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There's No Pamphlet for the Kind of Sex I Have: HIV-Related Risk Factors and Protective Behaviors Among Transgender Men Who Have Sex with Non-Transgender Men

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Abstract

Preliminary evidence has suggested that some transgender men who have sex with non-transgender men ("trans MSM") may be at risk for HIV and STIs and that their prevention needs are not being met. Quantitative ($n = 45$) and qualitative ($n = 15$) interviews explored risk behaviors, protective strategies, and perceptions of the impact of transgender identity on sexual decision-making among trans MSM. A majority of the participants reported inconsistent condom use during receptive vaginal and anal sex with non-trans male partners; HIV prevalence was 2.2%. Risk factors included barriers to sexual negotiation including unequal power dynamics, low self-esteem, and need for gender identity affirmation. Protective strategies included meeting and negotiating with potential partners online. Results of this study provide initial evidence that current risk behaviors could lead to rising HIV prevalence rates among trans MSM. Prevention programs must tailor services to include issues unique to trans MSM and their non-trans male partners.

Keywords

gender identity; HIV/STI prevention; MSM; sexual risk; transgender men

To date, research related to HIV risk among transgender people has almost exclusively focused on transgender ("trans") women (i.e., male-to-female [MTF] transgender people). This body of work has clearly demonstrated that HIV infection disproportionately affects trans women, especially persons of color (Herbst et al., 2008). Recent reports of HIV infection rates among trans women have been high, ranging from 19% among trans female youth in Los Angeles and Chicago to 35% among trans female adults in San Francisco (Clements-Nolle, Marx, Guzman, & Katz, 2001; Wilson et al., 2009). However, very little research has been conducted on the distinct HIV/STI risks and prevention needs of transgender men (i.e., "trans men", also known as female-to-male [FTM] transgender people), despite preliminary evidence that some trans

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Editors' Note: This article contains graphic language and content. JANAC's editorial staff is dedicated to preserving the integrity of the work of all of our authors. In qualitative research, this includes input from participants who are willing to share their experiences with the researcher and—eventually—with the reader. In this article, we have honored those individuals by leaving their words intact.

men are at high risk. Trans men are people who were assigned female gender at birth and have a male gender identity and/or masculine gender expression.

Trans men, like other men, claim a variety of sexual orientations and have sex with various types of sexual partners (Schleifer, 2006). Rates of HIV infection and sexual risk behaviors among trans men are not well understood because trans men are often assumed to be primarily having sex with non-trans women (Kenagy & Hsieh, 2005). Studies that have reported HIV prevalence rates among trans men either have not specified the gender of their participants' sexual partners or have predominately included men who identify as heterosexual (i.e., trans men who primarily have sex with women; Clements-Nolle et al., 2001; Kenagy & Hsieh, 2005). The few studies that have reported HIV infection rates among samples of trans men have reported 0–3% prevalence (Adams et al., 2008; Clements-Nolle et al., 2001; Herbst et al., 2008; Schulden et al., 2008; Xavier, Bobbin, Singer, & Budd, 2005). Due to low reported rates of HIV among trans men relative to other groups with high-risk behaviors, there has not been much emphasis on further exploration of HIV/STI risk behaviors among trans men. However, preliminary evidence has suggested that there is a significant subgroup of trans men who engage in unprotected sex with non-trans men (i.e., men who were assigned male gender at birth and identify as male), including some trans men who engage in sex work (Adams et al., 2008; Clements-Nolle et al., 2001; Clements, Wilkinson, Kitano, & Marx, 1999; Xavier & Bradford, 2005). In this article, trans men who have sex with non-trans men will be referred to as *trans MSM*.

Some trans men who use testosterone have reported increased sex drive and increased interest in sex with non-trans men after beginning hormone use and have cited these factors as contributing to their willingness to take sexual risks (Clements et al., 1999). Previous studies have found that a majority of trans MSM have reported not using condoms consistently during receptive anal and/or vaginal sex with non-trans male partners (Clements-Nolle et al., 2001) and low rates of HIV testing and perception of risk (Kenagy, 2002; Namaste, 1999). In urban areas where HIV prevalence rates among non-trans MSM have been estimated to be 17–40% (Catania et al., 2001; Koblin et al., 2003; Schwarcz et al., 2007) and STI rates are increasing (Centers for Disease Control and Prevention [CDC], 2008), trans MSM who engage in risky receptive anal and/or vaginal intercourse with non-trans MSM may be especially vulnerable to HIV and STI acquisition.

Low self-esteem has been cited as a primary reason for sexual risk taking among trans men (Adams et al., 2008; Clements et al., 1999; Xavier & Bradford, 2005). Rates of depression, substance use, and suicide attempts are also high in this population, but multiple barriers exist to accessing culturally competent treatment (Clements-Nolle et al., 2001; Kenagy, 2005; Xavier et al., 2005). In addition, accurate information about the diversity of trans men's bodies and sexuality is not widely available. Trans men have different types of bodies, depending on their use of testosterone and gender confirmation surgeries (e.g., mastectomy, hysterectomy, oophorectomy, metoidioplasty, centurion, phalloplasty, scrotoplasty; see *Hudson's FTM Resource Guide* [2009] for further information). Trans men also use a broad range of terms and language to identify their gender, describe their body parts, and disclose their trans status to others (Morgan & Stevens, 2008). This diversity creates unique needs and barriers to adhering to safer sex practices that are not addressed by current HIV prevention programs.

The phenomenon of high-risk sex among trans MSM has not yet been fully explored despite the fact that trans men have been repeatedly identified as a group that lacks access to accurate and culturally appropriate sexual health information (Clements et al., 1999; Namaste, 1999; Wilkinson & Gomez, 2004). In addition, very little is known about alcohol and drug use among trans men and the extent to which risky sexual behavior might take place in the context of alcohol and drug use. This study was conducted to help address these gaps in research and

inform advocacy and education efforts to reduce the risk of HIV/STI exposure among trans MSM with non-trans male sex partners. The specific aims of this study were to (a) identify HIV/STI risk behaviors of trans MSM and (b) describe trans MSM's perceptions of the impact of their gender identity and gender expression on their sexual decision-making with non-trans MSM.

If HIV/STI prevalence and/or risk behaviors among trans MSM are indeed low, a better understanding of what prevention measures trans MSM utilize will enhance our ability to provide appropriate and effective HIV prevention education to trans men and their sexual partners to maintain their HIV/STI status. Study results not only provide a more complete picture of the diversity within trans men's communities and their unique HIV/STI risks and prevention needs but may also serve to increase understanding of the complex ways that gender and power dynamics contribute to HIV/STI risk in sexual relationships.

Method

Participants

Quantitative data were collected from a cross-sectional sample of 45 trans MSM living in various cities across the United States (Phase I); 15 of those 45 trans MSM were subsequently selected to participate in in-depth, semi-structured qualitative interviews (Phase II). Participants for the Phase II qualitative interviews were purposively sampled from the Phase I sample based on recency and frequency of sexual encounters with non-trans MSM. Participants with more recent and frequent sexual experience with non-trans men were sought for the qualitative interviews in addition to participants who added demographic variance in order to provide context for the qualitative data and achieve a diverse and balanced sample. Approval for the study protocol was obtained from the Committee on Human Research at the University of California, San Francisco.

Data collection occurred between March and November of 2007. Participants across the United States were recruited via snowball sampling, listservs, and Web sites of interest to trans MSM; two trans men-focused national conferences; and flyer distribution at community events and spaces frequented by trans MSM. All participants who met the following criteria were considered eligible for study participation: (a) assigned female gender at birth, (b) current gender identity is male, transgender male, or another gender identity that the interviewer and participant both agreed falls under the umbrella term transgender and is on the trans masculine spectrum, (c) age 18 years or older, (d) English-speaking, and (e) has ever had sex with a non-trans male as a transgender male. No restrictions were put on the degree to which the participant had transitioned physically or legally (i.e., hormone use, gender confirmation surgeries, legal identification, etc.) or was perceived socially as male. However, despite efforts to recruit a diverse sample in regard to testosterone use, only one participant who was not currently using testosterone volunteered for participation. Each participant received \$20 cash or a gift card for participation in the Phase I quantitative survey and \$50 cash or a gift card for participation in the Phase II qualitative interview.

Measures

Quantitative surveys—After screening participants and obtaining verbal informed consent, the interviewers administered a 30- to 45-minute structured survey that was conducted either in person or by telephone, depending on the method of recruitment. Participants who were recruited at conferences or in the San Francisco Bay Area were more likely to be interviewed in person than participants who lived in other locations. The survey included questions regarding demographic characteristics, hormone use, gender confirmation surgeries, HIV

status, history of STIs, HIV/STI testing behavior and perception of risk, sexual behavior with non-trans male partners, and alcohol and drug use.

Demographic and background information that was collected included age, current zip code, gender identity, sexual orientation, ethnicity, education level, income sources in the past year, and history of incarceration. Gender identity and sexual orientation questions were phrased as open-ended questions so that participants could describe these characteristics in their own words (i.e., *What is your gender identity?*, *What is your sexual orientation?*). Hormone use was assessed by asking if the participant had ever used hormones, was currently using hormones, how long the participants had been using hormones (if currently using) or how long the participant had used hormones (if not currently using), and other questions regarding hormone use that were not relevant to the present analysis.

Sexual behaviors were assessed using a series of questions about sex with non-trans men in their lifetime and in the past year, including oral, vaginal, and anal sex, both with and without condoms. Inconsistent condom use was defined as not always using condoms during oral, vaginal, and/or anal sex with non-transgender male partners. Only unprotected receptive vaginal and/or anal sex was considered high risk for the purpose of this study. Language used to describe genitalia and sex acts was introduced in the section on sexual behavior, and participants were asked to specify their preferences for language to ensure sensitivity and accuracy of responses (e.g., many trans men prefer the terms *front sex* or *front hole sex* to vaginal sex). The alcohol and drug use behavior scale included questions that assessed participants' drug use histories (i.e., ever used) and recent use (i.e., past year), including injection drug use.

Qualitative interviews—Following administration of the quantitative survey, participants who were selected for Phase II participation were invited to participate and were scheduled for a qualitative interview. Fifteen trans MSM were selected using data from the Phase I quantitative survey and were scheduled for a 90-minute qualitative interview. All participants who were invited to participate in Phase II agreed to participate. Two experienced interviewers, both of whom identified as genderqueer (i.e., a trans identity that rejects the notion of binary gender), conducted all of the interviews. Prior to the interviews, the interviewer explained to each participant that participation would be strictly confidential and that all contact information would be destroyed upon completion of the interview. Participants gave verbal consent so that their names would not be linked to study data.

Using semi-structured, in-depth interviews, interviewers elicited information about sexual risk behaviors with non-trans men, including oral, anal, and vaginal sex; sex work; gender identity and its impact on negotiating sex with non-trans MSM; substance use; hormone use; gender confirmation surgeries; and HIV/STI status including testing behaviors and access to sexual health-related services. Interviewers followed an interview guide, which was expanded and refined in response to emergent themes identified by the data analysis process outlined below. Qualitative interviews were digitally recorded and transcribed for detailed analysis of the social context of trans MSM's sexual risk and protective behaviors and perceptions of the impact of their gender identity and gender expression on sexual decision-making and negotiation of safer sex with non-trans MSM.

Data Analysis

Descriptive statistics from the quantitative survey included frequencies and percentages for categorical variables and measures of central tendency and variability for continuous variables. Qualitative interviews were analyzed using Atlas.ti, a software program designed for grounded theory analysis of textual and multimedia data (Atlas.ti Scientific Software Development, 2009). Analysis of the interview data began immediately following the first interview so that

emergent themes identified in initial interviews, such as colloquial language used in trans MSM communities, could be incorporated into subsequent interviews when appropriate. As codes were developed to categorize the data, memos were written to elaborate on frequently used codes, to record ongoing observations about the data, and to take note of themes that emerged during the coding process (Strauss & Corbin, 1997). The memos were then used to construct concepts about the data, against which additional data were compared and contrasted, and to synthesize and explain larger segments of data. These memos were then organized into broader themes that addressed the specific aims of this study.

Results

Demographic and Background Characteristics

Of the 45 trans MSM who participated in this study, 37 (82.2%) were White, 5 (11.1%) were Latino, 1 (2.2%) was African American, 1 (2.2%) was American Indian, and 1 (2.2%) was multiracial. Participants ranged in age from 18 to 60 years, although the majority of participants were between 18 and 35 years of age (see Table 1). Twenty-nine participants (64.4%) were from major metropolitan areas, and 12 (26.7%) were from suburban or rural areas in the United States. More than two thirds (68.9%) of the participants were employed full time, and more than three quarters ($n = 34$, 75.6%) reported having health insurance. The majority ($n = 33$, 73.3%) had at least a college education.

Gender and sexual orientation—When asked the open-ended questions, *What is your gender identity?* and *What is your sexual orientation?*, participants were permitted to answer in their own words and provide more than one response. Twenty-one (46.7%) gave more than one response to the gender identity question, and 6 (13.3%) gave more than one response to the sexual orientation question. In response to the gender identity question, 33 (73.3%) said they were male or masculine, 24 (5.33%) said they identified as transgender (e.g., trans man, trans, FTM), and 9 (20.0%) replied that they identify as genderqueer (i.e., a gender identity outside of the binary categories of male and female). The majority of participants stated that they are queer and/or gay in response to the sexual orientation question (see Table 1).

Interview participants elaborated on how they experienced their sexual orientation and whether or not that experience remained consistent throughout their transition. Many participants commented on the general sense in the community that many trans MSM experience a shift in their sexual orientation after initiating testosterone use. Of the participants who reported a shift in sexual orientation, some attributed it directly to testosterone and/or increased sex drive, while others reported that it felt more attributable to them becoming more comfortable in their bodies and with how others regarded them. A few participants commented on their sense of loss of a queer identity when other people perceived them as straight men. One participant stated:

In the back of my head or subconsciously, I think I always realized that I would be a fag. It was like I couldn't think about it or recognize it while I was getting there because it was too threatening or there was too much fear around like how people would react to me. So it was like, okay, I have to get this stuff [related to transition] first before I can even think about that, and that's kind of what I did.

Another participant explained, "In my experience as far as visceral gut attraction, [my sexual orientation] really did seem to start shifting when I started taking testosterone." Another participant elaborated:

There's a lot of stuff that I've heard about guys going on T [testosterone] and suddenly their sexual orientation shifting. I mean, sort of anecdotal stuff. For me, I actually had a pretty major shift in who I was attracted to or who I was dating when I originally

came out as trans. It wasn't at all related to medical or hormonal stuff but just being comfortable in my body.

And one participant reported:

I've been queer longer than I've been straight, so for me, all of a sudden, I lost my queer identity. I was dating a woman; we looked like a straight couple, and she's a strongly queer identified person, and we were both like, "What is going on? How do we deal with this? What do we do with this?" because neither of us wanted to be seen as straight.

Hormone use and gender confirmation surgeries—All but one participant were currently taking hormones (see Table 2). Participants had been using hormones for an average of 5.5 years ($SD = 3.4$ years). Thirty-two participants (71.1%) reported having had some form of gender confirmation surgery. Of the participants reporting hormone use, 41 (91%) were using injectable testosterone, prescribed by a primary physician ($n = 43$, 97.8%) or clinic ($n = 2$, 4.4%). All participants who were using injectable testosterone reported that they usually obtained their needles from a pharmacy; 5 participants (11.1%) used online pharmacies. Six (13.3%) had also obtained new, unused needles from friends. None of the participants reported needle sharing for hormone use. Most participants ($n = 38$, 84.4%) performed the injections on themselves. Twelve participants (26.7%) did not have initial blood work done before initiating testosterone use, and almost one third ($n = 13$, 28.9%) reported that they were not currently having ongoing yearly blood work done. One participant currently using hormones had never had a blood workup. The most common gender confirmation surgeries were mastectomies ($n = 29$, 64.4%) and hysterectomies ($n = 13$, 28.9%).

Social Impact of Gender Identity and Expression

Being socially accepted as male—The phenomenon of being socially accepted as male (i.e., sometimes described as "passing") was discussed at length by many participants. The importance of this phenomenon to each individual varied widely; some participants stressed the importance of having their male identity validated in this way, and others expressed ambivalence about people assuming they are a non-trans man. Several participants highlighted the importance of being accepted or socially recognized in non-trans gay male spaces because of the desire to meet people and be seen as a potential sexual partner. One participant conveyed:

I feel like the more I can pass as a guy in the normal world that doesn't really understand trans people or isn't used to them ...it definitely has opened up possibilities for meeting people and just giving me more self-assurance and confidence about being in gay male spaces that are mostly non-trans guys and feeling hot or confident or like someone who's meant to be there. So in that sense, in terms of meeting people or being out in the world, I think that passing has opened things up a lot.

Meeting male sexual partners—Many of the participants described meeting their non-trans male sexual partners over the Internet. By meeting partners through personal advertisements, they could describe their body and gender identity upfront (if they chose to do so) and have a dialogue with potential partners to ensure their own safety. Participants also described meeting partners in bars and clubs, at conferences, through mutual friends, and in gay men's bear and leather communities. Most participants stated that knowing that a potential partner was aware of his trans status and was knowledgeable, accepting, and respectful of his identity were the most important determinants of whether or not he would pursue a sexual relationship or encounter with a non-trans man.

Identity and language—Some participants reported that the language they used to describe their gender seemed to have a considerable effect on how people responded. A few reported

experimenting with different terms in different contexts in attempts to reduce surprise and potential stigma. Some participants reported that potential sexual partners sometimes struggled with what it meant about their own sexual identity that they were attracted to or were having sex with a trans man. For all participants, it was clear that language was often inadequate to describe their bodies and identities accurately. One participant explained:

There was a period of time when I used to say that I was born female. And I noticed when I used those words, it brought up a lot of stuff for them. Their [sexual orientation] was now in question. They came on to me, and if I was born female, what did that mean? Were they gay? Were they bi? What did my body look like? How was this gonna work? It got complicated very quickly, whereas if I use the words, "I wasn't born male," there's no assumption to wrap their head around.

Another participant discussed the importance of context to self-disclosure:

If I am in gay male sexual space, the words that I will use to describe myself are more appropriate to that space. So in those situations, I may identify as queer; in some of those situations, I will probably more than likely identify as gay. If I am doing disclosure or I am in trans space, the words that I use to describe myself are trans man or FTM. My ID says male. To me, that's a legal definition; it's not my identity. So I tend to avoid those in terms of conversation because they don't have a cultural context. If I'm not disclosing at all, I say nothing and let people assume what they want to assume.

Some participants described disclosing only on a need-to-know basis with sexual partners. For example, one participant remarked, "In general, if I'm gonna just suck dick I don't disclose." Another participant stated:

I hook up, and so I'll very often tie a guy up and not disclose. I kind of jerk them off or something like that. And so I think sometimes they think it odd that I'm not like whipping out my dick and jerking off or something, but mostly they're too busy. They're having a good time.

Many participants discussed the anxieties related to discussing their bodies and gender identities with potential sexual partners. They reported often being asked to give lengthy explanations about what it means to be a trans man and describe their body parts. Many had concerns about being exploited and/or fetishized as a curiosity or experiment. One participant explained:

It gets tricky because as soon as you are negotiating with a potential sex partner and they start asking all the questions, it puts you in a one-down power dynamic where you feel like you are being interviewed. I'm getting better about turning it around on people and being like, "Actually, I'm not going to be in a situation where this is about me giving information and waiting for you to either reject or accept me."

Another participant asserted:

I always put [in my online advertisements] in big bold--you know, "You better respect my identity. I am a boy. I expect you to treat me that way." I look like a boy; if you're not into boys, you're probably not going to be into me. And I don't want to be an experiment. I specifically try to find bisexual and gay boys. Like, "If you're curious, we might be able to talk and negotiate something," but I want to be sleeping with men who are attracted to men because that's the dynamic.

Sexual Behaviors and HIV/STI Prevalence and Testing Behaviors

The median number of lifetime non-trans male sexual partners was 25 (range = 1–1000; the mean was skewed by a few outlier participants who had a large number of partners). Forty

(88.9%) of the participants reported sex in the past year with a non-trans male partner. The range of non-trans male partners in the past year was 1–50, with a median of 3. Thirteen (28.9%) of the participants reported having at least one primary non-trans male partner in the past year, and this was defined as a man with whom you have a close, intimate relationship where you feel committed to him above anyone else and where you have sex together. Eighteen participants (40.0%) reported ever having had a primary relationship with a non-trans male partner.

Self-reported HIV status had a prevalence rate of 2.2% ($n = 1$; see Table 4). Forty-one (91.1%) of the participants reported having ever been diagnosed with an STI. Twenty-three participants (51.1%) said they personally knew at least one HIV-infected trans man. Inconsistent condom use was high in this sample, with only 4 participants (8.9%) who reported always using condoms during oral sex, 14 (31.1%) who reported always using condoms during vaginal sex, and 18 (40.0%) reporting always using condoms during anal sex (see Table 3).

Participants reported that their non-trans male partners often made assumptions about what it meant to have safer sex because for non-trans gay men, safer sex often only means condom use with anal sex. Because many of the participants' partners did not have experience with trans men or access to safer sex education about sex with trans men, they sometimes had misconceptions about what was safe and what was not. One participant recalled:

Sometimes the guys will be like, “Oh, I only have safe sex,” and what they mean is safe sex for anal sex. And then they start going in the front door with no condom, and you're like “Hello! Excuse me!” And they must have thought either because it's not messy or because they associate HIV with butt sex or they think you can't get pregnant, they don't need to use a condom.

Another participant described:

I had some guy try to tell me he had a vasectomy, and I'm on T and the chances for me getting pregnant are pretty unlikely anyways, so he was telling me that it's really safe – it's not a problem.

Participants also discussed the resistance they sometimes encountered from their partners when they tried to insist on condom use. One participant described how he was not always able to maintain his boundaries:

Often, there will be situations where you want the person to wear a condom, but they're not going to wear a condom and they don't. But I definitely do try really hard to get people to wear condoms ... but you know, it happens often enough that it's really a risk.

All of the participants reflected on the sense of validation that having sex with a non-trans man could provide. Many suggested that this was particularly powerful for trans men in their early years of transition and that being sexual with a gay non-trans man could feel like the “ultimate affirmation” of one's manhood. This led many participants to ponder the risks that they, and other trans men, were willing to take to receive this sense of affirmation. One participant explained, “So there's this thing that, this almost kind of hypnotic thing that can take over when the drive to be perceived as your core, core gender, as who you are, really trumps every other survival instinct.” Another participant affirmed:

I think a lot of times there's always this pull there. It's like, “Okay, this person is really affirming to me.” Like the sex we had is affirming to my gender. It's like you don't want to lose that, so it's like, “How can I make it better for them?” And the idea of not using condoms is always there, you know.

One participant declared:

There's what I call the anything-to-be-a-man syndrome and particularly in the first couple years of trans identity – not necessarily medical stuff, but it kind of overlaps with that, where the F to M identified person is so desperate for so much – so much validation.

Another participant added, "Particularly when I was going through a period where I was less comfortable with my body, it's really hard to talk about condom use when you don't want to draw attention to your body parts or anyone else's."

Sex under the influence of alcohol and drugs—Forty percent ($n = 18$) of the participants reported having 5 or more drinks in a single day within the past month (see Table 5). Lifetime drug use was high ($n = 43$, 95.6%); the most frequently reported drugs used in the past year were marijuana ($n = 24$, 53.3%), ecstasy ($n = 9$, 20.0%), and poppers ($n = 8$, 17.8%).

Participants varied in their experiences of having sex while drunk or high. Many discussed how drugs and alcohol enhanced sexual experiences, helped to relieve anxiety about their bodies during sex, and impaired their ability to insist on condom use, while others were adamant about not being intoxicated, especially while having sex with new partners. One participant asserted:

I have certainly used drugs on occasion to do what I believe to heighten a sexual experience but not with somebody I don't know and definitely not a first time with somebody I met over the Internet – although I don't see poppers as a drug, even though it is.

Another participant recalled:

There were definitely a couple of times with this guy where we would be drunk, and we would end up not using a condom for something that I would otherwise always want to use a condom for just because I don't know ... I would sort of be less aware of what was going on or more in the moment or whatever ... he would do things that weren't really what we normally did, and because of being drunk, I wouldn't really stop him.

And one participant reported:

As far as protecting myself, I don't think [substance use] has an effect. I still have – I'm still able to have my same requirements and everything like that. And then in other ways, it can just lead to me not being so wound up in my body parts or inadequacies that I may feel, so that may lead me to be more uninhibited in certain ways, but not when it comes to safe sex.

Some participants reflected on the role of drugs in gay men's culture, as this participant described:

To have access to certain parts of the culture, you have to be chemically enhanced ... There are trans guys who are not surprisingly subject to the pressures of having to be great, having to be hot, having to feel sexy, staying up all night. Why do we start social events at 10 or 11 o'clock at night? They're actually not doable without drugs.

Sex work—Eight (17.8%) of the participants reported exchanging sex for pay in the past year. Some participants reported that sex work was a fun way to make extra money and have more sex; for others it was a survival strategy. The frequency of condom use with paying partners varied. One participant elaborated:

I'll have sex with guys to get drugs from them, and I'll have sex to get some extra money. So yeah, I do have sex outside of the relationships. And some of them wouldn't be okay with that, so I wouldn't tell them.

Another participant said, "Working in the sex industry always has been to me like a no-brainer. Safe sex is work sex. And somehow leisure sex has always been unsafe sex."

Protective strategies—Participants often described how meeting partners over the Internet facilitated negotiation of safer sex because it allowed them to articulate their expectations upfront, describe their gender and their bodies, and determine through dialogue whether or not their potential partners were committed to having safer sex. They also discussed the need to be vocal and articulate about their bodies as well as the need to be willing to draw very firm boundaries around their decisions, even if that meant that they do not always end up getting the sex they wanted. As one participant reported, "I always put out there [in online postings] that you're going to use condoms if you're going to fuck me." Another participant explained:

I always use condoms for any sort of penetration but not for oral sex. So that's pretty much my line, and I don't really – I don't waiver in that. It's not an option. It's either going to happen that way, or it's not going to happen. But I have found, you know, some guys that I was with that were just like they couldn't stay hard with the condom on and they were like, "Oh, I can't stay hard with it on", so then I was like, "Okay, we can do other stuff." It was not like, "Okay, we don't have to use it."

Another participant relayed:

Especially in areas where there's not trans awareness, you need to be sober, you need to know your boundaries, you need to be articulate, you need to be able to talk about sex and things like that. Because otherwise – and I think because I have a lot of those things, I have less sex in a lot of ways which, you know, is kinda sad, but it's also – that means I'm taking care of myself. And that is priority number one.

Testing behaviors and access to resources—The majority of participants in this sample had been tested for HIV ($n = 43$, 95.6%) and had health insurance ($n = 34$, 75.6%). Many participants described seeking services, or wishing to seek services and sexual health information, from agencies that served non-trans MSM. Because they were seeking community among gay men, both trans and non-trans, they expressed the desire for gay male spaces and services to be more inclusive, knowledgeable, and receptive to their needs. Participants repeatedly expressed concerns about the inadequacy of data collection methods used by most agencies and providers, which did not allow participants to accurately describe their gender and often lead to false assumptions. One participant commented, "It occurs to me when I get tested [for HIV] that there's really no way for me to indicate that I'm a trans guy."

Another participant recollected:

One time, I was in a bar, and there was a guy doing a survey on gay men and HIV testing. And he offered me 10 bucks to do a survey or whatever, and at no point was there really a way for me to disclose that I was FTM, so I didn't.

Still another participant remarked, "If I'm going to a doctor, I don't check the [male/female] box. I let them think that I neglected to check the box and let them do it."

Discussion

Trans MSM have been repeatedly identified as a population with unmet HIV prevention education needs (Adams et al., 2008; Clements et al., 1999; Kenagy & Hsieh, 2005; Xavier & Bradford, 2005). The scarcity of culturally relevant, accurate sexual health information for and

about trans MSM, especially trans men who are having sex with non-trans MSM, puts them at risk due to misinformation, limited support, and lack of access to resources and partners who are knowledgeable and respectful of their bodies and identities.

Study findings begin to address a significant gap in the HIV literature about the risk behaviors, protective factors, and HIV prevention needs of trans MSM. While HIV prevalence among trans MSM was low in this study, reported sexual behaviors indicated a high level of risk. The majority of the participants reported not using condoms consistently for receptive vaginal and anal sex with non-trans MSM, who are among the highest risk groups for HIV/STIs (Catania et al., 2001; Schwarcz et al., 2007). In addition, many participants reported that they obtained affirmation of their gender identity through sex with non-trans MSM, the use of alcohol and drugs to alleviate anxiety about their bodies during sex, and unequal power dynamics in their sexual relationships with non-trans MSM that reduced their abilities to negotiate safer sex.

Many of the participants discussed seeking services from agencies that prioritized non-trans MSM, which was consistent with other needs assessment data collected from trans MSM (Adams et al., 2008). However, they reported often being miscategorized as non-trans MSM by health care personnel who were providing testing services, conducting surveillance work, or providing primary care. Often this miscategorization occurred because there was no opportunity for them to identify themselves as trans, they did not feel safe disclosing their trans status, and/or providers made assumptions that clients did not feel comfortable correcting.

It is imperative for client safety and quality of services that health care providers improve data collection processes, from intake forms to testing data to collecting client histories. Forms must be updated to reflect best practices for collecting data on gender, and staff and providers must then be trained on how to use and interpret these forms. The Center of Excellence on Transgender HIV Prevention has published clear policy recommendations regarding inclusive data collection on gender, and a number of organizations have endorsed and adopted these recommendations (Sausa, Sevelius, Keatley, Rouse Iñiguez, & Reyes, 2009). Rather than making assumptions about the gender and sexual orientation of clients, health care providers must know how to ask these questions in a culturally competent manner in order to create a safe space for clients to freely discuss their health concerns and for providers to give the best services and most accurate health information.

Sexual health resources for non-trans MSM must be fully inclusive of trans MSM to effectively address the prevention needs of MSM and their sexual partners. Some programs that serve transgender women seek to be inclusive of transgender men, but trans MSM are not always served well by programs that serve transgender women since the needs of these two populations can be quite different. A significant body of research on transgender women's service needs highlight HIV prevention and care, employment, substance abuse treatment, and housing (Clements-Nolle et al., 2001). Although some trans MSM need access to these resources as well, study findings suggest that top priorities for many transgender men may include access to accurate sexual health information for themselves and their partners, access to trans-knowledgeable service providers and gay male community spaces, trans-competent health care services including hormone therapy and gender confirming surgeries, and support services for negotiating and building sexual relationships with non-trans MSM.

The participants in this study reported high levels of Internet utilization to facilitate meeting and negotiating with potential sex partners safely, and the Internet can also be used to disseminate accurate sexual health information and raise awareness about trans men in gay male communities. Variability in testosterone use and gender confirmation surgeries produces different types of bodies and gender expressions among trans MSM, and sexual health information must address their unique and diverse needs.

Limitations

This study provided an initial investigation of sexual risk among trans MSM. Due to limitations of time and resources, the study used a relatively small convenience sample that yielded primarily White trans men with access to resources such as health insurance, stable housing, and employment. It is reasonable to assume that trans MSM of color and/or trans MSM with access to fewer resources might report different risk behaviors or degrees of risk than findings reported from this sample.

Future Directions

Additional research is needed with larger and more diverse samples of trans MSM that is more inclusive of trans MSM of color and trans MSM who are harder to reach, such as those who do not have stable housing or employment. One previous study found that transgender men of color were less likely than their White counterparts to have a primary care physician (Kenagy, 2005), and this differential access to resources should be further explored in future studies of transgender men. More information is needed about how best to meet the prevention and service needs of trans MSM as well as the needs of their non-trans male partners.

References

- Adams, A.; Lundie, M.; Marshall, Z.; Pires, R.; Scanlon, K.; Scheim, A., et al. Getting primed: Informing HIV prevention with gay/bi/queer trans men in Ontario. Toronto, Ontario: AIDS Bureau, Ontario Ministry of Health and Long-Term Care; 2008 [Retrieved June 1, 2009]. from <http://www.queertransmen.org/images/gettingprimed.pdf>
- Atlas.ti Scientific Software Development. Atlas.ti [Computer software]. Chicago: Author; 2009.
- Catania JA, Osmond D, Stall RD, Pollack L, Paul JP, Blower S, et al. The continuing HIV epidemic among men who have sex with men. *American Journal of Public Health* 2001;91(6):907–914. [PubMed: 11392933]
- Centers for Disease Control Prevention. Sexually Transmitted Disease Surveillance Report, 2007. Atlanta, GA: U. S. Department of Health and Human Services; 2008 [Retrieved June 1, 2009]. from <http://www.cdc.gov/std/stats07/Surv2007FINAL.pdf>
- Clements-Nolle K, Marx R, Guzman R, Katz M. HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health* 2001;91:915–921. [PubMed: 11392934]
- Clements K, Wilkinson W, Kitano K, Marx R. HIV prevention and health service needs of the transgender community in San Francisco. *International Journal of Transgenderism*. 1999 3(1 2)from http://www.symposion.com/ijt/hiv_risk/clements.htm
- Herbst J, Jacobs E, Finlayson T, McKleroy V, Neumann M, Crepaz N. the HIV/AIDS Prevention Research Synthesis Team. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. *AIDS and Behavior* 2008;12(1):1–17. [PubMed: 17694429]
- Hudson's FTM resource guide. 2009 [Retrieved June 1, 2009]. from <http://www.ftmguide.org/>
- Kenagy G. HIV among transgendered people. *AIDS Care* 2002;14(1):127–134. [PubMed: 11798412]
- Kenagy G. Transgender health: Findings from two needs assessment studies in Philadelphia. *Health & Social Work* 2005;30(1):19–26. [PubMed: 15847234]
- Kenagy G, Hsieh C. The risk less known: Female-to-male transgender persons' vulnerability to HIV infection. *AIDS Care* 2005;17(2):195–207. [PubMed: 15763714]
- Koblin BA, Chesney MA, Husnick MJ, Bozeman S, Celum CL, Buchbinder S, et al. High-risk behaviors among men who have sex with men in 6 US cities: Baseline data from the EXPLORE study. *American Journal of Public Health* 2003;93(6):926–932. [PubMed: 12773357]
- Morgan S, Stevens P. Transgender identity development as represented by a group of female-to-male transgendered adults. *Issues in Mental Health Nursing* 2008;29(6):585–599. [PubMed: 18569206]
- Namaste V. HIV/AIDS and female-to-male transsexuals and transvestites: Results from a needs assessment in Quebec. *International Journal of Transgenderism*. 1999 3(1 2)from http://www.symposion.com/ijt/hiv_risk/namaste.htm

- Sausa, L.; Sevelius, J.; Keatley, J.; Rouse Iñiguez, J.; Reyes, M. Recommendations for inclusive data collection of trans people in HIV prevention, care, and services. San Francisco, CA: University of California, San Francisco; 2009 [Retrieved June 1 2009]. from <http://transhealth.ucsf.edu/pdf/data-recommendation.pdf>
- Schleifer D. Make me feel mighty real: Gay female-to-male transgenderists negotiating sex, gender, and sexuality. *Sexualities* 2006;9(1):57–75.
- Schulden J, Song B, Barros A, Mares-DelGrasso A, Martin C, Ramirez R, et al. Rapid HIV testing in transgender communities by community-based organizations in three cities. *Public Health Reports* 2008;123:101–114. [PubMed: 19166094]
- Schwarzc S, Scheer S, McFarland W, Katz M, Valleroy L, Chen S, et al. Prevalence of HIV infection and predictors of high-transmission sexual risk behaviors among men who have sex with men. *American Journal of Public Health* 2007;97(6):1067–1075. [PubMed: 17463384]
- Strauss, A.; Corbin, J. Grounded theory in practice. Thousand Oaks, CA: Sage; 1997.
- Wilkinson, W.; Gomez, P. Assessing the needs of female-to-male transgendered people of color and their partners. San Francisco: FTM International; 2004 [Retrieved June 1, 2009]. from http://www.hawaii.edu/hivandaids/Assessing_the_Needs_of_FTM_TG_People_of_Color_and_their_Partners.pdf
- Wilson E, Garofalo R, Harris R, Herrick A, Martinez M, Martinez J, et al. Transgender female youth and sex work: HIV risk and a comparison of life factors related to engagement in sex work. *AIDS and Behavior*. 2009[Epub ahead of print] [DOI: 10.1007/s10461-008-9508-8]. Retrieved June 1, 2009, from <http://www.springerlink.com/content/d5476455368231jk/fulltext.pdf>
- Xavier J, Bobbin M, Singer B, Budd E. A needs assessment of transgender people of color living in Washington DC. *International Journal of Transgenderism* 2005;8(23):31–47.
- Xavier, J.; Bradford, J. Transgender health access in Virginia: Focus group report. 2005 [Retrieved June 1, 2009]. from <http://www.vdh.state.va.us/std/Research%20Highlights/TG%20Focus%20Group%20Report%20final%201.3.pdf>

Table 1

Demographic and Background Characteristics of a Sample of Trans MSM (N = 45)

	<i>n</i>	(%)
Age		
18 – 25	13	28.9
26 – 35	19	42.2
36 – 45	9	20.0
46 – 60	4	8.9
Gender Identity *		
Male/masculine	33	73.3
Trans (transgender, trans man, FTM, etc.)	24	44.4
Genderqueer	9	20.0
Sexual Orientation **		
Queer	25	55.6
Gay	20	44.4
Bisexual	6	13.3
Straight	1	2.2
Don't know	1	2.2
Education		
8th grade or less	1	2.2
High school or GED	3	6.7
Some college, Tech, GED test	8	17.8
College graduate	19	42.2
Postgraduate	14	31.1
Income Sources in Past Year		
Employed full-time	31	68.9
Employed part-time	16	35.6
Employed sometimes	10	22.2
School loans/scholarships	11	24.4
Sex for pay	8	17.8
Partner/spouse	8	17.8
Family/friends	7	15.6
Selling drugs	3	6.7
Social Security	2	4.4
Unemployment	2	4.4
Disability	3	6.7
Alimony/Child support	1	2.2
Other	9	20.0
Have health insurance	34	75.6
Incarcerated ever	6	13.3

* 21 (46.7%) gave more than one response

** 6 (13.3%) gave more than one response

MSM – men who have sex with men

FTM – female to male

GED - General Educational Development

Table 2

Hormone Use and Gender Confirmation Surgeries (N = 45)

	<i>n</i>	(%)
Hormone Use		
Current	44	97.8
Injection testosterone	41	91.1
Prescribed by doctor	43	95.6
Prescribed by clinic	2	4.4
Method of Obtaining Needles for Injection Hormone Use		
Pharmacy	41	91.1
Online pharmacy	5	11.1
Friend	6	13.3
Types of Gender Confirmation Surgeries		
Key hole mastectomy	5	11.1
Bilateral mastectomy	24	53.3
Hysterectomy	13	28.9
Metoidioplasty	2	4.4
Oophorectomy	4	8.9
Testicular implants	1	2.2

Table 3

Sexual Behaviors of Sample of Trans MSM (N = 45)

	<i>n</i>	(%)
Oral sex with non-transgender male partner		
Ever	44	97.8
Past year	38	84.4
Frequency of condom use during oral sex		
Never	19	42.2
Less than half the time	14	31.1
About half the time	4	8.9
More than half the time	4	8.9
Always	4	8.9
Front (vaginal) sex		
Ever	37	82.2
Past year	31	68.9
Frequency of condom use during front (vaginal) sex		
Never	2	4.4
Less than half the time	8	17.8
About half the time	5	11.1
More than half the time	8	17.8
Always	14	31.1
Anal sex		
Ever	32	71.1
Past year	27	60.0
Frequency of condom use during anal sex		
Never	2	4.4
Less than half the time	4	8.9
About half the time	2	4.4
More than half the time	6	13.3
Always	18	40.0

Table 4

HIV/STI Prevalence Rates and Testing Behaviors of Sample of Trans MSM (N = 45)

	<i>n</i>	(%)
HIV test ever	43	95.6
HIV positive	1	2.2
Perceived self at-risk for HIV	28	62.2
STI test ever	41	91.1
STI diagnosis ever	21	46.7
HPV	11	24.4
Gonorrhea	3	6.7
Chlamydia	5	11.1
Herpes	5	11.1
Trichomoniasis	3	6.7
Bacterial vaginosis	4	8.9
Hepatitis C	1	2.2
Pelvic inflammatory disease	2	4.4
Pubic lice (crabs)	1	2.2

Table 5

Alcohol and Drug Use in a Sample of Trans MSM (N = 45)

	<i>n</i>	(%)
Alcohol use (5 or more drinks in a single day in past month)	18	40.0
Drug use		
ever	43	45.6
past year	31	68.9
Marijuana	24	53.3
Ecstasy	9	20.0
Hallucinogens	7	15.6
Poppers	8	17.8
Pain medication (e.g., OxyContin, Percocet)	7	15.6
Cocaine	7	15.6
Downers	5	11.1
Amphetamines	3	6.6
Crack	2	4.4
Ketamine	1	2.2
Heroin	0	0.0
Gamma hydroxybutyric acid (GHB)	0	0.0
Injection drug use		
ever	7	15.6
past year	1	2.2