

**Community Planning Group
Planning Priorities Committee
Meeting Minutes**

Monday, August 24th, 2009

1:00 – 3:00 p.m.

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: Rick Feely

Excused: David Acosta, Marné Castillo (Co-Chair), Tony Daniel (Co-Chair)

Absent: Suk Gu Lee, Ameenah McCann

Guest: Dr. Kathleen Brady

Staff: Joseph Ellis, Michael Milsop

Call to Order

R. Feely called the meeting to order at 1:15 pm.

Approval of Agenda

After taking a moment to review the agenda, the group approved the document by general consensus.

Approval of Minutes (*July 20th, 2009*)

The group spent some time reviewing the minutes from their last meeting. However, R. Feely could not approve the document since he had not been in attendance at the last meeting.

Report of Staff

None

Report of Co-Chair

None

Discussion Items:

• **Application Update**

M. Milsop reported on two elements from the CDC's new application guidance. Primarily, he told the group that jurisdictions could apply for supplemental funding for the current contract by September 1st. He explained that the CDC had uncovered some additional funding for prevention initiatives; however, he noted that many jurisdictions would be applying for the money.

Additionally, M. Milsop informed the group that CDC was advising jurisdictions to add the sexual partners of PLWHA and IDUs to their prevention plans so that any additional funding could be directed towards services for them. They had not yet mandated that the

populations be prioritized, he explained, because doing so would necessitate a restructuring of the prevention system since contracts were already out. R. Feely asked whether he could recommend adding the populations to the next update of the prevention plan. M. Milsop replied that he could bring the matter to the CPG as a recommendation from the PPC. K. Brady said that she would check to see whether the Surveillance Unit had data on the sexual partners of PLWHA and IDUs. R. Feely noted that PCRS could also be a potential source for the data.

M. Milsop directed the group's attention to the developing list of prioritized populations, which the PPC had worked on at their last meeting. He told K. Brady that the group had not been able to make any determinations about Heterosexuals because the epidemiological update given by M. Eberhart at the May CPG meeting had lacked specifics on the population. K. Brady said that she would collect information on Heterosexual populations and forward it to the PPC. She then gave her support to the prioritization decisions the committee had already made.

- **Trans Population Discussion**

R. Feely took a moment to review the handouts he had provided for the meeting. He informed the group that *Physical and Emotional Health Needs of Transgender Individuals in Philadelphia: Summary of Key Findings* was only in draft form, stressing that it should not be distributed beyond the meeting. He said that the report focused on the overall health of Transgender individuals and that information pertaining to HIV/AIDS was only in one section of the document.

Continuing, he said that *TIP Data* was simply a breakdown of the program's HIV positive clients from the past year and a half. He noted that the data in the first section had come from CRCS while that in the second section had resulted from an HE/RR survey. K. Brady asked how the document defined Ryan White services, since it noted that some individuals were "in RW." R. Feely replied that "in RW" referred to medical care and case management, adding that the case worker at TIP had supplied all the data on positive clients. K. Brady asked whether those outside of Ryan White services had received care through other means. In response, R. Feely said that he believed care in general had been interpreted as Ryan White services.

R. Feely told the group that he had collected the information in *Compilation of Trans Data from Various Sources* over the course of a few years. He felt that the quote "What matters more than HIV is how you look" was very indicative of what put Transgender populations at such high risk for HIV. He explained that, because Transgender populations tended to highly prioritize the ability to inject hormones, it was important for them to have access to clean needles.

Before reporting the data that she had brought with her, K. Brady noted that the CDC had not been collecting data on Trans populations for surveillance purposes and that the Surveillance Department's new reporting system did not have much information on the population either because it had only become operational in July. Additionally, she said that the first cases entered into the database had come from the previous case report form,

which did not include questions about Transgender status. She told the group that the only way for those earlier cases to enter the system would be if they progressed from HIV to AIDS. However, she noted that, because the system would continue to collect data on Trans populations moving forward, more and better data would be available in the future. In response to a question by R. Feely, K. Brady said that individuals who had had their surveillance data collected through medical records were identified as MtF or FtM Trans under sex. Those who had their information collected through surveys, she continued, were asked what their sex was at birth and their current gender, noting that the variables were compared to ensure that there were no discrepancies. However, she reported that there had been very few Trans-related questions in the last IDU survey. She also said that very few Trans individuals had responded to the MSM survey, approximately two or three out of five hundred.

K. Brady informed the group that the Surveillance Department was about to conduct another IDU survey. She said that, since the survey was not venue-based, the department had to get seeds to take it. She noted that a hormone-injecting Trans individual would be an ideal candidate to take the survey. R. Feely replied that there were not many Trans individuals injecting drugs, only hormones. He added that, according to data from STARR (Strengthening Trans Adolescents' Risk Reduction), crack use was most prevalent among Trans individuals with substance abuse issues.

K. Brady provided the group with some data on Trans populations from counseling and testing services. She said that her data was only from the first nine months of 2008; however, she noted that the forthcoming Trans population Workgroup meeting would provide more information. She reported that, out of the 41,000 performed tests that included a gender variable, 89 individuals had reported being Trans. She clarified that 54 respondents had been MtF Trans while the remaining 35 were FtM. She informed the group that all 89 of the individuals had tested negative for HIV. According to 2007 data from the Ryan White Care System, she continued, only 69 individuals had been reported as Trans out of the EMA-wide total of 9,557 clients. She said that quality of care indicators had been the same for Trans populations as it was for all others. In closing, K. Brady reported that the Client Services Unit had tracked gender for all intakes in 2008, with a result of 27 Trans individuals (all MtF) out of 2,106 total intakes.

R. Feely informed the group that many Trans individuals would not take confirmatory tests after receiving positive results from a rapid test because they did not wish to disclose their names. K. Brady replied that individuals from other populations often would not take confirmatory tests as well for the same reason. However, she said that the ISU made a graph of preliminary positives who did not take a confirmatory test, which she said she would obtain so that the group could make a better determination about the matter. R. Feely also noted that many FtM individuals would not disclose that they were Trans on their testing forms, even in Trans-friendly locations such as TIP. K. Brady replied that it was sometimes difficult to get good data when relying on self disclosure. However, she pointed out that some providers might track sex at birth or make determinations about clients based on appearances.

M. Milsop reminded the PPC that, up to that point, they had been basing their population prioritization decisions on hard data. Since there was not a significant amount of hard data for Trans populations, he said that the group could either make an educated guess using the available data or reevaluate the population after more information became available. K. Brady stated that, following the available data, the Trans population in Philadelphia was likely small, both in general and compared to other jurisdictions. However, she noted that risk-levels among the population were certainly high. M. Milsop asked K. Brady whether she felt that the available data on Trans populations was sufficient for the group to make a prioritization decision. K. Brady responded positively; however, she warned against using the University of California data unless it was representative of the entire nation and not just San Francisco. Using the available data, R. Feely determined that African American, MtF Trans who were under the age of 40 were the most at-risk among the population. He noted that receptive sex with men and the injection of silicone and hormones were the behaviors that most put the population at-risk. Lastly, he listed the secondary factors that increased the risk of HIV infection among Trans populations, namely, homelessness, lack of education, substance abuse, mental health issues, poverty, lack of insurance or access to medical care, sex work, and violence. M. Milsop noted that the PPC had already included all of the mentioned secondary factors in their list of cofactors for general populations.

As the discussion came to a close, the group noted that more information on Trans populations would soon become available. R. Feely stated that data on the population would come from the Prison Health Survey and from STARR. K. Brady told the group that, in preparation for the Trans Workgroup Meeting, she would breakdown available data by different categories, such as age and race.

Old Business

None

New Business

None

Review/Next Steps

The committee took a moment to review their decisions and next steps:

- R. Feely recommended that the partners of PLWHA and IDUs be added as priority populations to the next update of the prevention plan in order to follow the recent updates to the CDC's application guidelines.
- K. Brady will provide additional epidemiological information on Heterosexual populations in time for the next PPC meeting.
- After reviewing the data on Trans populations provided by R. Feely, the group determined that African American MtF under the age of 40 would be the targeted subset of the population.

Announcements

None

Adjournment

The meeting was adjourned by general consensus at 2:31 pm.

Respectfully Submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*July 20th, 2009*)
- Physical and Emotional Health Needs of Transgender Individuals in Philadelphia: Summary of Key Findings (Draft)
- TIP Data
- Compilation of Trans Data from Various Sources
- Transgender Needs Assessment Summary (2005 Philadelphia Prevention Plan)
- Center of Excellence for Transgender HIV Prevention
- OHP Meeting Calendar

COMMUNITY PLANNING GROUP (CPG)

Planning Priorities Committee

Meeting Agenda

Monday, August 24th, 2009

1:00 – 3:00 p.m.

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia

Call to Order/Introductions

Approval of Agenda

Approval of Minutes

Report of Staff

Report of Co-Chairs

Discussion Items:

- **Application Update**
- **Trans Population Discussion**

Old Business

New Business

Announcements

Adjournment

Please contact the office at least 5 days in advance if you require special assistance

*The next meeting of the Planning Priorities Committee is **Monday, September 21st, 1:00 – 3:00 pm.**
The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia
Please refer to the Office of HIV Planning's attached Calendar of Events or its website, www.hivphilly.org,
for updated committee meeting information.*

**Community Planning Group
Planning Priorities Committee
Meeting Minutes**

Monday, July 20th, 2009

1:00 – 3:00 p.m.

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: Marné Castillo (Co-Chair), Tony Daniel (Co-Chair)

Excused: David Acosta, Rick Feely

Absent: Suk Gu Lee, Ameenah McCann

Staff: Joseph Ellis, Michael Milsop

Call to Order

M. Castillo called the meeting to order at 1:10 pm.

Approval of Agenda

After taking a moment to review the agenda, the members of the PPC approved the document by general consensus.

Approval of Minutes (*June 15th, 2009*)

The group spent some time reviewing the minutes from their last meeting. Afterward, they approved the document by general consensus.

Report of Staff

M. Milsop reported that he had spoken with Sam Cutler, the Co-Chair of SAMHSA's Epidemiological Committee and the manager of the Office of Addiction Services, about the issue of whether to change the language in the next prevention plan from IDUs to SIPs (Sharing Injection Paraphernalia), as had been discussed at the last meeting. He reiterated that the reasoning behind the proposed language change was to clarify that it was the sharing of needles and not drug use per se that put an individual at greater risk for infection. He said that S. Cutler had been completely supportive of the proposal and encouraged the committee to change the language, as other jurisdictions had already done. He told the group that S. Cutler had even suggested changing the term to SIIPs (Sharing Infected Injection Paraphernalia) for complete clarity. M. Castillo felt that the matter should be brought to the CPG in order to allow for a fuller discussion on the matter. The rest of the group agreed.

M. Milsop also gave the committee an update on the prioritization process. He said that the Literature & Education Committee would soon bring their factors for reviewing interventions to the CPG for approval. Shortly thereafter, he continued, the PPC would bring its cofactors for general populations and draft list of prioritized populations to the CPG for approval. He also said that, in a future work session, the CPG would weigh the factors for prioritizing the target populations. However, he noted that the next step for

the CPG was making a decision on concurrence even though the CDC had yet to release the application for continuation of the prevention grant.

Report of Co-Chair

M. Castillo reported that, since the group's last meeting, M. Ross-Russell had mapped the census data on poverty, as previously discussed. M. Milsop agreed and noted that the map had been included in the meeting handouts.

Discussion Items:

- **Populations Discussion – Epi Data Review**

M. Milsop reminded the committee that, during their last discussion on prioritization, they had decided to organize their list primarily by gender (male, female, and Transgender) so as to include the entire population. He then directed their attention to the epidemiological data contained in the handouts, noting that the group would use the information to further develop their prioritizations. Additionally, he informed the group that, following a directive from the CDC's Advancing HIV Prevention initiative, PLWHA would have to be prioritized first. He suggested using the data on concurrent HIV/AIDS to more specifically prioritize within the population.

As the group started to draft their list, M. Milsop pointed out that there was no data on Trans populations in the epidemiological data, which he said would make it difficult to prioritize the population. T. Daniel asked whether 'Trans' should be further broken down into 'MtF' and 'FtM' in the uppermost section of the prioritization list. However, M. Castillo reported that, when the group had started to draft the list, R. Feely had felt that such specificity was unnecessary at that level of the prioritization.

Having listed PLWHA as their first priority, M. Castillo asked the group whether they wanted to use risk group categories, race, or age as the next level of delineation for their priorities. T. Daniel felt that risk group categories should be the next level of prioritization because most interventions were structured around changing behaviors. M. Castillo agreed. However, she then asked whether the process required the CPG to weigh the various sources of data for prioritization before the PPC further developed their draft prioritization list. M. Milsop replied that it was not necessary for the group to wait for the factors to be weighted before developing the draft list further. Additionally, he pointed out that waiting for the factors to be weighted could delay the process and be detrimental to the development of the plan. He also noted that the epidemiological data contained in the handouts made some fairly clear indications of populations that should be targeted. The rest of the group agreed and continued with the discussion.

T. Daniel suggested using race as the next level below risk groups in the draft prioritization list. He then informed the group that new data was showing that many African American MSM across the nation were starting to identify as Transgender. He said that he had seen evidence of the new trend in Philadelphia as well and, therefore, wondered whether the group should plan their prioritization accordingly. M. Castillo replied that the PPC still had sufficient time to make any changes in their listing if they received any new data.

Using the information contained in the selected slides from the Epidemiological Update presentation, the group produced the following draft prioritization list:

	Men	Women	Trans
	PLWHA	PLWHA	PLWHA
IDUs (SIPs)	African Americans & Latinos 25 years +		
MSM	African Americans & Latinos 14 – 64; Caucasians 25 – 64		
Heterosexuals			(?)

As the conversation was brought to a close, the PPC noted that they would require additional data on heterosexual men and women, female IDUs, and Transgender populations in general. T. Daniel requested that the OHP forward any information it received in the interim to the members of the PPC so that it could be reviewed before the next meeting.

• Next Meeting Date

The group suggested coordinating their next meeting with R. Feely’s availability so that he would be able to provide some information on Trans populations. J. Ellis said that he would contact R. Feely and report to the rest of the members when a time was scheduled.

Old Business

None

New Business

None

Review/Next Steps

The committee took a moment to review their decisions and next steps:

- The committee determined a method for organizing their draft listing of prioritized populations.
- Using the method, the group nearly completed their prioritization of male populations
- The committee will request further epidemiological data on heterosexual men, IDU and Heterosexual women, and all Trans populations in order to continue their prioritization process.

Announcements

None

Adjournment

The meeting was adjourned by general consensus at 1:54 pm.

Respectfully Submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*June 15th, 2009*)
- Data Sources for Target Population Factors (excerpt from the AED Guidelines)
- Selected Slides from the Epidemiological Update Presentation
- Mapping of Census Poverty Data
- OHP Meeting Calendar

DRAFT

Physical and Emotional Health Needs of Transgender Individuals in Philadelphia:

Summary of key findings

Report Completed by: Lee Carson, MSW, LSW
Research Associate
Public Health Management Corporation

This study was completed with funding from the Commonwealth Universal Research
Enhancement (CURE) Program

DRAFT

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DRAFT

Acknowledgements

There were many people who helped to make this project a possibility from its conception to the end product. First I would like to acknowledge the state of Pennsylvania, Department of Health for providing the funding for this project through a Commonwealth Universal Research Enhancement (CURE) Program grant. Thank you to Jennifer Lauby who provided much of her expertise and insight into the development of measures, conceptualization of the project, data analysis and document editing. Archana Bodas-LaPollo for her assistance in helping to set up the working group and reviewing project materials. The members of the Transgender Health Working Group who spent time helping to conceptualize this project and providing guidance on developing the instruments used for this project. I'd like to acknowledge the community members who took the time to sit with me to refine the terminology used in the survey instrument.

There were also key people who helped to successfully execute this project through its different phases. I'd like to acknowledge Damon Constantinedes and Nia Henderson who served as co-facilitators for the focus groups. Cassie Cosentino, an MPH intern from Drexel who assisted with the focus groups and for her transcription of one of the groups. Danae Maragoutrakis, another Drexel MPH intern, for her work in helping to manage the process of getting the survey's to participating organizations, entering all of the surveys into SPSS, assisting with data analysis, and for completing all the other activities delegated to her on this project. To Allegra Gordon, who volunteered her time to transcribe several of the focus groups.

I'd like to acknowledge all of the organizations that agreed to administer the survey at their sites or through their groups. These organizations are: Action AIDS, AIDS Services in Asian Communities (ASIAC), The Attic Youth Center, The COLOURS Organization, Gay and Lesbian Latino AIDS Education Initiative (GALAEI/TIP), Mazzoni Center, Safeguards, Trans Masculine Advocacy Network (TMAN) and William Way LGBT community Center.

Last, but certainly not least, I'd like to acknowledge every single person who took the time to give us valuable information about their lives and experiences so that this project could be conducted and this report could be created. I hope their efforts will not be in vein and that this report will create positive change in the city of Philadelphia for its transgender citizens.

Background

The impetus for this project started in September of 2007, when members of the HIV research division of Philadelphia Health Management Corporation (PHMC) convened a meeting with members of transgender communities and stakeholders invested in improving the health conditions of transgender Philadelphians. The purpose was to discuss how PHMC might best be able to use the Commonwealth Universal Research Enhancement (CURE) Program funds we were applying for to benefit transgender communities in Philadelphia. The decision made by this transgender health working group was to complete an updated needs assessment for transgender communities in the metropolitan Philadelphia area.

The last comprehensive needs assessment conducted on transgender Philadelphians took place in the mid 1990's, so it was the sentiment of the working group that it was time to get an updated picture on the needs and experiences of transgender Philadelphians. It was acknowledged that The Office of HIV Planning released a report in 2006 on HIV prevention and care needs that included a section on the transgender population. Our plan for the needs assessment would include a broader picture of the experiences of transgender communities by focusing on health issues beyond HIV, such as other medical health conditions, mental health, experiences with discrimination, resiliencies, and experiences with medical providers to name a few.

The specific aims of the needs assessment were:

- (1) Gain an understanding of transgender individuals' experiences with physical and mental health care seeking, quality of relationships with healthcare providers, experiences with medical and behavioral health service systems, knowledge on trans and non-trans related healthcare seeking, experiences with employment seeking and identification of resiliencies;
- (2) Describe the general health status, housing status, usage of healthcare systems and gaps in knowledge on trans and non-related health care of transgender individuals in Philadelphia and assess differences by age or racial/ethnic group;
- (3) Create a report, with recommendations, based on the data collected to influence policy development and enhance service provision for transgender populations.

In order to address these objectives, we collected qualitative data using focus groups, and quantitative data using an online and self-administered survey.

Focus Group Findings

The information contained in this section is based on five focus groups completed between the months of May and June 2008. The five focus groups were: Male to Female and Female to Male ages 18-24, Male to Female and Female to Male ages 25+, and one group for Gender Variant persons ages 18+. All of these groups were conducted in a location well known to the target population located in Center City Philadelphia. Recruitment methods for these focus groups included fliers that were distributed at community-based organizations and given to social and support groups that served transgender communities. In addition, a smaller index sized card was made and distributed to potential participants during the Trans Health Conference via a peer outreach effort. Lastly, outreach for the groups were conducted during the Prevention Summit in June 2008.

Focus group participant demographics

Table 1: Participant demographics

<u>Race/Ethnicity</u>	<u>n</u>	<u>%</u>
African American/Black	10	45
White/European	7	32
Asian/API	2	9
Mixed Race/Other	3	14
<u>Age</u>		
18-24	9	41
25-39	12	55
40+	1	4
<u>Employment Status</u>		
Full time	12	55
Part time	4	18
Student	1	4
Unemployed	5	23

Table 2: Identity and Sexual Orientation

<u>Gender Identity</u> *	<u>n</u>	<u>%</u>
Transgender	16	72
Transsexual	4	18
Female	3	14
Male	7	32
Gender Queer	8	36
Other ¹	4	18
<u>Other Identity</u> *		
Male to Female	7	32
Female to Male	8	36
Gender Queer	7	32
Male	5	23
Female	2	9
Other ²	4	18
<u>Sexual Orientation</u>		
Heterosexual	4	19
Gay	3	14
Bisexual	0	0
Lesbian	9	43
Other ³		

* Could choose more than one option.

¹ Gender options written in the provided space were: transman, FTM, man, androgyne, gender variant, trans, and FtX.

² Participants were asked “Do you identify with any of the following identities?”. Included in the “other” category were: transman, FTM, man, person of transgender experience, androgyne, and gender variant.

³ Sexual orientation options written in the provided space were: queer, attracted mainly to women and MSM. Several participants checked this category, but did not provide a written response.

To solicit information from the participants, a semi-structured interview guide was used. This guide was developed with input from the transgender health working group. Each focus group was co-facilitated by the project's principal investigator and a peer facilitator with the same gender identity as the group they facilitated (ex: MTF groups were co-facilitated by a MTF transwoman).

This section contains experiences with health care providers, barriers and facilitators to health care access, sources participants use to get health information, experiences with the behavioral health system, experiences with discrimination via various mechanisms, and resiliency factors that help these participants mitigate the impact of the distress they may experience as a result of transphobia among other psychosocial oppressive forces.

Health Care Access

Participants shared various experiences with the level of trans related health care access they have experienced here in the city of Philadelphia. Both barriers and facilitators to accessing care were discussed and the need for more access points, including some outside of Center City was a sentiment shared by many of the focus group participants.

Barriers

Some of the barriers participants reported were due to insurance issues such as not being able to go to a specific provider who is known to be well versed in trans health care, because that provider isn't in that patient's insurance network. The issue of insurance coverage was a barrier for several participants, and for some the main barrier to accessing care was simply that they weren't able to find a provider they felt comfortable with. Barriers to specific transition-related procedures were also discussed as a means of sub-standard access to services desired.

Well a lot of those – not necessarily resources – but a lot of the doctors that are recommended are not within healthcare networks, so you have to pay out of pocket and that's just not a viable option a lot of the time. Gender Variant Group 18+

...because I say it straight up on the phone, "I'm genderqueer and I'm considering hormone therapy. I'd like to talk to somebody who just even knows the physical aspects of it." And as soon as they get the transgender vibe, they're like, "I don't know what to say." And they clam up and they say "I'm sorry I can't help you" basically – and I feel like I'm constantly getting the door. And that's really frustrating. Gender Variant Group 18+

A big issue is that a lot of the surgeons who kind of advertise themselves as providing trans services work in private practice and so if you're getting anything covered through insurance, whether it's breast reduction or reconstruction – to me it can be tricky to find a provider through your health insurance to do that. FTM 25+ group

My insurance, I found out, covers everything, but they have an unusually high deductible for everything. Like if I just wanted to see a therapist they wouldn't cover it until I finished like 500 bucks in therapy. And that makes no sense. But apparently that's what they have and they have certain limits to surgery as well. Like I can get the surgery, but if it's more expensive than x amount of dollars then everything else will be out of pocket. FTM 18-24 group

One participant shared her frustration with the process that one needs to undergo to start hormone replacement therapy and how this process turns certain segments of the trans population away from seeking hormones in a medical setting:

I think they should be able to do your lab work and stuff, but I don't think the psychological part I just don't really see that at all. I really don't really see that at all because like no one on this earth can determine what you are but yourself. If you're telling me that I am not fit to take hormones I am going to get them off the street. So, the blood work and stuff is fine to see if the hormones is capable with our bodies and stuff like that, but all that other evaluating that's why they don't have a lot of young girls coming in there because that pushes them away.

MTF Group 18-24

Another participant talked about their frustration with the process as well, but from the standpoint of needing a psychiatric diagnosis in order for their insurance carrier to pay for hormone replacement therapy:

I know with my insurance – my insurance plan won't cover hormone shots unless I go for [therapy] X number of weeks or months and my diagnosis for that period has been that I have whatever ridiculous GID or whatever they call it. I don't think they used GID – they called it transsexualism or something like that. But I have to be in therapy in order to get what I know I need. And I know I'm not mentally ill about this particular thing.

Gender Variant 18+ group

Not presenting with a clearly defined male or female gender presentation also serves as a barrier for those who don't prefer a binary gender presentation, but try to access hormone replacement therapy in a medical setting:

Even with services, okay so there's [name of institution] which provides hormones, but there's shade about hormones if you're, if you don't have a neat FTM or MTF trajectory with an easy story to tell. And there's lots of people accessing black and gray market hormones because they don't want to deal with that. Myself included.

Gender Variant group 18+

In the MTF 18-24 group, there was dialogue about how easy it can be to obtain government issued health insurance if one knows the steps to take. However, a barrier to obtaining insurance is encountered if the individual doesn't have access to the necessary documentation, such as their social security card or birth certificate. Additionally, they may experience difficulties navigating the process of applying because of the discrepancy between the gender on their documentation versus their gender presentation. While this issue was only mentioned in this particular group, it is applicable across the full spectrum of transgender persons who may encounter this issue:

The only way it's hard is if you're one of them girls that don't have a family behind you and your birth certificate and your ID and stuff is lost and you don't have nothing to get that stuff with.... That's the only reason why it gets hard, especially if you're a trans girl and your name is Richard and your girl name is Olivia and want them to understand that birth certificate and you have no documentation at all-that's when it becomes really hard.

MTF Group 18-24

Another participant in this group shared her experience of being embarrassed in the waiting room when applying for public insurance based on her gender status and how she coped with this issue to get her needs met:

..it's just that some people going to the welfare office and get a form and stand there and fill it out. I've done it as a transsexual and they called me by my boy name and you know what, I was embarrassed that they called me by my boy name, but I sat there and waited there for like 3 minutes and then went up and asked, "did you call such and such?" It's just that easy. Like you want to have to want it for yourself, if you don't want it for yourself you are not going to get it. MTF Group 18-24

The issue of confidentiality when it comes to health information was discussed as a barrier at times to accessing comprehensive health care at one place, which led at least one participant to split her care. While the statement below captures this one participants' views, it reflected the general sentiment of others in this particular group. This discussion primarily came up in the younger MTF group:

I would feel [more] comfortable going to an outside clinic than a LGBT clinic because so many people that work there and everybody knows somebody and if I one day come up with something, I'm going to hear that everybody knows what's going on with my personal life, so that's why I go to [name of institution] for my hormone treatment and go to a regular doctor for my physical. MTF 18-24 group

Facilitators

Participants talked about a variety of things that helped to connect them to health care, including accessing hormone replacement therapy.

One participant talked about how she feels the affordable hormone replacement therapy services provided by a local medical facility helps some get connected to care:

The other reason I think [name of institution] is really good with hormone therapy because whether you have insurance or not or you a sex worker or have no income, they do your blood work for free. They go by your income; they let you know what you have to pay. It's very, very feasible for people to go there. It really is. MTF 18-24 group

Another participant shared how she learned to get her medical needs met through the public health centers as a means of care until obtaining insurance:

If you can't get medical insurance, what I have learned is you can go to the free clinic and they give you that little yellow card that's your proof of identification and you can go there for a while and get services through them and then try to get your stuff set just with that yellow card because it has your name, and your date of birth. So, it's a step. MTF 18-24 group

A theme that arose from two of the focus groups was participants' desire to see more access points for transgender related health care. They felt that there was too much reliance on Center City and that not all transgender persons want to go there. In addition, some participants who identify as heterosexual didn't necessarily want to have to go to an LGBT identified health center to receive their care. Overall, the sentiment was that increasing the number of places one can choose to go for trans related care would likely lead to more people accessing care:

Or even just acknowledge that there are – I mean there are other trans-friendly doctors in the city. That the funding shouldn't be centered around one center in all of Philadelphia. Cuz even with just the location – you know, people have to travel just to do that. Everyone doesn't go downtown ... FTM 25+ group

I mean, there are other places that if funding was provided could expand their services to the trans community and not just be centrally located in one organization. FTM 25+ group

I think we need more than one clinic that advertises services for trans people in the city of Philadelphia. I think that [name of organization] – that that name keeps coming up as the only place to go – is ridiculous. And there have been some recent events at [name of organization] – I feel like if there were competition for them, those things wouldn't have happened because they would be held to a higher standard. FTM group 18-24

I think if there was more offices than that one, there would be more results in the transgender community. More girls would be like okay instead of going across the city, I can go two blocks down the street or around the corner. A secondary or tertiary office somewhere else (inaudible). That's my suggestion. Some type of fundraiser for another building in the city. MTF 18-24 group

[I] love [name of institution] and I go there for a lot of things, but if it's something outside like dealing with my genitals or my hormones I would never go to [name of institution] because I wouldn't feel – first of all I wouldn't go to an LGBT clinic every time I have a problem because I don't feel like I fall into that lifestyle. I don't want to go there for everything. But, if it's like real specific things with my genitals then I would feel comfortable there, but beyond that I have to go to another clinic. MTF 18-24 group

Experiences with Healthcare Provision

A portion of the focus groups explored the experiences participants have had with service providers, including support staff within medical institutions. Some participants talked about the attributes they found appealing in providers, which made them comfortable accessing services. Others shared experiences of sexual assault by a provider and other negative and traumatic experiences with providers that led to avoidance or ambivalence about engaging with providers outside of an emergency situation. Participants' experiences also varied within the same organization at times, where one person felt their treatment as a transgender person was really great, while another shared experiences of disappointment at the lack of sensitivity they received around their gender identity.

Distressing experiences with providers

Some of the participants talked about how their gender identity was not respected when they were in need of services:

Before I got my name changed, I had got into a little accident and I had to go to the hospital at [name of institution]. The only problem that I had with the doctors and stuff they was calling me Mr. (Name) and I didn't like that at all..... and I told them like I don't want to be addressed as that. I don't care what my medical records say, it's not how I want to be addressed and they did not respect that at all.... MTF 18-24 group

I had a totally different experience my first time at [name of institution]. I went there for a physical for a school that I was attending. The form was fine – it was a little big leaning towards oh, pick one, like pick the box. But they were calling me by my birth name and I was like this is the [name of institution], it's supposed to be inclusive and make me feel comfortable, and it was terrible, you know, I was shocked. Gender variant group 18+

I had an experience a year ago where I was sexually assaulted by a doctor when I attempted to access emergency care – that wasn't in Philadelphia, but that's really discouraged me from going

to an ER in Philly. Especially since there's no guarantees – even at [name of institution] where you call and they say “Oh, we have trans-competent social workers” – you never really know what that means. FTM 25+ group

One participant talked about his uncomfortable experience at a particular hospital when going in to get treated for a toothache. He felt that he was more of a spectacle given the procedures they wanted to go through, which he felt were inappropriate for the presenting problem:

Yeah, I went to [name of institution]. And I went in there for a toothache. And about 3 of the doctors in there tried to get me to put on a gown. After they sent probably 5 people to come in and ask me questions. You know they're looking at me, trying to give me a body exam, and I'm like “My tooth hurts I don't need to wear a gown – you know you don't have to give me a full body exam, I don't have to lay down.” But it was like, they were just sending people in, they'd look at me, ask me a few questions and go back out and send somebody else in to ask me questions, try to get me to put the gown on – it was like, “Just give me some pain medicine so I can leave” – it was basically, like you know, 6 hours of that. FTM 25+ group

Participants also had some negative perceptions of city run health centers and their ability to treat transgender patients with dignity and respect. This was underscored by perceptions some have of these health centers and others by actual experiences they encountered. However, while some had negative experiences with this system, they took the time to educate the staff there, so their needs could be met. The majority of the discussion regarding services at city run centers took place in the younger MTF group.

It's run by the City so you just have your own expectations. It has to be open and running because it's run by the city, but that don't mean they gotta treat you nice. Like they don't treat you nice if you're heterosexual, if you're this, or you're mainstream – they don't treat the people that come in that are mainstream like for STD testing and stuff like that – so if you are out of the mainstream and you already self-identify out of the mainstream, you definitely don't want to go there. FTM 25+ group

They don't know anything. They don't believe, to me its like transgender does not exist to them. You are either M or you're F. It's not like that no more. Sorry. It's not like that no more. That's my experience-learn something. So, me doing all that explaining to them might help a little, but I got to go through all that and it is a drawn out process and I get sick of it. MTF 18-24 group

Some people are not going to be open-minded to whether you're trans or not. You can explain it to them as much as you want, but they don't want to hear it. You are still a man to them. And especially like what I heard most clinics if they haven't been to [name of institution] you are not going to have a positive experience. MTF 18-24 group

Like, specially these health centers. I go to the one on [location of health center] Like I guess I was their first transgender, so I opened up a new world for them-they had no clue about Estrofem or anything. I had to sit there and like explain myself. So, I think like educating them health care centers and these hospitals would help with the situation. MTF 18-24 group

One young trans woman talked about the coping strategy she uses to combat discrimination when seeking care at the city run health center she has attended:

You know why I don't think I go through some of this stuff because I don't have time to be judged because I am sick and stuff like that so I don't have time to go through all that so I

fake and lie till I get back there. I'll act like I'm a biological woman and when it's time for the doctors to see me that's when I tell them I am a transsexual and this is what it is and how it's going to be. I am already back there, you got to see me now. FTM 18-24 group

Positive experiences with providers

Participants shared their experiences with health care providers that were positive for them and some of the attributes of those providers they liked. The use of language came up as an important factor in comfort with care, whether it be about labels given to body parts or about gender identity.

...where I go, they are very trans friendly.... they address you on how you look even if your name is not changed. They treat you actually better than their regular patients. I don't know why they may think they have to cater to you because you are trans, but they treat you exceptionally well and the mannerism is very good like, you get all your work done no problem, like its real good. They treat you like a normal human being. They don't look at you as trans, but they look at you as a woman and they give you good advice. MTF 18-24 group

The best medical care that I ever had where I really felt comfortable was actually at a program called [name of institution]. They have like a doctor there and he asked me like cause-it had to do with a full body checkup. He asked me what area you want me to call this and he was very like.... very sensitive and I had never had a doctor like that ever. So, I think that was the best medical care I ever had. MTF 18-24 group

I think the reason [name of institution] thus far has been the only healthcare provider where I can feel completely at ease is just from the first time I went there and I went to fill out all the forms that you have to fill out when you go to a new doctor and I got to the gender box and I didn't have to play the eeny meeny miny mo game. And I was very excited that there was a gender that I can fill in and they would know what I was talking about – and that was great. FTM 18-24 group

[My provider] uses reflective language that I use to talk about my body. And knows that I am, tells me what's going to happen. Like: "It's going to be like this. And it's going to be really fast." And has not made assumptions about who[I am] – and has been able to like continue to see me in my gender, even knowing that I have kids, and that I'm a biological parent of kids, which is apparently impossible, even for people with lots of experience with trans identities, that like she can get it. Gender variant group 18+

A couple of participants in the same group went on to support the idea of language being important to a positive health care experience:

I agree that vocabulary is incredibly important...like any sort of queer-friendly vocabulary – even the word fucking "queer" I'm like oh, great, sign me up. I'll be your patient for the next three years. Gender Variant group 18+

It's a really general recommendation, but if there was just some sort of expectation that doctors were going to come in and understand the extent to which gender affects every single aspect of healthcare from just stupid things like getting a mole checked out at the [explanative] dermatologist to like actually going and asking questions about hormone therapy and things like that. It's a whole missing set of terms. And that's a real problem. If it doesn't exist in the language that we're using to treat people then it just doesn't exist – the treatment doesn't exist. It's not a specific solution, but it makes a good starting place. Gender Variant group 18+

One participant expressed his appreciation for the medical provider he saw for a Colonoscopy to not bring up gender identity issues that the participant didn't feel were relevant to the procedure:

I actually had to have a Colonoscopy a number of years ago, about four years ago, and I did it through [name of institution] that is no longer – that shut down. Well, there was a specialist there that I was referred to – I can't remember what they are, the specialists that work with Colonoscopies – but obviously he knew I was trans and I had a pretty good experience. The issue of trans never came up once and I had a Colonoscopy, so I was, you know – and I felt very comfortable with him and his associate. FTM 25+ group

Sources of Healthcare Information

One of the areas explored in the focus groups is how participants obtained the information they needed related to transgender health issues. One of the common methods used is the word of mouth system from trusted peers in their social network.

Sometimes it's kind of like an underground market – you know somebody that knows somebody. Most of the people that I know that identify as trans too work in nonprofit organizations or a social service organization – they provide services to the queer community or the gay community and that will be the one point person and I'll usually go to them for services. FTM 25+ group

I ask my social networks and find out where are you going. I get information from the people I know. And at this point I have a doctor that I like. She's actually a nurse practitioner, no a physician's assistant, and I quite like her, and I trust her. Gender Variant 18+ group

....now that I've moved to Philly I feel like I'll be more likely to call someone and get advice. I called you [another FG member] for something a few weeks ago. Some sort of injection-related issue. So I haven't really needed to go online to look things up. Or to have to call my doctor to get information. FTM 18-24 group

Some of the participants also talked about using online resources to find out information not just on transgender related care, but also general medical care such as medication information. Online resources may be especially important to people who live in more rural areas where there is little to no local resources for trans related care. Using the Internet to find resources was mentioned primarily in the younger FTM focus group.

I found this one really good website that had a lot of information specifically for FTM that was broken down really well. There was health-related information and then basic sort of life passing skills, like how to tie a tie and whatever and I checked that source like every day or something – for the first couple months. FTM 18-24 group

I use WebMD.com. It's a pretty general website but it's got good information on any sort of condition or medicine that you want to look up. So I use that every time I get a prescription, just to see if I'm getting the right thing, or stuff like that. But that's the only thing that I've used. FTM 18-24 group

Another participant shared their thought on the need for a centralized information resource where trans persons can go to get information they feel is necessary for their transition process:

Like there are a lot of little aspects, like smaller aspects of transition that kind of get overlooked. Like, most transwomen need electrolysis. Everybody – most people need to get their name change, or their documentation changed. Some people need help navigating how to fill out the forms and use the court system to change your name. And like I don't have money to hire a lawyer to change my name. And there are places in the city that you can have it done for free – that will do it for you, that specifically work with trans people.....And I think there need[s] to be more availability of resources and networking of where to go for these things. Like, who's not going to scam you. And treat you like a human being, and stuff like that. FTM 18-24 group

Experiences with the Behavioral Health System

Another area of the focus groups explored the participants' experiences with the behavioral health system in Philadelphia. Because we didn't want participants to feel put on the spot about such a sensitive topic as accessing mental health or chemical dependency treatment, they were also encouraged to share experiences of their peers who have had interactions with these systems. In addition to participants sharing their experiences, they provided ideas they felt would help improve service provision for transgender populations.

Distressing experiences

Again, this hasn't been my direct experience, but from people I've talked to that they've just faced a lot of discrimination or abuse. You know trying to go to like recovery houses, programs, that kind of thing. Whether it's – again, if it's a gender-specific facility, not having options around where they want to go. You know, just being denied altogether because staff didn't want to deal with their gender. And having a friend who went to a hospital psych unit cuz he was suicidal and was asked pretty irrelevant questions around what kind of support he needed and that it was because he was trans that he was suicidal, and that he needed to deal with that issue when that wasn't at all related to why he came in there. FTM 25+ group

I think it's hard to find a therapist anyway. And just the regular process of trying to find a therapist and on top of that trying to find a therapist that's not going to try to change your mind about how you feel about yourself or actually addressing the trans issue. Because I've gone to therapists and one therapist I went to was in the community and you know basically she told me that I should forget about binding because I was too big or something like that. You know, I'm going to her as someone who's supposed to be trans-welcoming and here she's telling me that I shouldn't do certain things. That's hard. And then for me to wanna go find another therapist – I'd rather be depressed than have to deal with that.

FTM 25+ group

I've had friends that have gone to therapists that used the wrong name and pronoun even. And would switch back and forth on names and pronouns. Or they just didn't feel like their gender issues were being taken seriously.

FTM 18-24 group.

In the gender variant group, one of the participants expressed their disappointment in therapists who may be well versed in sexual orientation issues and may extend this expertise to gender identity issues, which are not the same and left this participant feeling they were receiving sub standard care:

If you get this referral for this queer therapist, any sort of queer mental health professional it's like, people seem like they're getting better if they're on the queer list,

with the like gay, lesbian, bisexual sexuality issues – but then you bring anything gender variant related into the mix and then I've just had really, really bad experiences. I've had doctors and I'm like "You're really awesome, we're just never going to talk about gender." It's like the elephant in the room. The gender variant elephant. Gender Variant 18+ group

One participant talked about their experience with mental health providers as one that was quite frustrating because the providers would keep focusing on their history of abuse as an issue, when that wasn't what they wanted to focus on for their treatment:

It's very hard for me to go anywhere for mental health stuff and for anyone that I'm talking to to understand that I'm not here because I'm gay or because I'm queer or because I'm gender variant. Those are not items on this table. It's impossible to separate. They just don't get it. I'm not depressed because I'm gay, I'm not depressed because I'm queer, I'm not depressed because I'm gender variant. I'm depressed because I had an abusive childhood. Let's start there. And they all: "Oh, so your abusive childhood made you gay." No!! And it's constantly, they want to go back to this as my root, and it's not. You know. And I think that's also the same sort of head butting I get with physicians in general. Gender Variant 18+ group

Barriers to mental health treatment

The issue of mental health treatment being too costly was cited as a barrier in a couple of the focus groups. Even though some of the well-known organizations in the community provide sliding scale payment options, even this was not completely feasible for some of the participant's economic situations. Some felt they were between a rock and a hard place as far as treatment options due to both economic issues and having negative experiences with providers, which severely limited their options for services.

On top of that is the whole issue of payment, because you know like we talked about, paying for therapists and psychiatric services is very difficult – and the sliding scale – there might as well not be a sliding scale. Like you said, it comes to "Do I wanna have dinner, or do I wanna get – not kill myself tonight." You know. That's a hard decision. FTM 25+ group

Yeah, you were saying it's hard enough to find a good therapist and most of the reputable therapists when it comes to trans issues are in private practice. So, having something like there's the [name of institution], and they offer sliding scale – it's still out of, it's still not affordable really. FTM 25+ group

It's very frustrating especially with mental health. It's always uncomfortable to try to get a hold of a therapist, starting from scratch, like with insurance providers and the ones that they say you can go to. You have to call them up, leave a message, talk about all your problems, and then they don't call you back and you're like "dammit, now I have to call another one!" And you just have to do that. It's a very heart-wrenching process. Gender Variant 25+ group

I did have a friend who wanted to go into a detox program through [name of institution] and that was really difficult for him, because they could not understand why he's talking on the phone, he's got this low voice, and he goes by this one name but the paperwork all has this other name. "I don't understand." And trying to find a place for him to go was really difficult. And when you're in that kind of a crisis situation, where he's ready to go now, he needs to have a placement by the end of the day, it's really not acceptable for that to be a barrier. Gender Variant 25+ group

It is worth noting that in the MTF 18-24 group, which was all African American, most participants shared the belief that mental health counseling was not something they engage in. Rather they used specific peer and family support (including family of choice), faith in God and/or a reliance on a higher power to help get them through difficult situations in their lives. More on this can be found in the resilience section later in this report.

Recommendations for mental health providers and systems

As part of the focus groups, we asked participants what they thought was important for mental health providers to know or to do so that they were providing culturally competent care to transgender and non-gender conforming clients:

...whatever I'm coming to you for, my identity is not necessarily what my problem is. That I could be a healthy, full-formed person that just might need someone to talk to, that might be going through some other issues unrelated to my identity – and that's not a problem.... Gender Variant group 18+

I was thinking it's kind of the same thing as with the medical providers. I want the mental health providers to assume that I know more about who I am than they do when we meet., and to listen, when I feel like I can fill the gap...and then have the competence to reflect, again, to reflect language. Like don't use the wrong pronoun for me; I will walk. That's a baseline of respect. Baseline. Language. Gender Variant group 18+

Treat me for the issue that I've come to you with, not for my identity. I think that should go without saying, but it doesn't. Gender Variant 18+ group

In a utopia, they can come out with something that all mental health care providers would need to at least take some kind of course and familiarization with different gender identities, in order to practice medicine, or whatever they do in the city of Philadelphia. Gender Variant 18+ group

There were also suggestions participants had that were directed at the behavioral health system such as training for social workers and other things that would hopefully improve the level of service provision provided when it comes to working with transgender and non-gender conforming clients:

I mean you can recommend training all you want and you can force people to go to trainings all you want, but if they don't believe what you're training them, that's not gonna help. Like if you send people to go do a training on trans people and they go in thinking "Trans people are just repressed lesbians and gay men, regardless of what their sexual activity really is" – um and then they'll probably still leave the thing going "trans people are repressed lesbians and gay men." You know? -- That try to be pitied or despised. Like if they go in with that attitude, they're probably going to come out with that attitude. So I guess better training earlier on with social work degrees, having more focused trainings within those kind of things to talk about issues with gender identity and what that actually is – I think would be helpful. FTM 18-24 group

Having a general program to educate everybody who's going to provide behavioral health service, and to establish some sort of a fee structure where a therapist can charge you these x amount of dollars if he and she has had these many hours of working with trans people. You know, like somebody charging you a ridiculous amount when they have had like two hours of trans people – of talking to a trans person for two hours. I'm not sure that's qualified. But if somebody has worked for like 100 hours with somebody then you can say that you have experience to deal with that issue. FTM 18-24 group

One participant acknowledged their support for the Department of Behavioral Health's "community generated recommendations to improve the behavioral health services provided to LGBT persons in Philadelphia" document that was released in 2007:

I really loved the recommendations that came out of the meetings with the BHSI system, that were recommendations to change their policies to reflect those legal changes that happened – like the fairer practices ordinance covering sexual orientation and gender identity – and one of them was to have a designation, like LGBT-affirming and you couldn't be LGB-fake-T or we take your T. Gender Variant 18+ group

Experiences of Discrimination

The focus group participants shared quite a few experiences they had of discrimination from law enforcement, from members of lesbian, gay and bisexual, non-transgender communities, and in employment.

Discrimination from law enforcement

Most of the experiences of discrimination when it came to law enforcement were discussed among participants in the MTF groups. They talked about their negative treatment by the police and how they had different experiences with the police depending on which part of the city they were in. The sentiment among the transwomen in the groups was that the police in Center City were much more derogatory to them than police in other parts of the city who may not be as savvy about detecting whether they are trans or not. One participant shared her perception of how police will treat trans women more harshly than gay men.

The police officers I've seen, even in Center City, I've seen police officers and I know they're supposed to be trained cause they supposed to work with girls all the time. I see them like yeah when the big man down there, they're going to call these girls young ladies, but as soon as like the big man's gone, when they arrest you or they talking to you they're like, 'move fellas' or they going to call you men. They called one of my sisters and she looks exactly like a woman and I guess they knew cause she was down there by the way she was speaking-they was calling her all types of 'he' and 'man'-then they try to be funny like, 'miss, haha' and started laughing-trying to be funny. MTF 18-24 group

A gay man on the street, a cop would be like, 'oh go here or go there', whereas a transsexual would get called an animal....You might not even be doing nothing next to the cops, but if a cop looks like he is going to get out of his car and beat you down, he's going to beat you down. MTF 18-24 group

A dialogue occurred in the gender variant group about the treatment of not just trans youth, but all LGBT youth, mostly of color, that convene in the area of Center City that encompasses the "gayborhood". These groups often consist of lesbian, gay, bisexual and transgender young people of color who may not be old enough to enter a bar or club, so they convene in close proximity of these establishments. This socialization outlet serves as a comfortable place for these young people to be themselves and express their sexual orientation and gender identities openly, however they are often met with some opposition by law enforcement as these participants note:

I'm just thinking about this place I work at, one of my kids got arrested, maybe 3 weeks ago? And the police officer said that – I think that there were complaints from neighbors, and I think they would not be complaining if these were not one black kid they would not be complaining if these were not gay kids – so even their presence in that space makes

people very angry – but that police officer told our staff members that a child will be arrested every single day until -- and I can't remember what the end of the result was, because the kids were not harassing other people, at that moment, no one was harassing anybody, nobody was physically handling anybody else, but they had the ability to say "your kids are going to get arrested every day," which I feel like they would not have said if this was a school or if this was another space for "normal" area children, you know?
Gender Variant group 18+

The Saturday night crackdown that happens is very much targeted to that group. And I think that I generally have distrust of the Phila police officers. Like, I don't think they're trained well, I don't think they have, no matter how many sensitivity whatever they are getting, they have to sit through, it doesn't get through. Gender Variant 18+ group

Discrimination in LGB non-transgender communities

In all of the focus groups, participants shared their experiences around transgender inclusion within LGB communities. Several participants talked about their feelings of marginalization or not being fully accepted in their identities, often being ascribed an identity that fits neatly with what others think of them versus full acceptance of them as they define themselves:

I was gonna say that also in the context of the larger LGB community in terms of discrimination – I mean I personally, I think I've gotten to a place in my own world and my own life that what other people think, it doesn't really effect me so much any more. I've worked on building up my own self esteem around lesbians having perceptions of me as a trans man or you know whatnot.... finding safe space as trans people, even within the LGB community – is not always possible.
FTM 25+ group

Before I started hormones, I would go to [name of club] and people would see me as a butch. I would pay 5 dollars. Go to [name of club] today, people see me as a trouble-maker guy, I pay 20 dollars to get in. Or, I just went to an alternative night at a new club, and it was specifically for trans – you know, alternative lifestyle is what they call it. Most of the people that were in there were trans women and some gay men and like two or three lesbians. But I went in there with two other trans guys and it was like, there was no acceptance there. We were being seen as felons, people who come in there on the wrong night, people who wanna try to make trouble for the trans people that are in there. It was like – it doesn't matter how we identify as ourselves, because they saw us as straight black men trying to start trouble, that's how we were perceived and treated. FTM 25+ group

The place that I find that I experience the most transphobia or whatever from is within the gay community, which I also identify with. And I've found some aspects of that to be kind of transphobic. Like I'm either not a real man or that, whatever, that I don't belong there. Or people like, "Yeah, I'm an ally and I think you're great, but I have absolutely no interest in ever having sex with you or anyone like you at all ever...." FTM 18-24 group

I think when it's hardest is when I'm in communities that I expect to be trans inclusive and they're not. So I see that in certain lesbian enclaves and certain gay male communities, where I just don't feel welcome on either side and that is always disappointing more than anything else. Gender Variant group 18+

In the gender variant group, issues related to not necessarily having a binary (male or female) gender presentation was discussed as an issue in both transgender and non-transgender communities. In addition, one participant talked about how their racial identity further complicates the ability to identify a community that feels comfortable.

My perception is that it's easier to be trans here, or trans FTM clear easy or like MTF spectrum that there's more room for that and that even within the large trans communities that exist here there's not much space for... well even then it totally depends on the community, but there's not always space for gender variance. Gender Variant group 18+

I find also that I don't fit in any communities here in Philadelphia. I'm a person of color, I don't know any other sort of gender variant male spectrum Asian people. I don't... it took me years to find other Asian lesbians in Philadelphia at all. So that is really difficult. I feel like I have a disjunct in community because where I think I might be accepted for my gender identity or my gender presentation, I don't feel I'm accepted on a racial level or socioeconomic level or on a political level, and so I'm still trying to find my people in a lot of ways. Gender Variant group 18+

In the younger male to female transgender group, there was some discussion about tensions that exist between them and gay men, in particular young gay men of color:

I just know that in this lifestyle, male figures-gay men don't like transsexuals. They have an issue with transsexuals, why that is I don't know because deep down in the surface, you know we are all the same. You know what I mean, but that is one thing that I find that gay men do not like transsexuals. I don't know why? MTF 18-24 group

I was telling a certain someone that my discrimination don't come from the heterosexual world, it comes from the gay world. It's like a lot of homosexual males really, really, really don't like the transsexuals. I don't really understand why like she said, but that's like really hard to deal with when you used to be them. MTF 18-24 group

Discrimination in employment

Participants shared their difficulties with transitioning while at a job that knew them as the opposite gender. While the discrimination they faced was not always overt, some talked about how they felt their employers became overly critical of their performance to the point that it felt they were being targeted because of their transition. Additionally, it was felt that even though the city of Philadelphia has legislation that is in place to protect them from discrimination based on their gender identity, it was too difficult to actualize this, so that they could engage in legal recourse from the discrimination they faced.

I've had situations, early, earlier on in my transition process where I had problems on jobs and things like that and kind of lost a job and I think it maybe could have been related to my trans stuff. It's hard to prove discrimination in those ways – very difficult to know for sure. But yeah, those forms, kind of discrimination can be very -- not very overt. So it's not like someone's saying "You're disgusting, you're a trans person" they're just kind of building a case against you and nitpicking like every little itty bitty thing that you might do, that someone else does in the same organization that they don't get in trouble for. FTM 25+ group

I worked actually for [name of institution], before, while I transitioned. And I had a lot of problems there...it wasn't with upper management, it was with kind of intermediate management. So I ended up leaving 'cuz I was constantly, I felt like,[I was] being badgered a lot by middle management over the most ridiculous things that someone else next to me [was] doing similar things and weren't having the same degree of badgering. FTM 25+ group

I have a very hard time with my old employers. And under the city ordinance that has the protection for gender identity, I don't think – it's not practical in the way that it's written because basically what you were saying about having to prove it in court... Basically, I had a situation

where I was being harassed in my job and I had all of the documentation approved, everything – up until maybe 6 months after I started hormones I had good reviews, I had stellar performance, everything. And then as soon as I started growing facial hair, you know I was always getting wrote up, people following me in my car to make sure I was where I was at – all this stuff was happening, and when I went to – I went to a couple places for legal advice and the lawyers basically said, “If you don’t have it on recording – video or audio – that they said something to you derogatory, like, specifically “I hate you because you’re trans,” then there’s no way that you can prove any of this other stuff.” I read -- part of this is saying that people – like if I identify as male and I go into a job and I tell them to refer to me as “he” if I’m on the floor, if I’m in the house and somebody says “she,” technically that’s supposed to be covered under that ordinance. That they’re supposed to refer to you as your chosen pronoun. But as far as far as trying to prove that – the ordinance will never be applied because there’s no way to prove that. FTM 25+ group

Resiliency Factors

It was important to capture not only the difficulties faced by transgender and non-gender conforming persons in Philadelphia, but to also identify the factors that help them to cope with the life difficulties many face on a daily basis.

Mentorship and role models

The connection with mentors was noted as a positive influence that some members of the focus groups had, while others expressed their desire to have more mentors to look up to, especially elders.

I would say that some of the older queer mentors in my life kind of show me that – they’re like elders, they’ve been around. And that in itself is pretty inspiring to see what they’ve gone through and that they are these amazing passionate people that are still here. FTM 25+ group

If you look at one positive role model that’s a transgender in the community and you look at this [explicative] and you knew her from where she came from to where she’s at now then it gives them that hope like [explicative], I can be her, I can probably be better than her. MTF 18-24 group

You do not see too many African American trans women over the age of 50. You don’t see it....when asked why she thinks this is, she replied: They get killed, they overdose on drugs, or they die from AIDS. MTF group 18-24

The use of support groups and other supportive networks was another means in which participants felt they received a connection that was needed to help mitigate the impact of the negative experiences they sometimes encounter as transgender or non-gender conforming persons.

I think for me the biggest support has been [name of group] – the support group that meets. And I think that just having the opportunity of seeing people like me, but you know, having the same experiences and being able to talk about that on a regular basis. I think is the most helpful part is not just – once every other month or once every six months. This is like something that I can say, ‘Ok, if it’s not this week, it’ll be next week. If it’s not next week, it’ll be sometime regularly. And I could say, it might hold me over. And even not so much the actual physical meeting, but just the people that I’ve met through that and the connections that I’ve made – not just in Philly, but now in New York, and across the country. FTM 25+ group

What has really helped me was actually the Trans Health Conference, that was my first time. And I really feel like I felt different after attending that. I just felt more positive. Also I’ve been

trying to make more friends in the community because I honestly now believe that there's nothing more effective than having that connection with people who are going through the same stuff like you are. And that's what I would encourage everybody to do. FTM 18-24 group

I think for me where I get most of my support is through doing activism. That's always been kind of what I do to feel better. Like I moved to Philly and I knew there were all these trans support groups that I could go to and I was just like "that's not really my thing" and the first thing that I looked up was how I could volunteer with the Trans Health Conference, cuz that was like what I wanted to do to feel better about life. And that was the first support in terms of being trans in Philadelphia. And now that I've been here longer I just have a really amazing network of friends that have been great. Actually, ironically enough, one of the best supports that I've had has been my church choir. They've been really awesome. FTM 18-24 group

When I need community, more and more I'm not going to the FTM community or the queer community – well, to the queer community, but more and more to like the radical faerie community. I'm finding my own alternative resources for what I need. But it's been really hard to get them. Gender Variant group 18+

Like the trans community really need to stick together because it starts with us. It's not going to happen over night, but we have a group called [name of group] and it's like so amazing because all the girls can be in one room together spilling their personal business, crying, talking about your problems, this that, and the other and there's no shame involved. MTF 18-24 group

In the 18-24 MTF group, there was a discussion about some of the very specific support people in their lives, which included supportive biological family members; friends, most of whom were also trans and/or part of the LGB community; and the creation of alternative family structures with non-biological supports. One area of resiliency that only came up in this group was the reliance on a higher power to help work through distressing situations:

You know what my mental health care's been like? Because I have gone through everything you just said with my family.... I've been tore down, knocked down, called every faggot in the book. I'm dead to them and everything, so my mental health care has been God. MTF 18-24 group

I have one girlfriend and everybody know who she is, you see me, you see her and you see her, you see me and like we were both rooted in the church and we talk to each other a lot about everything and there are some times that I can't talk to her. I will first and foremost turn to the Bible and ask God for His help. MTF 18-24 group

One transwoman talked about her belief in using the church and her belief in God to deal with distressing life circumstances instead of going to a counselor:

It's not like I'm some kind of racist, or everything like that, but I think black people-I think we're raised deeper in the church and everything like that. I think that's why it's easy for us to turn to the Lord and be like that cause our mommas and our grandmommas go to church every Sunday and everything like that. I think for-more so the counseling is meant more for –honestly the Caucasians and the Asians trans community because they weren't deep rooted-most of them, I'll say most of them weren't deep rooted in the church. So, they have to go to those counselors.... MTF 18-24 group

Survey Results

Methods

The quantitative survey was developed after the preliminary analysis of the 5 focus groups to identify themes we wanted to quantify through the survey. The goal for the surveys was to obtain a sample size of 150 and to try to achieve as much parity as possible racially and among gender status. Because of the diffuse and hidden nature of the target population, random sampling methods could not be used.

The survey was developed by the research team at PHMC, along with input from the transgender health working group convened by PHMC. In addition, once a draft of the survey was complete, we convened 2 meetings with members of transgender communities to review the survey and they gave us feedback on terminology and culturally sensitive ways to structure questions. Once the survey was finalized, organizations that provide services to transgender communities were identified and asked to participate. Once participating organizations confirmed their participation, a point person was identified at the organization that reviewed the consent form, administered the survey and assisted participants as needed if there were literacy difficulties. The survey was anonymous and participants were provided with a \$10 CVS gift card as compensation for their time and effort.

The survey was made available in two formats, either paper or online via Survey Monkey. The majority of participants completed surveys on paper, which was administered through the organizations. The participating survey administration sites were: Action AIDS, AIDS Services in Asian Communities (ASIAC), The Attic Youth Center, The COLOURS Organization, Gay and Lesbian Latino AIDS Education Initiative (GALAEI/TIP), Mazzoni Center, Safeguards, Trans Masculine Advocacy Network (TMAN) and William Way LGBT community Center.

The total sample size came to 127, with twenty of those being completed online. The remaining 107 were completed on paper and all surveys, both online and paper, were entered into SPSS. The following section provides a summary of the data from the survey and covers demographics, housing status, health care coverage and health conditions, mental health, substance use, cosmetic procedures, hormone usage and injection practices, and experiences of discrimination. Lastly, a section has been included summarizing the open ended responses to the question "If you could tell an elected official anything about the needs of transgender communities in Philadelphia, what would you tell them?".

Results

Demographics

Racially, 63% of participants identify themselves as African American, followed by 9% White, 11% Hispanic, 7% Asian/Pacific Islander, 9% with a mixed race and less than 1% identified as other. Among those who identified as mixed race, 3 persons were African American and Native American, 2 were African American and Latino, and 2 were African American and White. The ages of participants ranged from 18 to 64, with the median age being 31 years of age. There was a fairly symmetrical distribution across age with 32% between the ages of 18-24; 23% were 25-34; 24% were 35-44; and 22% were 45+,. As for sexual

orientation, 33% identified as heterosexual, 19% as bisexual, 19% as gay, 11% identified it as “other”, with 4 respondents writing in “queer”, and 15% selected the option “I don’t place a label on my sexual orientation. In relation to gender identity, 38% identified as transgender, 22% as transsexual, 15% identified as female to male (FTM), 17% as male to female (MTF), 11% as Gender queer, 16% as female and 15% as male. Upon further analysis of those who identified as “transgender”, 83% were given a male designation at birth and 17% were given a female designation.

Educationally, 17% of respondents had not completed high school; 37% had a HS diploma or GED; 15% had some college (no degree); 13% had a bachelor’s degree; and 4% had a master’s degree or higher. A full distribution of educational attainment can be found in table 3. Twenty eight percent reported working full time (>30 hours a week); 13% part time (<30 hours a week); 9% as self employed; 9% as a student; 30% as unemployed; and 14% as disabled. Thirty-nine percent of the sample reported an income of less than \$10,000/yr, and 11% reported an income of greater than \$45,000 annually (see table 3 for a full distribution of income).

Other measures of socioeconomic status included questions about living arrangements and whether or not they have run out of money for basic necessities in the year prior to taking the survey. When asked the question, “what living arrangements have been applicable to you in the past 12 months? Check all that apply”; 42% reported renting a house or apartment; 32% reported living with family or a friend; 18% in their own house; 15% with a partner or spouse; 12% reported being homeless; and 9% in a shelter. When asked the question “During the past 12 months, how many times did you run out of money for basic necessities, like rent or food?”; 31% answered never; 11% once; 18% twice; and 40% three or more times.

Table 3: Demographics

Race/Ethnicity N=127	n	%
African American/Black	80	63
White/European	11	9
Hispanic/Latino	14	11
Asian/API	9	7
Mixed Race/Other	13	10
Age N=127		
18-24	40	32
25-34	29	23
35-44	31	24
45+	27	21
Employment Status N=127		
Full time	35	28
Part time	16	13
Self-employed	12	9
Unemployed	38	30
Student	11	9
Retired	1	1
Disabled	18	14

Education n=123		
Grades 1-6	2	2
Grades 7-11	21	17
HS Diploma/GED	35	37
Technical School	9	7
Some College (no degree)	19	15
Associates Degree	4	3
Bachelor's Degree	16	13
Grad School (no degree)	1	1
Master's Degree or higher	5	4
Annual Income n=124		
< \$10,000	48	39
\$10,001-14,999	22	18
\$15,000-\$24,999	15	12
\$25,000-\$34,999	16	13
\$35,000-\$44,999	9	7
\$45,000-\$54,999	5	4
> \$55,000	9	7

Health Insurance Coverage

Participants were asked what kind of health insurance they had and if insured, what the source of their insurance was. Twenty-seven percent of participants reported having no health insurance, 43% reported having a government sponsored health insurance, 28% had private insurance and 2% checked the “other” option for this question. For those who reported having health insurance, 71% said this coverage was provided through an employer, 5% from a parent, 3% from a partner, 5% chose the “other” option, and 16% reported being self-employed, indicating they paid for their own health insurance costs.

It is of note that slightly more than one fourth (27%) of participants reported being uninsured, which is a significant concern particularly for transgender populations. For example, persons undergoing hormone replacement therapy or other procedures needed as part of their transition ideally should be followed by a physician. Lack of health insurance provides a barrier to accessing needed healthcare and may lead to uninsured persons seeking these treatments in non-medical settings, potentially putting them at risk for other adverse health outcomes.

Transition Related Procedures

The survey instrument covered several questions related to the kinds of transition related procedures participants were either currently engaged in or were completed, whether or not insurance covered these procedures, whether they have been denied coverage for a requested procedure, and whether or not cost has been an issue for getting desired cosmetic procedures completed. Additionally, participants were asked if they have taken estrogen or testosterone over the past 2 years, if so, the source of the hormones and how the hormones were administered (ex: orally, injection) and by who (ex: self or someone else).

Transition related procedures

The following is a list of cosmetic procedures participants were asked if they had completed or not:

- | | |
|---|--|
| <input type="checkbox"/> Hormones ('mones) | <input type="checkbox"/> Phalloplasty (bottom surgery) |
| <input type="checkbox"/> Breast implants | <input type="checkbox"/> Vaginoplasty (vaginectomy) |
| <input type="checkbox"/> Metaoidoplasty/centurion | <input type="checkbox"/> Hysterectomy (removal of uterus/ovaries) |
| <input type="checkbox"/> Top surgery (FTM chest reconstruction) | <input type="checkbox"/> Cheek implants |
| <input type="checkbox"/> Testicular implants | <input type="checkbox"/> Labiaplasty |
| <input type="checkbox"/> Silicone | <input type="checkbox"/> Orchiectomy (removal of testes; castration) |
| <input type="checkbox"/> Chondrolaryngoplasty (shaving of Adam's Apple) | |
| <input type="checkbox"/> Other: _____ | |

Of this list, only four procedures had greater than a 5% rate, which were, hormones (81%), Silicon (18%), Mastectomies (10%), and breast implants (9%). All other procedures listed above had a rate of less than 5%.

Participants were then asked if their insurance helped to cover any of the cosmetic procedures they engaged in and of the people who responded to this question (n=102), 25% answered "yes". When asked what procedures were covered, 13 respondents said their hormone replacement therapy was covered, 2 reported breast augmentation, 1 reported breast implants, 1 reported "top surgery" (mastectomies), and one reported "chest surgery".

When asked "Are there any transition-related procedures you would like to have completed, but can't, because the cost of such procedures is a barrier?", 55% responded "yes" to that question. A partial listing of the procedures participants desired, but could not afford include: 11 people listed breast implants, 7 listed full sex reassignment surgery, 3 listed vaginoplasty, and 3 listed Orchiectomy (removal of testes).

Hormone usage, sources and route of administration

Of the participants who answered the question about estrogen usage (n=105), 70% reported taking it at some point in the 2 years prior to taking the survey. Of the participants who answered the question about testosterone usage (n=74), 41% reported taking it at some point in the 2 years prior to taking the survey.

Participants were asked "If you have taken estrogen or testosterone, please check all of the sources you have used to obtain them in the past 2 years:". Of those who answered this question (n=94), 68% said a medical provider, 42% said a friend or associate, 23% got them online, 9% got them from someone they don't know well, and 3% got them from another source.

Participants were also asked "How are/was your estrogen or testosterone administered? (check all that apply)" Of those who responded to this question (n=120), 50% reported self injecting, 34% took hormones orally, 20% said they were injected by a medical provider, 17% were injected by another person, 6% responded "other", and 19% responded "not applicable".

Silicone usage, sources and route of administration

The survey included questions about silicone usage among participants. They were asked "If you use/used silicone, please check all of the sources you have used to obtain silicone in the past 2 years:". A total of 99 participants responded to this question, in which 16% got it from a friend or an associate, 16% from a skilled professional (not a

doctor), 8% from someone they didn't know well, 4% from the Internet, 3% responded "other", and 61% responded "not applicable".

Participants were then asked who injects their silicone, in which 77% said they get injected by another person, 31% reported self injecting, and 3% said "other". Participants were also asked about the sources they obtained needles from over the past 2 years for their hormone and/or silicone usage. Of the persons who responded to this question (n=82), 60% got their needles from a doctor's office, 33% from a needle exchange program, 32% from a friend, 12% from a website, and 6% from an associate.

Health Conditions

Participants were asked about various health conditions they have either been screened for, diagnosed with or treated for in the 2 year period preceding administration of the survey. The health conditions we asked about on the survey were: Diabetes, eye disease, high blood pressure, Hepatitis A, B and C, Asthma, Emphysema, high cholesterol, Cancer and there was room for them to write in a condition not listed in that section. Additionally, this section includes participants experiences with HIV testing and HIV diagnosis.

Screenings

Of the conditions listed above, 37% reported being screened for high blood pressure; 32% for Diabetes; 28% for high cholesterol; 27% for Hepatitis A; 27% for Hepatitis B; 22% for Hepatitis C; 26% for eye disease; 18% for Cancer; 15% for Emphysema; and 9% reported screening for another health condition not listed. Specific conditions screened for that participants wrote in were for ADD, Prostate Cancer, Cervical Cancer, Lung Cancer, and Genital Warts.

Diagnoses

Of the conditions listed above, there was a very low rate of participants being diagnosed with any specific health conditions. The highest diagnosed condition was Hepatitis C (12%), followed by High Blood Pressure with a 10% diagnosis rate. All other conditions had a less than a 10% rate of diagnosis.

HIV Testing

Participants were asked their HIV status, in which 64% reported being HIV negative, 26% HIV-positive, 2% reported an indeterminate testing result, and 4% didn't get the results of their last test. They were also asked the last time they had taken an HIV test and what the result of that HIV test was. Six percent of the sample reported never having taken an HIV test; 36% had tested in the past 6 months, 23% tested 6-12 months prior to taking the survey, 10% in the past 1-2 years, 7% 2-5 years ago, and 19% more than 5 years ago. When looking at those who hadn't tested in 5 or more years, 77% of these persons identified their HIV status as positive, which likely explains why they have not been tested in so long.

Smoking & Substance Use

Participants were asked about their smoking and substance using behaviors over the 2-years preceding the survey administration period.

Smoking

The survey asked about the smoking habits of the participants since some research has demonstrated that transgender populations have a high rate of nicotine usage. Fifty-eight percent of our sample reported smoking cigarettes in the 2 years prior to survey administration. Those who reported smoking were then asked how many cigarettes they smoked per week in this 2-year period. Seventeen percent said they no longer smoke; 21% reported smoking less than a pack a week; 38% 1-2 packs per week; 11% 3-4 packs a week and 13% more than 5 packs per week. Participants who currently smoked were asked if they would like to quit and 77% of current smokers responded affirmatively to this question.

This section highlights the need for increased health screening initiatives for transgender Philadelphians. Among some of the most common health conditions, relatively few participants reported even being screened for many of them. The majority of participants reported smoking in the past 2 years, and while some had quit recently, a large percentage continues to smoke. Interestingly, 77% of current smokers reported wanting to quit, which speaks to the need for better promotion of transgender culturally appropriate smoking cessation programs in Philadelphia.

Substance Use

Table 5 illustrates the substance use reported by participants.

Table 4: Substance Using Behavior*

“Have you used any of the following substances at least 5 times over the past 2 years?”

<u>Substance</u>	<u>n</u>	<u>%</u>
Marijuana	68	57
Alcohol	61	50
Cocaine	26	22
Crack	23	19
Ecstasy	14	12
Poppers	5	4
Heroin	4	3
Cough Syrup (to get high)	4	3
Crystal Meth	2	2
Not Applicable	26	22

* The percentage reflects the number of people who actually answered that question. There were 6 participants that didn't respond to the questions in this section.

As the table illustrates, the most commonly used substance was Marijuana (57%), followed by alcohol use (50%). Twenty six percent of the respondents reported no substance use in the past 2 years. The survey also included a question on binge drinking; “In the past 3 months, how many times a week have you had 5 or more drinks within a 4-5 hour period?”; 21% of respondents reported binge drinking less than once a week, 17% 1-2 times a week, 6% 3-4 times a week, 7% 5 or more times a week, and 50% reported no binge drinking episodes in the 3 month period the question covered.

Participants were asked if they would like to quit their substance use and nearly half, 48% (n=40) of those who responded to this question, said ‘yes’. For those who reported alcohol use of any form, 23% of those who responded to the question asking if they’d like to quit (n=89) said “yes”.

Mental Health

Participants were asked several questions about their psychological health. When asked, “Have you ever been diagnosed with any of the following mental health conditions?”, 56% reported a diagnosis of depression, 24% with anxiety, 22% with Bipolar Disorder, 18% with Gender Identity Disorder, 4% with Borderline Personality Disorder, and 32% reported having never been diagnosed with a mental health condition. The rates of reported mental health diagnoses among this sample may be skewed high given that the majority of participants took this survey at organizations that provide mental health and other supportive services.

The survey also included a 6-item psychological distress scale developed by the Center’s for Disease Control. Table 4 below illustrates the responses to the scale.

Table 5: CDC Psychological Distress Scale Results (in percents)*

“During the past 30 days, how often did you feel”:

	All/most of the time	Some/a little of the time	None of the time	Don’t know
So sad that nothing cheered you up	20	55	24	.8
Nervous	18	60	19	3
Restless or fidgety	19	53	24	4
Hopeless	19	42	34	3
That everything you did was an effort	24	56	18	2
Worthless	14	42	41	3

* If rows don’t add to 100% the difference is due to some participants not responding to that question.

Experiences with Discrimination

The survey included several questions on the participant’s experiences with discrimination from law enforcement as well as discrimination they may have experienced in various settings. Additionally, participants were asked if they have experienced physical or verbal abuse by strangers, family members or a partner/lover. Table 6 illustrates the responses to different kinds of people they may have experienced discrimination from and table 7 illustrates the different settings in which participants reported experiencing discrimination.

Table 6: Experiences with Discrimination

Have you ever been mistreated by the police and/or correction officers because they perceived you to be transgender or non-gender conforming?	<u>n</u>	<u>%</u>

Yes	59	47
No	64	50
Check the response that best fits your comfort level when interacting with the police:		
Very Uncomfortable/Somewhat Uncomfortable	30	24
Neutral	39	31
Very Comfortable/Somewhat Comfortable	56	45
Have you ever been physically or verbally abused by any of the following individuals, because you were perceived to be transgender or non-gender conforming (check all that apply)**:		
A stranger or someone you don't know well	82	68
A partner or lover	42	41
A family member	48	44

* Categories don't add up to 100% as not all respondents answered those questions.

** Represents the percentage of participants who answered, "yes" to this question.

When asked the question, "Check the response that best fits your comfort level when interacting with the police.", 45% said "somewhat or very uncomfortable. This supports the sentiments shared during the focus groups, when participants discussed their experiences of discrimination from law enforcement. Another notable finding is that nearly 70% of respondents reported being physically or verbally abused by a stranger at some point in their lives based on the attacker's perception of their transgender or non-gender conforming presentation. Additionally, 41% and 44% reported being abused by a partner/lover or family member respectively.

Table 7 below illustrates the percentage of participants who experienced discrimination in the various settings asked about in the survey.

Table 7: Experiences of Discrimination in Different Settings

"Based on your experience as being transgender or non-gender conforming, have you experienced discrimination in any of the following areas?" (check all that apply)

Place	Denied Equal Treatment or Service	Verbally Harassed or Disrespected	Physically Attacked or Assaulted	Sexually Attacked or Assaulted
Job	32%	25%	< 5%	< 5%
School	18%	32%	8%	< 5%
Church	10%	15%	< 5%	< 5%
Government Offices	17%	13%	< 5%	< 5%
Judge or Court Official	11%	15%	< 5%	< 5%
Doctor's Office, Hospital, or an Emergency Room	17%	14%	< 5%	< 5%
Mental Health or a Drug Treatment program	9%	17%	< 5%	< 5%
Ambulance or EMT	11%	13%	< 5%	< 5%
Public Transportation (ex: bus, train, or taxi)	14%	20%	6%	< 5%

Retail Store	16%	25%	< 5%	< 5%
Restaurant or Other Dining Facility	13%	20%	< 5%	< 5%

Identified Needs of Transgender Philadelphians

In this section, the narrative responses of participants are shared as they answered the question “If you could tell an elected official anything about the needs of transgender communities in Philadelphia, what would you tell them?” This section doesn’t include all responses, as there were quite a few of them, but does include a sampling of responses separated by themes.

Health care

“That transgender individuals need health care that pays for surgery”

“Surgery coverage and hormonal coverage; male healthcare for trans girl M-F listed as F on insurance and female health insurance for trans men F-M listed as M on health insurance.”

“For the government to help transgender people with their surgeries through medical insurance because it would cut down on prostitution and also less risk of contracting or giving STDs or HIV and AIDS”

“We desperately need full-time employment services and rental assistance and health insurance or some other kind of program that would pay for gender reassignment surgery. I have been on estrogen for over two years, and meet all the standards of care requirements to get surgery, but I’m now stuck being a woman with a penis because I can’t afford surgery.”

“Public health clinics run by the Dept. of Health should hire trans-competent doctors and nurses as well as train existing staff.”

Anti-discrimination

“Trans people need equal rights in the work force. Not only when you work for [an] LGBT organization, but across the board. We need to recognize within our own community that even though you’re a peach and I’m a pear we’re both still fruit. So stop hating on each other. PLEASE!!!”

“I would ask them to train police officers to be more sensitive to LGBT in the city; we face a lot of prejudices that can have a lifetime effect.”

“For people in all areas of work (Judge, court, classroom hospitals, etc.) to be more sensitive to transgender people and their needs.”

“I would talk to them about police harassment”

“We are human beings. We have feelings. We are productive citizens. We would like to be treated like human beings. We would like to be accepted by society. We deserve to be happy.”

“Please help transgender girls feel comfortable with their lifestyle by monitoring businesses, offices, officers, and etc. We are people too.”

Employment & Housing

“Need for employment protection”

“What gender variant people need most is housing and employment opportunities.”

“Provide training and jobs. Deal with us on our actions and deeds, not appearance”

“To get affordable housing for transgender or low-income housing”

“There should be greater emphasis on hiring trans individuals to positions in city government.”

“Jobs and economic viability are most important for trans folks in order to ensure that they equal access to the rights that non-trans people in Philadelphia enjoy. This could be accomplished with targeted job training grants for trans organizations and recruiting of trans individuals into city government positions.”

“That more businesses should give all transgenders the opportunity to receive good paying job[s] to help us stay off the streets so we can live a positive life.”

Increased Visibility

“Need for transgender voice to be heard more in community”

“That we need to have our voices heard”

“Listen to us...we are not aliens from beyond. We have needs – health, mental wellness, education, housing. We need to be heard.”

Miscellaneous

“Why is there so much talk about transgender needs but very little action”

“The elimination of gender exclusions; non-discrimination protection for all transgender persons; community education to raise the awareness of trans issues; sensitivity and awareness training for all public & private school educators, also for all elected officials.”

“Just like we took our time to vote an African American into presidency. Take time and treat the transgender community as equal human beings. We should be able to live with no labels.”

Recommendations

This section contains recommendations to improve services for transgender Philadelphians in an effort to make a case for the expansion of services, and increase the level of culturally competent services provided to transgender persons. The recommendations have been derived from an analysis of the focus groups and the survey results, and from discussions that transpired during Transgender Health Working group meetings.

Health Recommendations

- ✓ Because there may be quite a few uninsured transgender persons in Philadelphia (27% in this study), ensuring public health center support and medical staff are culturally competent and sensitive to transgender patients is essential to improving health care access.
- ✓ The City of Philadelphia should consider identifying trainers/consultants who can work with city run health centers to provide cultural competence training to these facilities to increase their competence in the area of transgender health.
- ✓ Health care providers with transgender patients should take time to understand how the patient feels about their body and how they identify their body parts. This level of sensitivity may help to increase health care access among transgender populations.
- ✓ Outreach to transgender communities who don't have health insurance to educate them on free and/or low cost health services they can access.
- ✓ A significant number of participants expressed their desire to quit smoking (77% of current smokers), to quit using illicit substances (48% of respondents), and to quit their alcohol use (23% of respondents). It is recommended that organizations serving transgender persons actively assess for these issues and connect clients to culturally appropriate services as necessary.
- ✓ A comprehensive guide of resources specific to transgender communities should be compiled and made widely available. Resources should include, but not be limited to medical and mental health providers known to be competent in transgender issues, places one can obtain health care if uninsured, legal services, support groups, community based organizations with transgender inclusive programming, and guidelines on how to report discriminatory experiences.
- ✓ Institutions providing hormone replacement therapy should consider re-examining their policies on providing hormones to patients that don't desire a clear male or female binary gender presentation.

Behavioral Health Recommendations

- ✓ Providers should pay close attention to the use of language and respect the preferred pronoun choice of transgender or non-gender conforming clients.

- ✓ Providers should be sure not to assume that a client's gender status is the main root of what is bringing them to counseling. Client centered approaches where the provider sees the client as an expert on themselves is important.
- ✓ Providers should attend trainings specific to working with transgender and non-gender conforming clients. Training on working with lesbian, gay and bisexual clients often doesn't encompass the complexities that gender identity issues may add.
- ✓ Exploring the role religion and spirituality may play in the lives of transgender individuals may be an important engagement tool.
- ✓ A substantial percentage of respondents have experienced verbal or physical abuse by strangers (68%), a partner or lover (41%), and/or a family member (44%). Providers should assess for the impact of these experiences on consumers who have experienced them.

General Recommendations

- ✓ Institutions should review their intake, and all other forms that collect demographic information to make sure they provide options appropriate for gender variant or transgender persons. This may include providing selections for "FTM", "MTF", "Gender Variant" and "other _____".
- ✓ Institutions should incorporate and enforce policies that prevent discrimination against transgender and non-gender conforming persons and place their anti-discriminatory policies in a place where patients/consumers and staff can view them.
- ✓ An effort should be made to educate transgender communities that Philadelphia has a Fair Practices Ordinance that includes protections against discrimination based on gender identity in public accommodations. Additionally, education on how to operationalize this policy when one has been discriminated against is necessary.
- ✓ Currently the AIDS Activities Coordinating Office doesn't have a concrete, methodical mechanism to track HIV incidence rates among transgender populations. This makes it difficult to identify rates of infection to track if additional resources need to be allocated. It is recommended that AACO make the changes necessary to the HIV testing system so they are able to track HIV/AIDS trends among transgender Philadelphians.
- ✓ Several of the participants through the focus groups and surveys shared about the insensitivity they have experienced from law enforcement. Forty seven percent of survey respondents said they feel they have been mistreated by the police based on their gender identity. It is recommended that in addition to continued cultural sensitivity training for police officers, that stricter enforcement of anti-discrimination policies within the police force be employed.

Support for Existing Transgender Supportive Initiatives

- ✓ Support groups and other mechanisms that provide opportunities for networking were cited as helpful mechanisms for participants.
- ✓ Support was cited for the “Community Generated Recommendations to Improve the Behavioral Health Services Provided to Lesbian, Gay, Bisexual, and Transgender Persons in Philadelphia” document developed by the Department of Behavioral Health/Mental Retardation Services.
- ✓ The Trans Health Conference that occurs annually in Philadelphia was cited as a source of inspiration and provides many other positive opportunities for members of transgender communities.

DRAFT

TIP is a project of Prevention Point Philadelphia and GALAEI.

The following is the breakdown of TIP clients by HIV + status over 2008-2009 YTD

CRCS 2008-2009 YTD

71 clients receiving prevention services from TIP/PPP. **18 known HIV+**

11 of these receiving RW services (somewhere else)

of the 18 HIV+; 2 are FTM, 16 are MTF

14 are African-American, 1 is white, 1 is asian, 2 are latino

2 are under age 24

9 are age 25-39

6 are 40-59

1 is age 60+

GLI's 2008:

60 clients

8 known HIV+:

5 MTF

all Af.am.

3 age 35-45, 2 in RW, 1 not

2 age 50, both in RW

3 FTM

all Af.am

2 age 20, 1 in RW, 1 not

1 age 48, in RW

2009 YTD GLI:

22 total

5 known HIV+, all Af.am. MTF, all in RW

2 age 18-24

3 age 40-45

HIV Prevention and Care. Extrapolating from cross-sectional data, University of California San Francisco's Center for Transgender Excellence reported at the 2008 United States Conference on AIDS that in multinational needs assessments, an estimated 56% of all African-American MTF are HIV+, 28% of all MTF, and 3-10% of all FTM.

Although CDC and Health Dept do not yet report surveillance data on Trans, a Trans needs-assessment included in the Philadelphia CPG's Prevention Plan (Office of HIV Planning 2005) indicated the following: 7% of survey participants were living in shelters, all of whom were HIV+ people of color, 96% of respondents injected hormones or steroids, 40% self-reported they did not use a new needle the last time they injected; 80% of these people were people of color, 88% were HIV+, and 60% said they did not clean the needle with bleach. 47% of respondents reported having an STI, 79% of which were HIV+. 83% of needs assessment participants reported they had been paid with drugs or money to have sex with someone, and 83% of these respondents were HIV+; 32% of participants reported having 11 or more partners within the past 12 months; 11% of white and 36% participants of color reported that they did not use a condom the last time they had sex.

As part of the needs assessment, 13 interviews were conducted with Trans participants who were HIV+, most of whom identified as African American. These participants cited barriers to receiving medical care, including lack of Trans sensitivity of medical/front desk staff, being referred by their legal name rather than their chosen name, unease of disrobing before medical staff (particularly for pre- or partial-operative T people who have both male and female body parts), lack of knowledge of the interaction of hormones and HIV medications, and fear of a doctor requiring them to stop transition. One was quoted as saying "What matters more than HIV is how you look".

Both Action AIDS (1997) and THAC (2001) did Trans HIV needs assessments in Philadelphia. They found that for particularly vulnerable subpopulations, one of the few employment options is sex work—particularly for African-American MTFs, who are already denied opportunities due to their race, class, and educational status. MTF sex workers, in particular, have a higher rate of HIV prevalence (68%) than male sex workers (Elifson et al., 1993). Sex work also correlates highly with Injection Silicone Use (ISU). HIV risk is higher for MTFs than MSM in terms of number of sex partners, prevalence of sex work, and having an IDU sex partner (Nemoto et al., 1999). While the perceived risk of HIV infection among local Trans people is low, actual risk is high: 73% of MTFs and 93% of FTMs were at risk for HIV infection due to sexual practices, yet 57% of MTFs and 67% of FTMs believed their chances of contracting HIV were "none" or "low" (Action AIDS, 1997). A majority also reported a lack of Trans specific information on HIV. HIV prevalence is higher among Trans IDUs (86%) than non-Trans IDUs (32%) (Gattari et al., 1992). Clements-Nolle (2001) found that 34% of MTF respondents had an IDU history, with 63% sharing needles. While only 18% of FTMs had an IDU history, 91% shared syringes. McGowan (1999) reports that 43% of Trans people injecting hormones also shared needles, some while HIV+; 10% were IDU, with 50% sharing needles.

Trans people encompass all sexualities and interact with more groups than the category "Trans" implies. The misunderstanding and misclassification of Trans communities and individuals may also be considered a barrier to HIV prevention, testing, linkage to care, and medical treatment

adherence. Trans communities represent the most understudied and underserved group at substantial risk for HIV infection and non-adherence to medical treatment in Philadelphia. Not only are reliable statistics scarce, much of the population is invisible, extremely sensitive to perceived judgment or rejection, and miscounted with other populations. Many prevention and care interventions simply fail to appropriately address or adequately reflect Trans bodies and the ways Trans construct their identities and sexualities. Fear of diagnosis, denial of HIV status, and failure to access medical care is rampant in Trans communities. Out of the 63 T's entering TIP Prevention Case Management in 2008, 13% identified their status as HIV+, of those, only 1 was in medical care – though 50% now are.

TIP Data

Year	Intervention	Measure	Totals	POC	HIV+	<30	YOC
2004	HERR	Clients	92	61		49	34
		Sessions	27				
	CRCS	Clients	44	21		19	8
		Sessions	132				
2005	HERR	Clients	119	54		60	27
		Sessions	32				
	CRCS	Clients	46	26		19	9
		Sessions	143				
2006	HERR	Clients	32				
		Sessions	82				
	CRCS	Clients	51				
		Sessions	200				
2007	HERR	Clients	125				
		Sessions	32				
	CRCS	Clients	61	45	9	35	26
		Sessions	352	282	123	201	236

Recruitment to CRCS 2008	
Recruited from	Number Recruited
Street/Club	4
Drop-in	7
TMAN	10
Internet	3
TIP HE/RR	4
Social Network	10
Other agency	18

CRCS 2008		
	CRCS Clients	CRCS sessions
POC	93%	89%
Youth <25	54%	40%
POC Youth	52%	37%
HIV+	18%	34%
TOTAL	56	240

TIP HE/RR 2008						
Subpopulation	Month	POC	Youth	YOC	HIV+	Total
MTF homeless	Jan	5	3	3	0	5
MTF homeless	Feb	7	1	1	0	7
MTF homeless	Mar	3	1	1	0	3
FTM gay/bi	April	1	1	1	0	2
MTF homeless	Aug	4	0	0	0	4
MTF homeless	Oct	5	2	2	1 (20%)	5
MTF homeless	Oct	13	2	2	2 (15%)	13
FTM of Color	Nov	14	11	11	3 (21%)	14
Totals	8 cycles	52 (98%)	21 (39%)	21 (39%)	6 (11%)	53

Risk Category	Item on pre/post test	Population	Correct on Pre-test	Correct on Post-test	Percentage Point Gain
Hormone Injection	Someone can't spread HIV via semen while using estrogen	MTF	57%	87%	30%
	You can get HIV from sharing needles/syringes	MTF	100%	100%	0%
		FTM	75%	100%	25%
	Only people shooting drugs (not hormones) can get HIV	MTF	100%	100%	0%
		FTM	50%	86%	36%
	Name 4 things someone should do to properly inject hormones	MTF	13%	45%	33%
		FTM	25%	100%	75%
	Describe the best way to clean skin for injection	MTF	0%	55%	55%
FTM		0%	71%	71%	
Safer Sex	The number 1 safest sex act is using a condom/barrier every time	MTF & FTM	44%	67%	23%
	The first thing to do when using a condom is check the expiration date	MTF & FTM	13%	50%	28%

Out of 89 CRCS clients that Adrian worked with					
Homeless	Total	Tried to access shelter	Service barriers due to gender	Accesses shelter in some way	Still homeless
	54	27	15	12	27
Mental Retardation	Diagnosed	Undiagnosed	Barriers accessing due to gender	Accesses MR services in some way	Has never accessed MR
	3	1	3	2	1
Mental Illness	Diagnosed	Tried to access MH services	Service barriers due to gender	Acute Psych Emergency resulting in ER/inpatient	Left inpatient due to gender barriers
	36	31	16	5	2
Drug/Alcohol	Self-report D/A use is a problem	Tried to access D/A services	Service barriers due to gender	Was able to access 12-step community	Was able to access institutional support
	39	23	16	5	2
HIV+	Self-reported	Lost to care in past 3 years	Have never accessed care since diagnosis	Deny status afterward "oh, it was all a mistake"	Now deceased
	19	10	3	2	1