The Washington Transgender Needs Assessment Survey

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# 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 <u>not</u> 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.