	PERCENT
INACCESSIBLE TRANSGENDER CARE	Transgender-related Psychotherapy	14	51.9
	Transgender-related Endocrinology	13	48.1
	Hormone Prescriptions	13	48.1
	Electrolysis	10	37.0
	Transgender Surgery of Any Kind	7	25.9
	Transgender-related Speech Therapy	2	7.4
BARRIER TO CARE	Can't Afford It	13	48.1
	Don't Know If Service Is Available	10	37.0
	Health Insurance Doesn't Cover It	8	29.6
	Provider Insensitivity/Hostility	8	29.6
	Problems Accepting TG Status	6	22.2
	Can't Afford or Get Transportation	3	11.1
	HIV Positive Status	3	11.1
	Fear of HIV Status Being Revealed	2	7.4
	I Know Service is Not Available	2	7.4
	Lack of Bilingual Services	2	7.4
	Fear Immigration Status Revealed	2	7.4
	Denied While Incarcerated	2	7.4
	(other reason not listed)	0	0.0

Table 13: Inaccessible Transgender Care Services & Barriers To Accessing Them Among Those Who Report Barriers to Transgender Care (n=27)

Those participants who had accessed transgender health care services were asked to rate them. Once again, the quality of the services and the provider(s) sensitivity to the participant as a transgendered person are both rated on scales from 1 (Extremely Poor) to 5 (Excellent), and only those who have actually received the specific type of care were instructed to rate it. In the majority of these services and procedures, fewer sensitivity ratings are reported than quality ratings. Although participants who have not disclosed their transgender status to their providers again were instructed not to rate their sensitivity, some participants clearly omit their sensitivity ratings. Since this data was ordinal, median values again are provided in Table 14, with the service or procedure listed in order of highest access, along with the percent of all participants who had accessed each type of care or service. Once again, the overall ratings of quality and sensitivity are found to range mostly from Good to Excellent.

HEALTH CARE SERVICE/PROCEDURE	RATING CATEGORY	FREQUENCY	PERCENT RESPONDING	MEDIAN RATING
Transgender-related Psychotherapy	Quality	80	31.7	4
	Sensitivity	72		4
Hormone Prescriptions	Quality	60	23.8	4
	Sensitivity	56		4
Silicone Injections -Breasts/Face/Hips	Quality	48	19.0	4
	Sensitivity	46		4
Substance Abuse Treatment	Quality	44	17.5	4
	Sensitivity	39		5
Endocrinology	Quality	37	15.5	4
	Sensitivity	33		5
Electrolysis	Quality	19	7.5	5
	Sensitivity	17		5
Facial Cosmetic Surgery	Quality	10	4.0	4.5
	Sensitivity	10		4.5
FTM Top Surgery	Quality	7	2.8	4
	Sensitivity	7		5
Oophorectomy	Quality	6	2.3	5
	Sensitivity	5		5
Saline Breast Implants	Quality	5	2.0	5
	Sensitivity	4		5
Speech Therapy	Quality	5	2.0	4
	Sensitivity	4		4
Vaginoplasty	Quality	3	1.2	5
	Sensitivity	2		4
Hysterectomy	Quality	3	1.2	5
	Sensitivity	3		5
Silicone Breast Implants	Quality	3	1.2	5
	Sensitivity	3		5
Liposuction	Quality	3	1.2	5
	Sensitivity	3		5
Tracheal Procedure	Quality	2	0.8	5
	Sensitivity	2		4
Labiaplasty	Quality	2	0.8	5
	Sensitivity	1		4
Hair Transplantation	Quality	2	0.8	4
	Sensitivity	(none)		
Vocal Cord Surgery	Quality	1	0.4	4
	Sensitivity	1		3
Orchiectomy	Quality	1	0.4	3
	Sensitivity	1		3
Vaginectomy	Quality	1	0.4	5
	Sensitivity	1		5
Breast Reduction	(No Ratings)	(none)	0.0	
Clitoral Release Procedure	(No Ratings)	(none)	0.0	
Metaoidioplasty	(No Ratings)	(none)	0.0	
Phalloplasty	(No Ratings)	(none)	0.0	

Table 14: Assessment of Accessed Mental Health, Substance Abuse Treatment and Transgender Care Services (n = 252)

The most commonly-accepted means for the professional administration of hormonal and surgical sex reassignment is the *Standards of Care (SOC)* promulgated by the Harry Benjamin International Gender Dysphoria Association (HBIGDA). The *Benjamin Standards* are a set of clinical guidelines used by caregivers (endocrinologists, surgeons and psychotherapists) with the intention of ethically administering care to transsexual patients. While the SOC minimize the chances of making mistakes, they have been criticized by many transgendered people as a burdensome "gatekeeper" system. Nevertheless, they are the only recognized guidelines for the administration of transgender care, and thus they are used by most careful and reputable clinicians.

However, less than 10% of the WTNAS participants knew what the SOC were. Of those participants who did know about the SOC, only slightly more than half report their health care providers mentioned the SOC during their course of treatment. In spite of this ignorance regarding the SOC, a third of all participants report they had to educate their medical or mental health providers about their needs as a transgendered person. This included 43% of those who had ever taken hormones and 70% of those currently taking hormones.

Substance Abuse and Suicidal Ideation/Attempts

Due to its scope, the WTNAS limited its assessment of behavioral health to substance abuse and suicide issues (Table 15). Thirty-four percent of the participants feel their drinking is a problem for them, but only 36% of them actually sought treatment for it. Thirty-six percent feel they have a drug problem, but only 53% of them sought treatment for it. Thirty-five percent report experiencing suicidal ideation, and 64% of them attribute it to their gender issues (Table 16). Of those with suicidal ideation, 47% report they had actually made attempt(s) to kill themselves – or 16% of the entire sample.

VARIABLE	RESPONSE	FREQUENCY	PERCENT
ALCOHOL PROBLEM	YES	86	34.1
	NO	119	47.2
	Never Drank Alcohol	29	11.5
	(no response)	18	7.2
DRUG PROBLEM	YES	91	36.1
	NO	98	38.9
	Never Used Drugs	42	16.7
	(no response)	21	8.3
SUICIDAL IDEATION	YES	88	34.9
	NO	144	57.1
	(no response)	20	8.0

Table15: Alcohol and Drug Problems, and Suicidal Ideation (n=252)

VARIABLE	RESPONSE	FREQUENCY	PERCENT
SUICIDAL IDEATION RELATED TO GENDER ISSUES	YES	56	63.6
	NO	32	36.4
SUICIDE ATTEMPTS	YES	41	46.6
	NO	43	47.7
	(no response)	5	5.7

Table 16: Suicidal Ideation Related to Gender Issues and Suicide Attempts Amongst Those Who Have Experienced Suicidal Ideation (n=88)

HIV/AIDS Knowledge, Testing and Status

The most commonly-reported sources of information about HIV and AIDS for all participants are HIV seminars, workshops and focus groups (22%) doctor's offices (12%) gay and lesbian bars or nightclubs (11%) and schools (11%), as shown in Table 17.

SOURCE OF HIV/AIDS KNOWLEDGE	FREQUENCY	PERCENT
Seminar, Workshop or Focus Group	55	21.8
Doctor's Office	31	12.3
Gay or Lesbian Bar or Nightclub	28	11.1
School	27	10.7
Support Group	22	8.7
Other Health Care Facility	20	7.9
(other source not listed)	17	6.7
Hospital	4	1.6
Counseling Sessions	1	0.4
Church	1	0.4
TV/Radio	1	0.4

Table 17: Sources of HIV/AIDS Knowledge (n=252)

Twenty-five percent of the participants report being HIV positive, with 53% report being negative and 22% who did not know their HIV status. Table 18 shows the reasons given by those who did not know their HIV status for not knowing it.

REASON	FREQUENCY	PERCENT
Feels Healthy	18	32.1
Always Have Safer Sex	9	16.1
Don't Want to Know	9	16.1
Other Reason	5	8.9
Fear Others Will Know	3	5.4
Don't Know Where to Get Tested	2	3.6
Probably HIV Positive	2	3.6
Afraid Insurance Will Find Out	0	0
Don't Care	0	0

Table 18: Reasons Given for Not Knowing HIV Status By Those Who Did Not Know (n = 56)

Of those who are not seropositive (including those who do not know their HIV status), nearly forty percent report being tested within the last six months, and a third report a testing frequency of every six months. However, 18% report never being tested. Table 19 shows the most recent HIV test and test frequency of those who were not seropositive.

VARIABLE	RESPONSE	FREQUENCY	PERCENT
MOST RECENT HIV TEST	Never Been Tested	34	18.0
	Within Last Six Months	74	39.1
	Six Months to One Year	44	23.3
	One or Two Years Ago	25	13.2
	More than Two Years	9	4.8
	(no response)	3	1.6
HOW OFTEN TESTED FOR HIV	Never Been Tested	34	18.0
	Every Six Months	63	33.3
	Once Every Year	52	27.5
	Once Every Two Years	19	10.1
	Rarely	18	9.5
	(no response)	3	1.6

Table 19: : Most Recent HIV Test and Frequency of HIV Testing for Seronegative Participants (n = 189)

HIV Seropositive Participants and HIV/AIDS Services

Seventy percent of the seropositive participants report being diagnosed more than two years ago, and two-thirds believe they became infected with HIV through unprotected sex with non-transgendered males (Table 20).

VARIABLE	RESPONSE	FREQUENCY	PERCENT
WHEN DIAGNOSED HIV+	More Than Two Years Ago	44	69.8
	One to Two Years Ago	13	20.6
	Within the Last Six Months	4	6.3
	Six Months to One Year	1	1.6
	(no response)	1	1.6
HOW INFECTED	Unprotected Sex with non-TG Male	42	66.7
	Don't Know	10	15.9
	Sharing Needles	3	4.8
	Sexually Assaulted/Raped	2	3.1
	Unprotected Sex with non-TG Female	1	1.6
	Unprotected Sex with MTF TG	1	1.6
	Received Tainted Blood Product	1	1.6
	(other means of infection not listed)	1	1.6
	(no response)	2	3.1

Table 20: When Diagnosed and How Infected with HIV, for Seropositive Participants (n=63)

The majority of the seropositive participants report CD Counts in the 201 to 500 range and undetectable Viral Loads (Table 21).

VARIABLE	RANGE	FREQUENCY	PERCENT
CD4 COUNT	Above 500	14	22.2
	201 to 500	25	39.7
	100 to 200	8	12.7
	Less Than 100	6	9.5
	Don't Know	10	15.9
VIRAL LOAD	Undetectable	16	25.4
	400 to 9,999	14	22.2
	10,000 to 49,999	12	19.0
	100,000 to 499,999	3	4.8
	50,000 to 99,999	2	3.2
	500,000 to 999,999	1	1.6
	Above a Million	1	1.6
	Don't Know	14	22.2

Table 21: CD4 and Viral Load Ranges For Seropositive Participants (n=63)

Seventy-one percent of the seropositive participants are currently taking HIV-related medications, and 50% report they have simultaneously taken hormones for transgender-purposes. Of those undergoing hormonal sex reassignment while also on HIV medications, 84% report their doctors knew they were also taking hormones, yet only 58% of them report their doctors having discussed the possibility of interactions between their HIV/AIDS medications and hormones. A total of 8 participants in this group (26%) self-report health problems they attributed to these interactions (Table 22).

HEALTH PROBLEM(S)
High Blood Pressure, High Blood Sugars, High Cholesterol
High Blood Pressure
Liver Problems, High Blood Pressure
High Blood Pressure
Seizures, Arthritis, Neuropathy
(Three others: non-specific)

Table 22: Health Problems Self-reported as Attributed to Interactions between HIV/AIDS Medications and Hormones (n=8)

Only 8% of the seropositive participants report encountering barriers to receiving HIV/AIDS services. The most common inaccessible service is hospitalization (3 cases), and the most common barrier cited is provider insensitivity or hostility to transgendered people (3 cases), with all cases shown in Table 23.

VARIABLE	RESPONSE	FREQUENCY
INACCESSIBLE HIV/AIDS SERVICES	Hospitalization	3
	Emergency Room Visits	2
	Outpatient Clinic	1
	HIV-specific SA Treatment	1
	Counseling/Psychotherapy	1
	Resource & Referral Info	1
	Other HIV/AIDS Service	1
BARRIERS TO ACCESSING HIV/AIDS SERVICES	Provider Insensitivity to TGs	3
	Can't Afford Services	2
	Can't Get Financial Assistance	1
	Know Services are Unavailable	1
	Can't Get Transportation	1
	Lack of TG Staff	1
	Lack of TG Outreach Workers	1
	Lack of People of Color Staff	1
	Fear Immigration Status Revealed	1
	Shame	1

Table 23: Inaccessible HIV/AIDS-related Services and Barriers to HIV/AIDS-related Services (n = 5)

Only those seropositive participants who had accessed HIV/AIDS-related services were instructed to rate their quality and care-giver sensitivity, in a manner identical to the previous sections on regular and transgender-related medical care. Median values for this ordinal data are provided in Table 24. With a few exceptions, the overall ratings of quality and sensitivity were quite high.

HIV/AIDS SERVICE	RATING CATEGORY	FREQUENCY	PERCENT RESPONDING	MEDIAN RATING
Outreach Services	Quality	51	81.0	5
	Sensitivity	50		5
HIV/AIDS Testing	Quality	51	81.0	4
	Sensitivity	50		4
Education & Prevention	Quality	50	79.4	5
	Sensitivity	49		5
Resource & Referral Info	Quality	39	61.9	5
	Sensitivity	38		5
HIV/AIDS Medications	Quality	31	49.2	5
	Sensitivity	30		5
Case Management	Quality	31	49.2	5
	Sensitivity	30		5
HIV/AIDS Support Group	Quality	27	42.9	5
	Sensitivity	26		5
Medical Testing	Quality	22	34.9	5
	Sensitivity	21		5
Counseling/Psychotherapy	Quality	22	34.9	4
	Sensitivity	20		3.5
HIV-specific SA Treatment	Quality	21	33.3	4
	Sensitivity	21		4
Emergency Room	Quality	19	30.2	4
	Sensitivity	19		4
Outpatient Care	Quality	15	23.8	5
	Sensitivity	14		5
Hospitalization	Quality	14	22.2	4.5
	Sensitivity	13		4.5
Financial Assistance	Quality	13	20.6	5
	Sensitivity	13		5
Legal Services	Quality	13	20.6	5
	Sensitivity	13		4
Transportation Services	Quality	12	19.0	4.5
	Sensitivity	12		4.5
Food Services	Quality	12	19.0	5
	Sensitivity	12		5
Crisis Intervention	Quality	11	17.5	4
	Sensitivity	10		3
In-Home Health Care	Quality	4	6.3	4
	Sensitivity	4		2.5

Table 24: Assessment Of Accessed HIV/AIDS Services (n = 63)

Sexual Risk Behaviors

All participants were asked to review a list of sex practices and co-factors known to be associated with the transmission of HIV and other sexually-transmitted diseases. If they responded to each behavior, there were four possible time-based outcomes: they had never done the behavior, they had done it at least once, they had done it in the last year, and they had done it in the last month. By scaling the time-based outcomes, it was possible to obtain a cumulative lifetime figure for each behavior, shown in bold in Table 25. Because transgendered

people tend to be extremely sensitive about their genitalia, and since the behaviors had to be applicable to both gender vectors (MTF/FTM), explicit anatomical terms were avoided and general terms ("genital", "oral", "anal", "manual", etc.) were used wherever possible in the behavioral descriptions.

BEHAVIOR	INCIDENCE	FREQUENCY	PERCENT	CUM. PERCENT
Unprotected Oral-Genital Contact	In the Last Month	90	35.7	35.7
	In the Last Year	51	20.2	55.9
	At Least Once	53	21.0	76.9
	Never	53	21.0	
	(no response)	5	2.0	
Unprotected Genital-Genital Contact	In the Last Month	48	19.0	19.0
	In the Last Year	46	18.3	37.3
	At Least Once	73	29.0	66.9
	Never	79	32.1	
	(no response)	6	2.4	
Sex While Drunk or High	In the Last Month	40	15.9	15.9
	In the Last Year	37	14.7	30.9
	At Least Once	39	15.5	46.1
	Never	133	52.8	
	(no response)	3	1.2	
Unprotected Oral-Anal Contact	In the Last Month	46	18.3	18.3
	In the Last Year	34	13.5	31.8
	At Least Once	29	11.5	43.3
	Never	137	54.4	
	(no response)	6	2.4	
Unprotected Genital-Anal Contact	In the Last Month	27	10.7	10.7
	In the Last Year	35	13.9	24.6
	At Least Once	43	17.1	41.7
	Never	90	35.7	
	(no response)	57	22.6	
Unprotected Fisting	In the Last Month	21	8.3	8.3
	In the Last Year	16	6.3	14.6
	At Least Once	11	4.4	19.0
	Never	194	77.0	
	(no response)	10	4.0	
Unprotected Sex While HIV+	In the Last Month	13	5.2	5.2
	In the Last Year	7	2.8	8.0
	At Least Once	10	4.0	12.0
	Never	217	86.1	
	(no response)	5	2.0	

BEHAVIOR	INCIDENCE	FREQUENCY	PERCENT	CUM. PERCENT
Unprotected Sex with Someone HIV+	In the Last Month	8	3.2	3.2
	In the Last Year	6	2.4	5.6
	At Least Once	9	3.6	9.2
	Never	227	90.1	
	(no response)	2	0.8	
Shared Unclean FTM Prosthetic/ Dildo/Sex Toy	In the Last Month	5	2.0	2.0
	In the Last Year	5	2.0	4.0
	At Least Once	4	1.6	5.6
	Never	231	91.7	
	(no response)	7	2.8	
Shared Needle(s) for Injections	In the Last Month	0	0.0	0.0
	In the Last Year	3	1.2	1.2
	At Least Once	7	2.8	4.0
	Never	235	93.2	
	(no response)	7	2.8	

Table 25: Sexual Behaviors Risk Assessment (n = 252)

Additionally, 5% of the participants respond that they had received a blood transfusion or other blood product. The top three reasons given by the participants who admitted to unsafe behaviors in the previous question are that they Trusted their Sex Partner (41%), their Partner(s) Appeared to be Healthy (36%) and they Didn't Know There Was a Risk associated with the behavior (25%). All of the reasons given by the participants for unsafe sex or risk behaviors are shown in Table 26.

REASONS GIVEN	FREQUENCY	PERCENT
Trusted Sex Partner	104	41.3
Partner(s) Appeared Healthy	91	36.1
Didn't Know There Was a Risk	64	25.4
Drunk or High	55	21.8
Don't Feel Sick	45	17.9
Partner(s) Preferred Unprotected Sex	36	14.3
Had Unprotected Sex While Doing Sex Work	29	11.5
Did It To Obtain Drugs	23	9.1
In a Monogamous Relationship	14	5.6
(other reason not listed)	14	5.6
Depression	15	6.0
Problems with Acceptance of HIV+ Status	13	5.2
Sexually Assaulted (Raped)	11	4.4
Low Self-Esteem	7	2.8

Table 26: Reasons Given For Unsafe Sexual Behaviors (n = 252)

Housing Issues

Eighty-one percent of the participants report that they had their own living space, defined as at least a room of their own. Of those with their own living spaces, 45% live in or share a rental apartment, followed by 19% who live free in a house or apartment. A median of 1 room-mate or other occupant was found for those for those who did not live alone. Descriptions of current living situations are given in Table 27.

VARIABLE	RESPONSE	FREQUENCY	PERCENT
LIVING SITUATION	Lives in or Shares Rental Apt	114	45.2
	Live Rent-Free in House or Apt	47	18.7
	Lives in or Shares Rental House	19	7.5
	Lives in Own/Co-Owned House	13	5.2
	Homeless - Live in Shelter	10	4.0
	Homeless - Live on Street	6	2.4
	Own/Co-Own Condo/Co-op	4	1.6
	Other Living Space	2	0.8
	Asst Housing Thru DC Govt	1	0.4
	Asst Housing Thru Pvt Agency	1	0.4
	Temporary/Transitional Housing	1	0.4
	Halfway House	1	0.4
	(no response)	33	13.1
WHO ELSE SHARES	Live Alone	65	25.8
	Live with Gays, Lesbians or Bisexuals	35	13.9
	Live with Immediate Birth Family	30	11.9
	Live with Other Birth Family Members	26	10.3
	Live With Other Transgendered Persons	24	9.5
	Live with Significant Other/Partner	21	8.3
	Live with Strangers	16	6.3
	Live with Straight People	8	3.2
	Live with Spouse Thru Marriage	6	2.4
	(live with others not listed above)	4	1.6
OCCUPANCY DENSITY (NUMBER OF OTHERS)	1	45	17.8
	2	26	10.3
	3	22	8.7
	4	9	3.6
	5	5	4.4
	6	5	2.0
	7	1	0.4

Table 27: Current Living Situation, Who Else Shares, and Occupancy Density (n=204)

Seventy-five percent respond that they feel safe in their living spaces, but 12.5% did not, with another 12.5% who did not respond. A geographical breakdown by residential zip codes given by the participants is shown in Table 28.

ZIP CODE	FREQUENCY	PERCENT
20009	27	10.7
20020	19	7.5
20001	18	7.1
20010	18	7.1
20011	18	7.1
20002	15	6.0
20032	14	5.6
20019	13	5.2
20012	5	2.0
20003	3	1.2
20005	3	1.2
20015	2	0.8
20017	2	0.8
20037	2	0.8
20006	1	0.4
20007	1	0.4
20008	1	0.4
20016	1	0.4
20024	1	0.4
20036	1	0.4
(no response)	87	34.5

Table 28: ZIP Code of Residence (n=252)

Nineteen percent did not have their own living space, and the most common barriers to housing they report are economic situation (38%), housing staff insensitivity or hostility to transgendered people (29%), estrangement from birth family (27%) and lack of employment (23%) as shown in Table 29.

BARRIERS TO HOUSING	FREQUENCY	PERCENT
Economic Situation	18	37.5
Housing Staff Insensitivity/Hostility to TGs	14	29.2
Estrangement From Birth Family	13	27.1
Lack of Employment	11	22.9
Other Residents Insensitivity/Hostility to TGs	6	12.5
(other reason not listed)	4	1.6
Discrimination Due to Being TG	2	4.2
Lack of Affordable Housing in Area	1	2.1
Discrimination Due to HIV+ Status	1	2.1
Discrimination Due to Racism	1	2.1

Table 29: Barriers to Housing (n=48)

When all the participants were asked about their preferred living situation (Table 30) only 26% state they are happy with their present situation, with 36% wanting their own rental apartment, and another 27% owning or co-owning a house.

PREFERRED LIVING SPACE	FREQUENCY	PERCENT
Rental Apartment	91	36.1
Own/Co-Own House	68	27.0
Satisfied with Present Situation	66	26.2
Shelter	5	2.0
Temporary/Transitional Housing	4	1.6
With My Birth Family	3	1.2
Assisted Housing	2	0.8
(other housing not listed)	2	0.8
Hospice	1	0.4
(no response)	10	3.9

Table 30: Preferred Living Situation (n = 252)

Nineteen percent of all participants report they had been evicted during their lifetimes, and the most common reasons they mention for their evictions are inability to pay the rent (64%) and drug or alcohol issues (32%), as shown in Table 31.

EVICITION REASON	FREQUENCY	PERCENT
Couldn't Pay Rent	30	63.8
Drug or Alcohol Issues	15	31.9
Couldn't Get Housing Assistance	10	21.3
Other Reason	4	8.5
Discrimination due to Being Transgender	1	2.1
Discrimination due to HIV+ Status	1	2.1

Table 31: Eviction Reasons (n = 47)

Self-Perceived Needs

Self-perceived needs are assessed in two methods in the WTNAS. In order to measure the Potential Demand for transgender-specific and transgender care-related services, all of the participants were asked to check those services which they might be likely to use if they were available to them. The results are shown in Table 32, with the services ranked in order of popular demand. To better assess their Most Important and Immediate Needs, all participants were asked to rank their most pressing needs at the present time. Their first-ranked need was assigned a value of three (3), their second a two (2) and their third a one (1), and the results for each category were summed and scored. As shown in Table 33, the top three Most Important and Immediate Needs are Housing, Employment, and HIV-related Care.

RANK	SERVICE	FREQUENCY	PERCENT
1	Transgender-specific HIV Education & Prevention Materials	200	79.4
2	Transgender-related Health Care Information	197	78.2
3	Condom Distribution by Transgender Outreach Workers	166	65.9
4	Transgender-led Safer Sex Seminars	163	64.7
5	Transgender-specific Resource & Referral Information	153	60.7
6	Transgender-related Hormone Prescriptions	148	58.7
7	Transgender-related Hormonal Therapy	128	50.8
8	Transgender-sensitive HIV/AIDS Testing	127	50.4
9	Transgender-sensitive Case Management Services	107	42.5
10	Vocational Training	99	39.3
11	Transgender-sensitive Legal Services	99	39.3
12	Transgender-sensitive Substance Abuse Treatment Services	92	36.5
13	Transgender-staffed Hotline/Crisis Intervention Services	90	35.7
14	Transportation Assistance	76	30.2
15	Transgender-related Information in Native Language	32	12.7
16	Other Service	2	0.8

Table 32: Self-Assessment (Potential Demand)
for Transgender-specific & Transgender-sensitive Services (n = 252)

SELF-PERCEIVED NEED	RANKINGS	SCORE	FREQUENCY	PERCENT
Housing		290	140	
	First Highest Need (3)		48	19.0
	Second Highest Need (2)		54	21.4
	Third Highest Need (1)		38	15.1
Employment		286	145	
	First Highest Need (3)		42	16.7
	Second Highest Need (2)		57	22.6
	Third Highest Need (1)		46	18.3
HIV/AIDS-related Care		206	82	
	First Highest Need (3)		55	21.8
	Second Highest Need (2)		14	5.6
	Third Highest Need (1)		13	5.2
Job Training		172	107	
	First Highest Need (3)		14	5.6
	Second Highest Need (2)		37	14.7
	Third Highest Need (1)		56	22.2
TG-related Medical Care		112	57	
	First Highest Need (3)		17	6.7
	Second Highest Need (2)		21	8.3
	Third Highest Need (1)		19	7.5
Routine Medical Care		95	46	
	First Highest Need (3)		18	7.1
	Second Highest Need (2)		13	5.2
	Third Highest Need (1)		15	6.0
Other Need(s)		20	10	
	First Highest Need (3)		4	1.6
	Second Highest Need (2)		2	0.8
	Third Highest Need (1)		4	1.6

Table 33: Self-Assessment of Most Important and Immediate Needs (n = 252)

VI. Discussion of the Data

HIV Prevalence

The overall HIV prevalence rate of the WTNAS participants was 25%, but the MTF (Male-to-Female) prevalence rate was 32%, with MTFs comprising 75% of the total sample. This 32% compares with the 35% MTF HIV prevalence rate of the largest known study of transgendered people in San Francisco (Clements et al, 1998) and the 18% prevalence rate in the 1997 Philadelphia Needs Assessment Survey (done by Action AIDS of Philadelphia, Unity and the University of Pennsylvania). Ninety-five percent of the seropositive participants in the WTNAS are Male-to-Female, and 81% are African-American. For a rough comparison of the WTNAS prevalence rate with other high risk populations in the District of Columbia, Table 34 is reproduced from the DC HIV Prevention Three Year Plan for 1999-2002, with the WTNAS figures added. The HIV prevalence rates from the Three Year Plan were obtained through blood tests conducted in double-blind studies, while the WTNAS HIV prevalence is self-reported.

POPULATION	HIV PREVALENCE
MTF Transgender Persons in the WTNAS	32%
Black Male IDUs attending an STD Clinic	27%
All GV Persons in the WTNAS	25%
White Male IDUs attending an STD Clinic	15%
MSM attending an STD Clinic	15%
Hispanic Male IDUs attending an STD Clinic	11%

Table 34: Comparison of HIV Prevalence Rates in the District of Columbia (from District of Columbia HIV Prevention Three Year Plan 1999-2002, page 5.2)

Sexual Risk Behaviors

While nearly 53% report they are seronegative, another 22% did not know their HIV status, and 18% had never been tested for HIV. But most significantly, the levels for high-risk sexual behaviors are quite high. On a lifetime basis, the highest rates were in the risk categories of Unprotected Oral-Genital Contact (77%), Unprotected Genital-Genital Contact (67%), Unprotected Oral-Anal Contact (43%) and Unprotected Genital-Anal Contact (42%). In some of these categories the rates remained high on more recent time scales (i.e., Within the Last Year or Within the Last Month).

These figures for high-risk sexual behaviors, taken in a mostly seronegative sample, demonstrate a population at a significantly high, immediate risk for HIV/AIDS and other STDs.

In other studies, MTF transgendered sex workers have been shown to be at high risk for HIV and other STDs. Although only 3% of the participants who work classify their job as Sex Worker, 12% report unprotected sex while doing sex work as a reason for having unsafe sex, and of those 72% were HIV positive. Two-thirds of the seropositive participants believe they became infected with HIV by having unprotected sex with non-transgendered men.

With regard to alcohol and drug abuse co-factors, 46% of the participants report having sex while drunk or high (on a lifetime basis), and 22% admit to drug use as a reason for having

unsafe sex, along with 9% who had unsafe sex to obtain drugs. These figures correspond to the 34% and 36% who admit a problem with their alcohol use or their drug use, respectively. However, only 36% of those with alcohol problems and 53% of those with drug problems have sought treatment for Substance Abuse (SA). This indicates a need for further study to assess the barriers to accessing treatment when transgendered people acknowledge an SA problem.

Access to Health Care

In other populations, the impact of demographic factors such as age, race, education, language, income and citizenship/residency status become principal if not determining factors in access of regular health care. When other factors like unemployment and underemployment, lack of housing or substandard housing, fear of violence and violence itself, discovery of transgender status, internalized transphobia and negative body issues – all products of the social stigmatization faced by gender variant people in an intolerant culture – are added to the above, the limited access to health care by transgendered people becomes readily understood. While the numbers who report barriers to accessing all three categories of health care in the sample are quite low, the most common barrier across all categories is their economic situation. Can't Afford It was a consistent response, followed by Lack of Insurance, Failure of Insurance to Cover Care, and Caregiver Insensitivity or Hostility to Transgendered People. One telling figure is that nearly one-third of those who report barriers to regular medical care attribute it to fear of their transgendered status being revealed.

Obviously, unemployment and under-employment deprive many participants of the commonly-afforded, job-related benefits of health insurance. Nearly thirty percent of the participants report no income at all, and another 32% report earning less than \$10,000 per year. Their lack of income hampers their ability to pay directly for care, and likely discourages at least some from seeking care when necessary. The 42% of all participants who are unemployed compares with the 47% who lack health insurance (a figure nearly double the national average) as well as the 39% that do not have a doctor for regular health care. The source for those who had health insurance split evenly between private insurance (self-paid or through employers) and public insurers (Medicaid and Medicare).

Despite the low numbers of participants reporting barriers, the low numbers of those actually rating the quality and sensitivity of regular medical care reveal an overall low level of access. For example, 45% of the participants did not report getting annual physical exams, and the frequency of routine ER visits and DC EMS access (about 30%) indicates a reliance upon urgent care rather than preventative care. Only 22% of all participants (43% of those with health insurance) belong to HMOs, many of which emphasize preventive care as a means of reducing their costs. Yet in spite of the difficult economic situations of many participants, other factors, such as distorted body image and low self esteem, may be extremely relevant in failure to access necessary medical care.

A good measure of accessing transgender-related care are questions involving hormonal sex reassignment. More than half (52%) report they have taken hormones at least once in their lifetimes, 36% are currently taking hormones and another 14% are planning on taking them in the future. However, almost two-thirds report their doctors did not do blood work in conjunction with their endocrinology, and of those responding to whether they had gotten their hormones from someone other than a doctor, 71% said yes. Perhaps more alarmingly, 90% of all the participants were not familiar with the HBGDA *Standards of Care*. Although critics consider the

SOC to be too burdensome, the quality of care delivered by clinicians who follow them is generally regarded to be much higher than those who do not.

Housing

Only 26% of the participants are satisfied with their current living situation. Employment is cited as the principal barrier to housing (by over one-third) but other participants report the hostility and insensitivity of housing staff (29%) and other residents (13%) as factors in their lack of housing.

VII. RECOMMENDATIONS

A Paradigm Shift

It is strongly recommended that the traditional approach of including transgender populations in MSM categories for prevention planning be seriously re-examined, if not abandoned altogether. Although nearly two-thirds of the WTNAS participants identified their sexual orientation as "Gay", this is misleading and should not be viewed as justification for the continuance of this approach, for the following reasons. Self-identification by transgendered people of their sexual orientation is extremely problematic, and often seems confusing and quite contradictory. Cultural, ethnic and psychosocial factors also render the sexuality of transgender people difficult, if not impossible, to definitively ascertain. Many of those who successfully assimilate into non-transgender populations choose to base their sexual orientation on their internal gender identity, especially post-operative transsexuals. Some examples: a transsexual woman (MTF) who has sex with women can identify herself as lesbian, regardless of her pre-operative status (i.e., the presence of male genitalia). A transsexual man (FTM) who has sex with women can view himself as heterosexual, although he has not had a phalloplasty. Still others in the process of physical transformation of their sexual anatomy feel it is impossible to accurately label or describe their sexual orientation. While some MTF transgender people who have sex with men may view their sexual orientation as heterosexual, many others will identify themselves as gay, due to cultural or peer group norms, or a desire to identify with the larger gay community, based upon affinity needs or as an expression of solidarity.

There are however, some significant factors that distinguish Gender Variant populations from the traditional MSM category:

- *The Impact of Per Capita Rates of Discrimination and Violence on Educational, Employment and Housing Opportunities.* Due to the overt, unconcealable nature of gender variance, transgendered people are far more likely to incur discrimination at per capita rates higher than gay men or lesbians with passing privilege (who are straight-acting and straight-appearing). The resulting lack of health insurance from unemployment and under-employment, or insufficient coverage from underinsurance, probably means a lesser ability or willingness to access necessary health care services. The lack of employment opportunities significantly reduces housing opportunities as well, and may explain why some MTF transgendered people chose sex work to survive.
- *The Impact of Transphobia and Trans-ignorance in Health Care.* Transphobic bias has been anecdotally reported in many health care institutions located in the District. It is even a problem in DC Government agencies, as demonstrated by the negligence of the DC Fire Department in the 1995 death of transgendered resident Tyra Hunter. Hostile or

insensitive caregivers reduce the willingness of transgendered people to access care, and fear of discovery of transgender status keeps many away from the health care system altogether. To cite one example, although most transsexual men (FTMs) do not have vaginectomies, regular gynecological care becomes extremely problematic for them, due to their outward appearances as ordinary men. This lack of gynecological care must directly increase their morbidity rates, since research has indicated that as many as one-half of them may be at risk for Polycystic Ovary Syndrome (PCOS), which increases their risk for endometrial cancer and breast cancer.

- *The Urgent Need of Transgendered People for Access to Transgender Care.* It is common for transgendered people, especially transsexuals, to place a higher priority on successful access to the transformative medical technologies of transgender care, quite often to the neglect of other health care priorities. This need is not easily explained by someone who is transgendered, nor easily understood by someone who is not. Transsexual people will take all sorts of risks – financial and health-related – to accumulate the money required for the various cosmetic, hormonal and surgical sex reassignment procedures.
- *The Impact of Negative Body Issues.* Transgendered people who encounter barriers to accessing transgender-related care are probably less likely to take care of their bodies, to access other health care services when necessary, to practice safer sex and probably more likely engage in substance abuse.
- *The Invisibility of Transsexual Men (FTMs).* Transgendered people are often thought to be only MTF, and thus transsexual and transgendered men are usually completely ignored in education and prevention efforts. Yet many transsexual men identify themselves as gay or bisexual and actively engage in sex with other men.
- *The Impact of Gender Identity Issues on Education and Prevention.* Since gender does not equal genitalia for transgendered people, non-transgender gender-specific education and prevention efforts targeted at male and female populations probably will have much less of an impact. Specific materials should be researched, developed and evaluated.
- *The Influence of Self-perception of Sexual Anatomy Through Gender Identity.* Some transgender people refer to their existing genitalia or anatomy in terms congruent with their gender identity. For example, a transgendered man can view his enlarged clitoris as a penis, or a transgendered woman can view her rectum as a vagina. Accordingly, genitalia-specific reduction methods are likely to be less effective with these transgender individuals.
- *The Impact of Changing Sexual Anatomy Over Time.* The process for surgical sex reassignment can have many stages, with multiple procedures conducted over many years. In the interim, transsexual people can also refer to their existing genitalia in terms congruent with their gender identity. Upon completion of genital sex reassignment, post-operative transsexual people need to be targeted for HIV and STD prevention efforts specific to their new genitalia. Many transsexual women may be completely unaware of their increased susceptibility to hard to see STDs.
- *The Undetermined Adverse Drug Experiences Arising from Simultaneous Administration of HIV/AIDS Medications and Hormonal Sex Reassignment.* Administration of anti-

retroviral drugs like AZT, DDI and 3TC has been found to lower serum hormonal levels in non-transgendered Persons Living with AIDS. Moreover, with Transgendered Persons Living with AIDS, there is sufficient anecdotal evidence to suggest that adverse drug experiences created by concurrent administration warrant specific medical and perhaps psychological strategies. *Additional research is critical for Transgendered People Living With AIDS.*

While some of these points may seem speculative and based on anecdotal evidence, many of them may be born out in further study of the WTNAS data. Although obtaining funding for such research is very difficult, the WTNAS data demonstrates that research limited to just sexual behaviors ignores the other potent, holistic factors that drive gender variant people into high risk categories in the first place. In the absence of research and research opportunities, some assumptions can be and should be made, based upon what limited data is available and most certainly, for the purposes of effective prevention of HIV and other STDs.

Regretfully, ranking Gender Variant people in the current prioritization system used by AHA and the HIV Prevention Community Planning Committee (HPCPC) is impossible. This prioritization system relies upon population size and total number of AIDS cases per population category. Figures for the size of the GV population and total number of GV AIDS cases in the District are unavailable, because transgender people are not counted in the US Census, nor are they counted as a separate at-risk category by the Centers for Disease Control and Prevention – precisely due to the erroneous approach of lumping them with MSMs.

Therefore, the establishment of a separate Gender Variant (GV) category for prevention efforts directed at the reduction of transmission of HIV & STDs should be seriously considered.

Housing

This is the top-ranked Most Immediate Important Need of the participants, and of course is directly related to unemployment and underemployment. The lack of affordable housing is an intractable problem that affects many other residents of the District, and does not lend itself to easy solutions. Some creative solutions should be explored, including the establishment of transgender-only housing units, floors in existing housing facilities, lockable rest-room or separate wash-room facilities if necessary, and additional training for staff of assisted housing agencies.

Vocational Training

In the Self-assessment of Most Important, Immediate Needs, employment and job training ranked second and fourth, respectively. A majority of the unemployed participants of the WTNAS obviously want to work, and even some who are employed seek to better their skills. Development of a pilot program, with some entrée into the District's vocational rehabilitation programs, should be planned in conjunction with the appropriate agency, along with sensitivity training for its personnel.

Educational Programs for Transgendered People About Transgender Care

Transgender-related health care information ranks second highest in the Self-assessment measuring Potential Demand, with nearly 80 percent of all participants requesting it. Ninety percent report ignorance of the Benjamin *Standards of Care* – which puts them potentially at risk

when they seek transgender-related care. The popularity of silicone injections – a high-risk, now illegal extra-medical practice, long since banned in non-transgender populations – to add desired curves in breasts, faces and hips is quite disturbing. As shown by the under-reporting of gonadal anatomy, many do not completely understand their own sexual physiology. While the low numbers of those accessing transgender-related surgical procedures is mainly attributable to inability to pay for them, lack of information about these possibilities is also likely.

Health education plays a key role by empowering transgendered people to become informed consumers of transgender-related care. Educational in-reach programs regarding transgender care for transgender support groups, preferably led by transgendered people working with medical and mental health care providers experienced in dealing with transgendered patients and clients, would clearly be of great benefit. These programs would help transgendered people become more informed about their bodies and sexual anatomy, the risks involved in transgender-related care, the procedures and treatment options available to them, and their rights as consumers under the Benjamin Standards. This would increase their likelihood to seek greater access to transgender care, which would impact positively on their overall health. Successful resolution of incongruent gender identity and somatic states should reduce the impact of negative body issues that lower self-esteem and create opportunities for high-risk sexual behaviors and substance abuse. Such in-reach programs also present excellent opportunities for additional efforts to raise awareness about HIV/AIDS and its prevention.

Establishment of a Local Clinical Program for Hormonal Sex Reassignment

In the sample 36% are currently taking hormones, and another 14% plan to do so in the future. However, only 34% of those who had taken hormones report that a doctor monitored their blood levels as part of their care. Equally alarming is that 58% of those who had taken hormones received them from someone other than a doctor. Since large dosages are commonly prescribed to suppress endogenous hormonal production, their administration must be carefully followed with regular blood tests. The adverse effects of hormonal therapy in transgender and transsexual persons include thromboembolisms that can cause phlebitis, stroke, heart attack, and death (estrogen only); liver damage; and increase in lipid levels (testosterone only). These risks demonstrate the importance of informed, medically-supervised administration of hormonal sex reassignment. In the Self-assessment measuring Potential Demand for specific transgender-related services, 59% indicated hormone prescription service (59%) and hormonal therapy (51%). The establishment of a clinic in a local community-based or government-run facility would facilitate a standardized approach to hormonal sex assignment, assuring the best source of care. The same clinic could also deliver respectful, medically-necessary gynecological care to both FTM transgender persons and post-operative transsexual women.

Educational Programs for Medical Providers About Transgender Care

The evident lack of knowledge about the HBGDA *Standards of Care* by caregivers is a concern, as is the failure by some to perform the appropriate blood work to monitor for the adverse experiences associated with hormonal sex reassignment, and the failure by others to mention the possible interactions between HIV/AIDS medications and hormones. The need for an in-service program for education on the clinical management of transgender and transsexual patients in the District is clearly indicated.

Transgender Sensitivity and Awareness Programs

To non-transgendered people, the myriad terms and labels that many trans people use to identify themselves can appear to be ill-defined, confusing, and sometimes contradictory. While self-identification is an important personal right, it can defeat even well-intentioned care givers who lack specific knowledge and/or experience in dealing with the various subtypes of transgendered people.

The low numbers of those rating quality and sensitivity of their medical care revealed an overall low level of access, especially those that were transgender-related and HIV/AIDS-related. In some areas (Counseling/Psychotherapy, Crisis Intervention, and In-Home Health Care) the sensitivity ratings for the service providers were only Fair. As more transgendered people become empowered as health care consumers, increased access of a variety of services may be expected. Another area in which a need for sensitivity and awareness programs was indicated was assisted housing.

Therefore, ongoing and continuous in-service presentations regarding transgendered people, their needs, issues and concerns for professional and service staff members of ASOs, hospitals and other health care delivery facilities, social service CBOs, substance abuse treatment facilities, and housing agencies should be made a permanent part of their necessary training. It also should be made available to willing residents of assisted housing agencies.

Development of Transgender-specific HIV/AIDS Education and Prevention Materials.

The development of HIV education and prevention specifically targeted at transgendered people is an immediate and pressing need. It was the single highest-requested service in the Self-assessment measuring Potential Demand (nearly 80%). As with other populations, the materials must be culturally-appropriate and sensitive to transgender populations if they are to be effective.

Continuance and Expansion of Transgender Outreach Efforts

Although condom distribution and information about HIV and other STDs by transgender outreach workers is a relatively new program, it ranked third in the micro needs assessment. There was also some data which suggested that it was an important source of resource and referral information for many transgendered people. Expansion of outreach efforts to include additional transgender subpopulations, especially Latino/a and FTM groups, should be carefully evaluated and seriously considered.

VIII. Methodological Limitations

Because the transgendered residents of the District of Columbia constitute a largely hidden, underground population, random sampling was impossible. Thus the WTNAS used convenience sampling, employing a snowball sampling technique by which participants were identified through transgender support groups, outreach workers and social networks. This strategy is commonly used for hard-to-reach populations.

The WTNAS data gives us a first snapshot of an underground population not previously studied quantitatively in the District. Further analysis of the WTNAS data using bivariate and multivariate stratification will allow a richer understanding of the complex and widely varying

sub-groups within the transgendered community, including those born male vs. those born female, and HIV positive vs. negative or unknown.

Despite careful screening of potential participants, the financial incentive for participants caused duplication of three questionnaires, which were identified as duplicated by acrostic comparison, and therefore discarded. Another eight questionnaires were discarded because they were grossly incomplete, or were missing key fields (the participant's acrostic, age, race, physical sex at birth, gender identity, sexual orientation, relationship status, and HIV status), or contained inconsistent responses.

The WTNAS data is self-reported and thus subject to a number of biases including forgetfulness, selective memory, trauma-induced specificity and other associated detriments. Since most of the questionnaires were administered by interviewer, there is potential for biased responses in either direction. However, the Survey Administrators were instructed not to lead the participants in their responses, but only to explain questions and responses using the glossary found in the *Administrator's Manual*. Still, the presence of an interviewer creates the potential for respondents to give socially desirable responses, especially when asked personal and socially stigmatized behaviors. It also is likely that the fear of negative comments regarding specific types of care might negatively impact on or even cause the loss of care currently being accessed – which is reflected in the high quality and sensitivity ratings of categorical care.

The low numbers of those responding they had encountered barriers in assessing regular medical care; mental health, substance abuse and transgender care; and HIV/AIDS care were quite puzzling in light of the low numbers who report actually accessing those services. While it is possible that the way the three questions were asked (Have you ever been prevented from receiving routine physical, medical care / transgender-related health care / HIV/AIDS-related services?) may have caused participants to answer in the negative, this was not revealed in the pilot testing of the survey, involving ten African-American MTF transgender members of TADD during Phase One of the project. There may have been other factors behind the low numbers of those reporting barriers to care, such as denial of one's illness and thus a self-perceived lack of need for medical care; low self-esteem or body hatred commonly associated with transgendered people that causes physical neglect in time of illness; ignorance of when health care intervention is necessary; and other cultural and socioeconomic factors.

The validity of the fifty-five questionnaires translated into Spanish is not known. Although a bilingual survey was deemed necessary due to the sizeable number of participants who needed to answer in their vernacular, there are inevitably some errors in both comprehension and translation. Transgendered people born in ten different Latin-American countries participated in the WTNAS, and their comprehension of the questions may have been affected by the particular dialect of Spanish in which they were raised.

Additionally, some literal translation errors were made and discovered only during data entry of the questionnaires. One mistakenly-written instruction resulted in 14 of the 55 Spanish-speaking participants bypassing the questions regarding alcohol and drug abuse, as well as suicidal ideation and attempts. More significantly, all of the Spanish questionnaires omitted a question regarding genital/anal contact in the Sexual Risk Behaviors Assessment. The 57 missing responses for this behavior yielded a lower figure (42% lifetime) that was likely significantly higher. Finally, due to a lack of oversight, many of the Spanish-speaking participants chose not to assign numbers but simply check-marked their most

immediate important concerns in the immediate, important needs assessment. Therefore their responses were not be included in the summary table for Most Important, Immediate Needs.

Because the data could not be assembled from a population-based, representative sample, the findings give us a descriptive, exploratory understanding of the respondents in the study. The findings may or may not reflect the larger transgendered population in the Washington, D.C. or elsewhere in the U.S. Large, population-based studies require vast resources which were unavailable for this study.

Since this sample could not be randomly selected, it is desirable to examine the degree to which it is representative of other populations in the District. According to 1997 U.S. Census figures, African-Americans comprised 63% of the total population of the District, versus 69% of the total sample. In the same year, African-Americans comprised 79% of AIDS cases, as compared with 81% of the seropositive participants in the sample. In this study, Latino-American participants constitute a somewhat larger percentage (22%) than their 1997 population in the District (7%), but the census figures likely are inaccurate due to the omission of those without residency documents. Gender variant Latino/as also were easier to identify, due to their higher visibility within their smaller community. The smaller percentage of white participants captured in the sample is attributed to their more closeted nature and unwillingness to participate. Male-born participants outnumber female-born participants at a rate of three-to-one, which compares with the estimated incidence of natal sex origins for Gender Identity Disorder in the *Diagnostic and Statistical Manual* of the American Psychiatric Association.

Eighty percent of the sample is under the age of 37, and 40% have not finished High School. Sadly, the most likely reason for the higher numbers of younger participants is the high mortality rate for transgendered residents in the District. A sad duty of Earline Budd, Transgender Outreach Coordinator of the HIV Community Coalition at the time of the survey, was to help coordinate funeral arrangements for deceased transgendered people. In her estimate, an average of twenty transgendered people died each year from 1997-1999, many in their youth. Another possible reason for the high number of youth and young adult participants is that older transgendered people tend to be more closeted and thus less willing to participate in surveys of this kind. The lower education, employment and income levels of the participants may be attributed to the youthfulness of the sample and/or discrimination based upon general and institutional transphobia.

In summary, the WTNAS data, while imperfect, represent a first step forward in understanding a heretofore unknown, hidden population of the District of Columbia. The data illuminate the pressing need for additional research while pinpointing areas which deserve immediate attention for the promotion of health and the prevention of HIV and STDs in this underserved community.

IX. Additional Research

The Principal Investigator strongly recommends additional funding for the continued analysis of the WTNAS data for several important reasons. Subset analysis of transgender subpopulations and their respective data subsets is likely crucial to the design of education and prevention materials, as well as the development of sensitivity and awareness programs for the staffs of health care delivery agencies. The factors that would drive such analyses include:

- *Gender vector*, which describes the direction of gender and/or physical sex change transpeople make, i.e., from female-to-male (FTM) or from male-to-female (MTF).
- Race: racial breakdown of the WTNAS participants revealed a largely African-American population, followed by Latino-Americans.
- Age: a sizeable youth population was found in the WTNAS. 71 participants, or 28% of the total, were 21 years or younger.
- HIV Status

Using the above as guidelines, the Principal Investigator has identified the following as principal transgender subpopulations of the District that would benefit from additional subset analysis:

- MTF (Male-To-Female) Transgendered people
- FTM (Female-To-Male) Transgendered people
- African-American MTF Transgendered people
- Latino-American MTF Transgendered people
- Transgender and visibly gender variant gay and lesbian youth (those 21 years of age or younger)
- African-American Dominant Lesbians (Doms) : a subpopulation not identified elsewhere as transgendered, but an African-American cultural equivalent to "passing women". In the WTNAS, their characteristics were a female physical sex at birth, a gender identity of "woman", a Lesbian sexual orientation, and they reported no interest in hormonal sex reassignment, now or in the future.
- HIV Positive Participants
- HIV Negative Participants

Some significant and possibly determinant differences in barriers to and access of various types of health care, employment, discrimination, housing, as well as sexual behaviors, might be reasonably expected within all these subpopulations. For example, elsewhere unsafe sexual behaviors have been higher in the Male-To-Female population than the Female-To-Male, which would dictate different approaches to education and prevention, as well as risk reduction models.

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XI. TRANSGENDER RESOURCES

National Organizations

Gender Education and Advocacy is a national nonprofit organization with twin missions of education and nonpolitical advocacy in the areas of health and the media. GEA is the successor organization to AEGIS (American Educational Gender Information Service). GEA, P.O. Box 65, Kensington, MD 20895. Phone: (301) 949-3822, voice mail box #8, website: www.gender.org

FTM International is a support and information organization for female-to-male transsexuals. FTM International, 1360 Mission Street, Suite 200, San Francisco, CA 94103. Phone: (415) 553-5987, website: www.ftm-intl.org, email: TSTGMen@aol.com

The American Boyz is a national organization with local affiliates for female to male transgendered persons and their significant others, friends, family members and allies (SOFFAs). The American Boyz, 212A South Bridge Street, Suite 131, Elkton, MD, 21921. Phone: 410-392-3640, website: www.netgsi.com/~listwrangler, email: transman@netgsi.com

The International Federation for Gender Education (IFGE) is an excellent source for information, referrals and books. IFGE also publishes the quarterly magazine *Transgender*. IFGE, PO Box 229, Waltham, MA 02254-0229. Phone: (781) 899-2212, website: www.transgender.org/tg/ifge, email: office@ifge.org

The **Intersex Society of North America (ISNA)** is the best source for intersexed individuals seeking information and support. ISNA, P.O. Box 31791, San Francisco, CA 94131, email: info@isna.org

The National Youth Advocacy Coalition (NYAC) is a national organization focused on advocacy, education and information for gay, lesbian, bisexual, transgender and questioning youth. NYAC, 1711 Connecticut Avenue, NW, Suite 206, Washington, DC 20009-1139. Phone: (202) 319-7596, email: NYouthAC@aol.com

The **Gender Political Advocacy Coalition** is a political organization working for gender, affectional, and racial equality. GenderPAC, 733 15th Street NW, 7th Floor, Washington, DC 20005. Phone: (202) 347-3024, website: www.gpac.org.

Washington, DC Resources

Transgender Support Groups

Transgender Health Empowerment (THE, formerly known as Transgenders Against Discrimination and Defamation, or **TADD**) – contact Earlene Budd at (202) 299-0702. Support, education, outreach and advocacy for transgender persons. Meetings every Friday night from 7:30 to 9:30 a.m. at the Drop-in Center of Safe Haven Outreach Ministry, 805 Florida Avenue NW.

DC Area Transmen Society – contact Drey at (202) 206-0311, or via email : hangdog18@hotmail.com. Social/support group for FTM transsexuals and female-bodied transgendered people. P.O. Box 9363 Washington, DC 20005.

Helping Individual Prostitutes Survive (HIPS) 1-800-676-HIPS (24 hour helpline). Referrals and information for sex workers. It has a transgender-specific group, **Divas Against AIDS**, whose members are involved in HIV outreach, education and advocacy.

Sexual Minority Youth Assistance League (SMYAL) – (202) 546-5940. Support & services for gay, lesbian, bisexual, transgender and questioning youth.

Transgenders Are People – contact Tyineshia Robinson at (202) 543-6777, ext. 13. Education and prevention information and support for transgender persons. Meetings every 2nd and 4th Mondays 6-7 p.m.

Metro Teen AIDS – (202) 543-9355. Support groups and education for HIV+ adolescents.

Metro Area Gender Identity Connection (MAGIC) - (301) 949-3822, voice mail box # 7. Support and information for transsexual persons, their significant others, families and friends.

LGBT HIV/AIDS & STD Information, Services, Counseling and Support Groups

Whitman-Walker Clinic – (202) 797-3500 (Main Number) HIV+, and gay, lesbian, and bisexual health services. **HIV Support Groups** – (202) 797-3591. Leave message for discrete return call. **Lesbian Services Program** – (202) 939-7875. Services include the Lesbian Health Center (breast cancer screening; pelvic exams for LBT persons; screening and treatment of sexually transmitted diseases, including HIV; and affordable mammography referrals) as well as support groups, information and referrals.

Us Helping Us-People Into Living – (202) 546-8200. Education and prevention services, support groups and other care services for African-American HIV+ persons.

HIV Community Coalition – (202) 543-6777. Services and support groups for HIV+ persons.

Safe Haven Outreach Ministry – (202) 588-5983. Substance abuse treatment, mental health, case management and transitional housing services for HIV+ persons.

DC AIDS Information Line – (202) 332-AIDS (2437)

Deaf AIDS Action TTY: (202) 546-9768

Informacion y Servicios En Espanol

La Clinica Del Pueblo – (202) 462-4788. SIDA y otros servicios de salud para Latinos/Latinas.

SALUD – (800) 322-7432. Linea de informacion del SIDA. Lunes a Viernes, 9 am-5 pm.

Linea de informacion de servicios del SIDA – (202) 328-0697. Whitman-Walker Clinic. Si contesta una grabacion, deje un mensaje.

Gente Latina de Ambiente (GELAAM) – (202) 293-7219. Programas social, educacional y SIDA para LGBT Latinos/Latinas.

Substance Abuse Treatment Information, Counseling and Support Groups

DC Metro Hotline – 1-888-294-3572. Information and Referrals, 10 am to 2 am, 7 days/week.

National Drug & Alcohol Treatment Referral Service - 1-800-662-4357

Alcohol Anonymous - (202) 966-9115 (10 am to 10 pm)

Narcotics Anonymous - (202) 399-5316

Anonymous HIV Testing

Whitman-Walker Clinic – (202) 332-EXAM (3926)

Washington Free Clinic – (202) 667-1106

La Clinica Del Pueblo – (202) 462-4788

Crisis Hotlines

Whitman-Walker Crisis Line: (202) 797-4444

DC Rape Crisis Line: (202) 333-RAPE (7273)

DC Hotline: (202) 223-CALL (2255) (24 hours)

DC Crisis Line: (202) 561-7000. (24 hours)