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Isabeth Mendoza Date

Un granito de arena: Exploring Trans health services in the Clínica Especializada Condesa of Mexico City, México

By
Isabeth Mendoza
MPH

Global Health

____

Karen L. Andes, PhD
Committee Chair

____

Dawn L. Comeau, PhD, MPH
Committee Member

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By

Isabeth Mendoza

B.A., University of California, Berkeley, 2014
Emory University
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Thesis Committee Chair: Karen L. Andes, Ph.D.

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Abstract

Un granito de arena: Exploring trans health services in the Clínica Especializada Condesa of Mexico City, México
By Isabeth Mendoza

Background Clínica Especializada Condesa is the only public medical facility that offers transgender-specific health services in Mexico City, Mexico. While the private sector offers surgical options to the estimated 26,700 transgender individuals in the capital of 8.9 million people, the public sector prioritizes HIV and STI treatment. The clinic began offering hormone replacement therapy in 2009 after the ministry of health acknowledged the treatments importance and since then a total of 1,600 transgender individuals have utilized the clinics services. Yet, it is common for the transgender population to self-prescribe and inject substances for body modification without medical intervention.

Methods The study took a qualitative approach and conducted 13 in-depth interviews with persons identifying as *transgénero, travesti, transexual* (TTT) who were patients of Clínica Especializada Condesa in Mexico City, as well as two key informant interviews with clinic providers. Research questions focused on knowledge, accessibility and utilization of available services by the transgender community in México City. A thematic analysis was used to identify key patterns in the data.

Results Learning about trans health services was tied to social networks that included virtual and physical spaces such as Facebook, YouTube, forums and friend or familial networks. Yet none reported learning about trans health services from the health sector itself. Four participants reported directly experiencing discrimination, transphobia or stigma, and all participants reported its pervasiveness in the health and employment sectors. These experiences affected the population's willingness to seek, access and continue use of transgender health services. Barriers to health listed by Key Informants included: lack of HIV testing and information, high expectations for transition, and transphobia. Contrastingly, for participants they were a lack of information, high cost, lack of publicly funded surgeries, and trans competency.

Discussion There is a generational shift in how the trans population engages with healthcare including seeking formal medical care, family accompaniment and learning of services through virtual social networks. Although discrimination persists in various sectors, there is a positive impact on the interpersonal relationships of clinic trans patients. The clinic only existing in Mexico City has caused internal migration and residents to "stay put."

Key words: *Trans, transgénero, travesti, transexual, Mexico City, hormone therapy treatment, gender affirming surgery, clinica condesa*

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During my two years, I looked around the classroom and saw a wave of change. The students mirrored the countries we were discussing in class. Practicum goals included returning to the motherland and positively impacting our countries health. Field work changed in that the front lines were not filled with only saviors and good intentions, but rather residents of the same communities, speaking the same languages and sharing a heritage.

Tell me that isn’t revolutionary.

So, I want to take the opportunity to affirm the people of color, immigrants, refugees, first-gen, low-income and all identities that aren’t represented in academia and less so research. I believe we have the power to change our field and grant restitution to our communities that have been exploited through research and pushed away from and out of academic institutions.

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INTRODUCTION

There is a lack of affordable and accessible transgender-specific health services for the growing transgender population in Mexico City, Mexico. Consequently, the population has resorted to self-prescription and body modification without medical intervention as a means to advance transition goals and/or harmonize their identity body and mind. Thus, further exacerbating health disparities and vulnerability of the transgender population.

La Clínica Especializada Condesa (CEC) serves as the only public medical facility offering transgender-specific health services in Mexico City, Mexico to the estimated 26,700 transgender individuals (Sanchez, 2016). The capitol of 8.9 million people has the option of utilizing public or private health services, but until 2009 the transgender population could only obtain transgender-specific services through the private sector (Sanchez, 2016). The private sector offers gender affirming surgery and hormone replacement therapy (HRT), but now with the CEC, the public sector offers HIV and STI treatment, mental health and HRT. Since the Ministry of Health acknowledged HRT's importance in 2009 a total of 1,600 transgender individuals have utilized the clinic's services (Sanchez, 2016). However, it is common for the transgender population to self-prescribe, inject hormones and perform other forms of body modification without medical intervention (Sanchez, 2016). Additionally, transgender advocates feel there is still a lack of public sector provisions for gender affirming surgeries, and substance abuse and addiction counseling.

Transgender migrants, asylum-seekers and refugees also comprise the population in Mexico City as the capitol has become a sanctuary for the LGBTQ community. Mexico City is

the first city in Latino America to grant transgender people the ability to legally change their gender without a court order in 2014. Additionally, the city's anti-discrimination law includes gender identity, explicitly designating transphobia as discriminatory (Lavers, 2015).

In 2016, a study was conducted to reconceptualize categories related to gender identity in Mexico City. As a result, the removal of the transgender diagnosis from the mental disorders chapter within the World Health Organization (WHO) classification was supported (Robles et al, 2016). Conducted in collaboration with the Clinica Especializada Condesa, their findings supported the "idea that stress and dysfunction may be the result of stigmatization and maltreatment rather than integral aspects of transgender identity" (Robles et al, 2016, p 857). The reality of law not translating into practice is palpable in Mexico City, where LGBTQ inclusive legislation has not decreased transphobic attacks highlighting the source of stress, stigmatization and maltreatment. According to Cornell University Law School, Mexico has one of the highest rates of transphobic violence in the world (Woodman, 2016). Specially targeted are transwomen who are "easier to detect" and whose bodies serve as the battlegrounds for confusing sexuality with gender identity (Woodman, 2016). Many transwomen are sex workers since they are discriminated based on appearance from having traditional employment. Consequently, increasing their vulnerability of HIV and STI infection, exploitation from drug cartels, and alcohol and substance abuse (Woodman, 2016).

In response to the 2016 field trials of Mexico City, a United Nations advocate was quoted as saying --"transphobia is a health issue" (The Lancet, 2016). The various socio-contextual determinants of health such as bias medical definitions and perceptions by healthcare providers,

and the limited healthcare services in Mexico City, have contributed to the gravity of the health disparities, public health and social injustices endured by the transgender population. Thus, calling for the prioritization of transgender health globally.

It is necessary to evaluate the impact of available, although limited, transgender-specific health services in Mexico City. With the continuance of transphobia in society and healthcare facilities, the lack of law implementation in Mexico City, and the reality of self-medication and clandestine services available to the transgender population, a gap in the literature needs to be addressed. One in which shifts the focus of transgender-specific health services from only HIV to holistic and gender inclusive services. A knowledge gap exists in how the transgender population in Latin America, Mexico and Mexico City learn of formal transgender health services, accesses and utilizes private, public or clandestine services. With this knowledge, services made available to the transgender population can be properly advertised and made aware to providers, barriers can be prevented and mitigated, and services can be highly utilized by those who need them.

This study was designed for the context of Mexico City, Mexico where the Clinica Especializada Condesa is located and the transgender population is made up of Mexican residents, immigrants and refugees. Since the Clinica Especializada Condesa is the only public medical facility that offers transgender-specific health services in Mexico City to the estimated 26,700 transgender individuals, it is essential to understand how the transgender community is engaging with the clinic and other existing transgender-specific health services. In order to explore the possibilities, 13 in-depth interviews were conducted with *transgénero, travesti,*

transexual (TTT) patients who were in care with the Clinica Especializada Condesa during July 2017. Additionally, two key informant interviews were conducted with the clinic's mental health provider and endocrinologist. The following three aims guided the in-depth and key informant interview:

Aim 1: Identify the knowledge and attitudes the Trans community in Mexico City, has regarding Trans-specific healthcare.

Aim 2: Determine the access the Trans population has to Trans-specific healthcare services in Mexico City.

Aim 3: Identify the sociocontextual factors that impact the utilization of Trans-specific healthcare services in Mexico, City.

More research can be informed from what was discovered through this study. Barriers and facilitators to the learning, accessing and utilizing services will contribute to how the Clinica Especializada Condesa carries its work and other clinics that follow. Moreover, the quality of life for the transgender community will be positively impacted, their health disparities decreased, and the policy changes emboldened.

In this study the term transgender is used as an umbrella term to refer to individuals whose identity or behavior falls outside the stereotypical gender binary (Diehl et al, 2017). The term encompasses many identities including people who live part-time in another gender, people who identify as bi-gender or pangender (non-binary gender) (Diehl et al, 2017). However, it is

important to note that terms and definitions are not universal. In Mexico City, three terms are used and have distinct definitions: *transgénero, travesti, transexual.* As noted on the CEC website, *transgénero* shares the aforementioned definition but further explains that being *transgénero* does not imply a specific sexuality but does mean the person is already living in the gender they self-identify with, have gone through a phase of self-acceptance, have gone through psychological therapies that have aimed to guide the person through the process and NOT to "return to the normalcy", and perhaps initiated hormone therapy (CEC, 2011). *Travsesti* is defined as a person who wears clothes of the opposite sex, may not want to undergo HRT or surgery and is happy with their sex and gender. *Transexual* is defined as persons who desire gender affirming surgery, specifically genital surgery. While each term has a different meaning, it is understood and accepted to use the term *trans* as an umbrella term.

The parameters of what is considered to be transgender-specific health services and thus covered by Ministries of Health and governments, applies to surgery, specifically either being considered aesthetic or necessary. Services that are included as necessary without debate are HRT, HIV and STD prevention and treatment. Services that are contested are surgeries relating to primary or secondary sexual characteristics, facial aesthetics, internal and external corporal and genital interventions, mental health, substance abuse and addiction counseling, gynecology, and dermatology.

BACKGROUND

Transgender Health in Latin America and the Caribbean (LAC)

Unfortunately, there is very limited data on the health status and disparities of the transgender community in Latin America and the Caribbean (LAC). Much of the available data focuses on HIV/AIDS, and very recently, there are region specific studies on the health status of the transgender community. Many of the existing studies focus solely on the population of transwomen, excluding data and experiences of transmen. Nevertheless, the available data confirm that the transgender population in LAC are a marginalized community with limited access to prevention and treatment services that are general health and trans-specific (PAHO, 2011). The primary documented health problems for the transgender population are: high disposition to verbal, emotional, financial abuse and fatal hate crimes; high frequency of mental health issues due to external factors; high rate of HIV and STD prevalence; high consumption of alcohol and drugs; negative outcomes of self-administered medications for body modifications; and reproductive health issues (PAHO, 2011). Other health issues the LAC transgender community face are skin problems due to the use of garments and fillings made of synthetic fibers, excessive sweating and lack of access to basic hygiene services; dental, sleep, and nutrition problems such as anorexia, bulimia and malnutrition; wounds including the consequences of sexual violence; and physical and psychological consequences of bullying, harassment and transphobia (defined as fear or hatred of transgender people) (PAHO, 2011).

According to Pew Research Center, the following Latin American countries have had the most recent legal and social strides towards the inclusion and protection of the LGBT community: Argentina, Brazil, Uruguay, México, Ecuador, Perú, Colombia, and Chile (Lipka,

2015). Although all vary in the advancement of transgender rights, it is vital to review such advances and their impact on the health status of the transgender community in the region.

Overview

Across all countries, transgender health becomes accessible through the passing of gender identity laws with the exception of Brazil, which established a governmental response to the AIDS epidemic as its first policy related to trans health (Berkman et al, 2005). Specifically, Argentina is known as the world leader in transgender rights for being the first in passing the Gender Identity Law in 2012 as well as legislation that allowed transgender individuals to change their gender on identity documents without prior medical or psychological testing (He, 2016). Additionally, Argentina made hormone treatment and surgery a legal right in both the private and public heath sectors of the country. Uruguay has also been a leader in providing social support services that positively impact trans health such as, food assistance programs, focus on trans persons living in extreme poverty, documentation of discrimination and human rights violations and partnering with academic institutions to improve understanding of social vulnerability and design interventions (Santisteban et al, 2016). Lastly, in Ecuador the transgender community has the right to "aesthetic freedom" applied to public and private spaces, "family diversity" that applies to transgender sex workers who act as a single economic and social unit (AWID, 2013).

Access

The ability to access services (legal or health related) varies across all countries even though they are considered by the Pew Research Center as being the most inclusive for trans

individuals. For example, gender identity laws do not specifically remove judges, psychologists or medical providers as gatekeepers of healthcare. In Peru, one needs to appear before a judge to make changes to identity documents and it leads to discrimination, inability to have accurate documents and consequently, a barrier to health (Fraser, 2016). In Colombia, a psychological evaluation is needed and a gender dysphoria diagnosis in order to obtain HRT (Aguayo-Romero et al, 2015). In Chile, the procedure currently available requires medical diagnosis of gender dysphoria, "medical sexological examination and assessment," two witnesses must state that the person has been using the preferred name for at least 5 years (Riquelme, 2017). It has been reported that some courts have even required "DNA tests and that the solicitant undergo sterilization and genital modification surgeries" in order to obtain approval (Riquelme, 2017). Initially, in Brazil only transwomen with a trans diagnosis and who wanted to undergo gender affirming surgery had access to transgender health care (Tagliamento and Paiva, 2016). The resolution was modified in 2010, such that gender affirming surgery, mastectomies and hysterectomies are no longer considered to be experimental (Tagliamento and Paiva, 2016). Additionally, Brazil's 2013 Ministry of Health Amendment Rule, extended inclusion to trans people not interested in undergoing gender affirming surgery (Tagliamento and Paiva, 2016).

Medical Facilities and Personnel

Although countries have laws and transgender-specific services, the facilities are not necessarily accessible to all and personnel are reported to not be culturally sensitive or competent when delivering care. In Brazil, there are four specialized centers specifically for transgender health, however they lack integration, and do not adhere to public health system guidelines as they offer only partial services (Perucchi, et al, 2014). Additionally, these four centers only exist

in state capitols, leaving people in the other 21 Brazilian states no other choice but to join a waitlist, depend on trans ambulatory service, and delay surgery (Tagliamento and Paiva, 2016). In Ecuador, doctors lack proper training in prescribing hormone treatment and many trans persons wait until the situation is dire to seek consultation (Telesur, 2017). Providers usually focus on trans patients' sexual health as "trans patients are not always perceived as human beings...but [are] seen as potential transmitters of sexual diseases — especially in the case of trans sex workers" (Telesur, 2017).

Religion, Transphobia and Stigma

Religion, transphobia, homophobia and stigmatization of sex work impact health providers, governments and societies extending health services to the trans community. In Peru, its large Catholic and increasing Evangelical population have slowed progression of LGBT rights through its openly homophobic declarations by Congress members and curtailing of funding away from LGBT rights organizations by religious Congress members (Lavers, 2014). Advocates have emphasized LGBT discrimination and violence are serious problems where trans girls and women are forced to work at hair salons or become prostitutes because they do not have access to other employment opportunities (Lavers, 2014). While some private sector providers offer healthcare to transwomen, this requires an income that not many transwomen have, as evidenced by data showing that about 70% of transwomen are engaged in sex work (Fraser, 2016). Lastly, Barbados, the Dominican Republic, and Jamaica have made progress in reaching out to the trans community however the political and cultural context contributes to the transphobia, strict gender norms and a criminalizing environment. Homophobia has impacted the silence, denial, stigma, and discrimination against the transgender community, having negative

consequences for the provision of accurate prevention information, power to negotiate consistent and correct condom use, and access to treatment, care and support for those living with HIV or AIDS (HPP, 2015). In regard to providers, they do not receive training related to transgender health, gender identity, or sexual minorities. In the Caribbean region the stigma and discrimination in the healthcare sector have been recognized, including in these three countries (HPP, 2015).

Transgender Health in México

The country of México passed the Federal Law to Prevent and Eliminate Discrimination in 2003, which includes "sexual preference" as a protected category (TLC, 2016). However, there are no explicit federal laws protecting transgender individuals from discrimination based on their "gender identity" across all 31 states (TLC, 2016). Additionally, México passed legislation to protect women from gender-based violence but did not explicitly include transwomen (TLC, 2016). Only in México City is "gender identity" included as a protected category in addition to sexual preference. Other protections exclusive to México City include: the ability to change a person's legal name and gender marker without a court order (2014), same-sex marriage, same-sex couples' ability to adopt children, apply jointly for bank loans, inherit from one another, and be included in spousal insurance policies (2009) (TLC, 2016). It was in July 2015 that same-sex marriage was legalized in all 31 states in México (TLC, 2016).

Health System

In 2009, transgender health care was extended to all Mexican citizens who do not have formal employment or qualify for *Seguro Popular*, the public health system. *Seguro Popular* is

public health insurance that covers many services without copays, established by the Mexican government in an effort to expand health care to the uninsured and reduce health inequities (World Bank, 2018). *The Ley de Salud del Distrito Federal* does not positively impact transgender persons who are a formally employed citizens (or dependents of), a public service employee (local, state and federal), a marine, or a military member, as they are unable to access the services offered for free by institutions that are funded by *Seguro Popular*. Individuals meeting these requirements have to utilize the services offered by their specific public healthcare programs. Transgender specific health services are defined to include mental health, hormone therapy and STD/HIV prevention and treatment. According to the *Ley de 2010 de Refugiados y Protección Complementaria,* migrants and refugees are to be granted access to *Seguro Popular* institutions, however very few migrants and refugees know of their rights to free healthcare access and healthcare providers are unaware of migrants' and refugees' rights to healthcare access.

Clinica Especializada Condesa

Clinica Especializada Condesa (CEC) is a level one government funded primary health clinic with an endocrinology specialty that was established in 2000 as an HIV prevention and diagnosis facility. After the inclusion of transgender health in the *Ley de Salud del Distrito Federal* in 2010, the CEC became the first public institution to offer transgender-specific health services. CEC is considered to be the largest and most dynamic center for persons living with HIV in México, given that México City has the highest number of documented HIV cases in all of the country (TLC, 2016). México City's prevalence is 0.79% and in 2013, 30% of persons with HIV detected in the country were in México City, México (CEC, 2013).

Currently, CEC serves more than 14,000 persons through various services and programs specialized in STI's, HIV, mental health, counseling, and transgender health. It is estimated that about 18 transgender individuals arrive for the first time at the clinic every month; more than 30% of all CEC patients test positive for HIV (CEC, 2013).

CEC also serves victims of sexual violence, migrants (sanctuary clinic), homeless individuals and drug users. Programs in collaboration with community partners include mitigation of health risks for persons deprived of liberties and sex workers. In 2015, a second location was opened, Clínica Condesa-Iztapalapa, serving the area with the highest density population in Mexico City. The same services are offered in addition to child care for persons who receive outpatient care. Additionally, providers from CEC split their time in both locations (CEC, 2013).

Private Health Sector

In the private sector, hormone replacement therapy and surgery services are offered, however it is more common for surgery-specific services to be sought by the transgender community than other kinds of services. Surgeries are only performed in private settings by urologists and plastic surgeons in the cities of Monterrey, Guadalajara and México City (Diehl et al., 2017). They have also been highly utilized by the global transgender community as their marketing caters to tourists. For example, the México Transgender Center boasts having the best transgender services in México, and is located in Hospital Jardines de Guadalupe in Guadalajara, Jalisco (MTC, 2016). Its website is in both English and Spanish, providing a thorough outline of

surgery deposits in U.S. dollars, what is and is not included in the consultation, services offered and payment options. In México City, the Hospital General Dr. Manuel Gea González offers surgery specialties such as reconstructive plastic surgery and urology. Miguel Ángel Gaytan, a plastic surgeon, urologist and gynecologist, reports that approximately 70 gender affirming surgeries are performed annually at Gea Gonzalez (Mendoza, 2017). It is one of ten specialized hospitals in México City that has the capacity to perform gender affirming surgeries but does not have official statistics (Mendoza, 2017). In México City, the surgery process for a patient is reported to span two years, which includes the requirement of living in the self-identified gender and undergoing hormone therapy before undergoing surgery (Mendoza, 2017).

The private sector requires a psychiatric evaluation prior to surgery consultation to assess the level of maturity in regard to surgical changes and the mental and emotional transition as a trans person (Duron, 2017). It is with the mental health providers' approval that the patient is seen as "fit" and "effectively" trans (Duron, 2017). This process is intended to ensure that the patient is aware of the irreversible nature of the surgery and remove liability from providers. Private sector providers report that the majority of patients seek surgery after obtaining body modifications via hormones and liposculpture or breast implants for transwomen (Duron, 2017). Providers have continual follow up with their patients for one-month post-surgery and encourage ongoing mental health services for a supported emotional and social transition into society (Duron, 2017). The legal age to obtain surgery is 18 and while recovery time frames vary per surgery and per person it ranges from one to six months (Duron, 2017).

In México City, community organizations such as Sexología Sí attribute the low number of gender affirming surgeries due to high costs, doubts about risks, and uncertainty about preserving sexual sensitivity (Mendoza, 2017). These concerns are not unfounded as the high costs of surgery have driven many transgender persons to seek clandestine health services (EBD, 2015). While México City does not collect statistics on such procedures, medical experts have commented that uncertified providers deliver incorrect hormone therapy treatment and poor surgeries to the transgender community (EBD, 2015). Some of the problems that result from inadequate hormone therapy treatment are thrombosis, pulmonary embolism, decrease in sex drive and erection, osteoporosis, and vesicular and hepatic damage (EBD, 2015). Most of these problems pertain to transwomen as they have higher risks of health complications due to hormone treatment than transmen (EBD, 2015). Hormones can be purchased through social networks or at pharmacies in México City, allowing persons to determine their own regimen - and price. The cost for clandestine surgical procedures is significantly less - between 20 and 70 thousand pesos ($1,000-$3,700 US dollars) for mastectomy, and 180,000 pesos (~$9,600) for vaginoplasty (EBD, 2015).

Muxes

Third gender identifying persons in Mexico, called *muxes*, applies to individuals who were born male but present as women and who usually play feminine gender roles (Diehl et al, 2017). Although there are shared similarities with trans identifying persons, differences stem from ethnographic, cultural and anthropological backgrounds (Diehl et al, 2017). *Muxes* are biologically male individuals indigenous to the *Itsmo de Tehuantepec, Juchitán*, in the state of Oaxaca in southern Mexico (Diehl et al, 2017) and describe themselves as a third gender sharing

some characteristics of both men and women. With only two public healthcare facilities offering adult trans care, *muxes* rarely use them because of distance from their homes (Diehl et al, 2017). As a result, *muxes* have used rubber foam to give their bodies a more feminine shape, self-medicate hormones or injections of domestic edible oils or other harmful substances (Diehl et al, 2017). Private specialists offer body transformation services that more *muxes* are desiring however their high costs may increase the *muxe* community's involvement in sex work to finance services (Diehl et al, 2017).

Violence and Transphobia

In both LAC and México specifically, it is important to highlight the violence against the transgender community amidst the legal and health systems advancements. In Argentina, two years after passing of the Gender Identity Law in 2012, the physical and sexual abuse by law enforcement fell 10% (He, 2016). Sex work still remains the most frequent form of employment for transwomen (but not transmen) (He, 2016). According to the International HIV/AIDS Alliance 2012 report, *Impunity and violence against transgender women human rights defenders in Latin America*, 90% of violence against transwomen was related to sex work. It was reported that the high incidence of HIV cases was also linked to transwomen and sex work (Gillette, 2013). In Latin America, transwomen are the population with the highest prevalence of HIV/AIDS averaging 35% (Alliance, 2012). Transwomen are more likely to be ousted from their homes at younger ages being excluded from education and employment opportunities. In conjunction with limited healthcare services, non-transgender specific health care services offered, sensitive and competent healthcare professionals, this means that transwomen do not seek healthcare services, conceal their identity and are put at a risk for STD's/HIV (Alliance, 2012).

The Alliance report (2012) conducted by REDLACTRANS and HIV/AIDS Alliance aimed to highlight how transphobia has permeated various social structures and document the number of murders and extra-judicial killings of transgender women human right defenders in Latin America. The reported included three key findings. First, 80% of the transgender activists in Latin America interviewed reported experiencing violence or threats of violence from state officials (Alliance, 2012). Second, transphobia has led to systematic impunity in multiple countries. This is evident in the murder of 60 transgender women in Colombia between 2005-2012 where not one single person was brought to justice (Alliance, 2012). In the same time period in Guatemala, 25 transgender people were murdered and only one person was brought to justice (Alliance, 2012). In Honduras between 2008-2011 a total of 61 murders of LGBTI persons were reported and only 10 persons were brought to trial but none for the murders of transgender women although they accounted for ⅔ of the cases (Alliance, 2012). Lastly, the report highlighted the risk of transgender human right defenders in Latin America facing extreme risk of being subjected to human rights violations. About 95% of the interviewed trans rights activists align their activism to sex work (Alliance, 2012). In the report 90% of the cases of violence reported were related to sex work, exemplifying the opportunities taken for retaliation by law enforcement against transwomen sex worker activists. These women also face discrimination from family, the larger community and organized crime groups, as shared by all transgender women.

Quantifying Violence against the Transgender Population

It is difficult to quantitatively capture the violence against the transgender community due to the lack of specific data on the population, and the inconsistent laws across Latin America allowing changes to personal identification documents. However, the 2011 Trans Murder Monitoring Project (TMM) led by Transgender Europe (TGEU) and Liminalis captured data from January 2008 to December 2011 showing 80% of global murders of transgender people came from Latin America (TGEU, 2009). Latin America has 5 of the 14 countries around the world with the highest number of violent deaths per 100,000 inhabitants - Colombia (27), Guatemala (43), Honduras (48), El Salvador (60) and Venezuela (45).

Since the first TMM project report, TGEU publishes an update every November 20th in honor of Transgender Day of Remembrance (TDoR). As of 2017, a total of 325 cases of murders of trans and gender-diverse people occurred between October 1st 2016 and September 2017 (TGEU, 2017). This was an increase of 30 cases compared to the 2016 report and the majority of the murders took place in Brazil (171), México (56) and the United States (25) (TGEU, 2017).

México

México is also a contradictory country in its climate for transgender individuals. México has made strides in legal protections, healthcare access in public health systems and celebrates a distinguishable PRIDE celebration but is considered the second country with highest number of transgender violence. This year on the International day of Homophobia, Transphobia and Biphobia the non-governmental organization, Letra S, reported that for the first time the number of killed transwomen (108) exceeded the number of killed gay men (93) (EFE, 2017). Also noted

was the change in how hate crimes were committed against the LGBT community, specifically gay men as they were being lured by robbers in person or online then once inside the home, robbers and gangs would kill and rob the person (EFE, 2017). Transwomen's bodies would be dumped in vacant lots and public areas (EFE, 2017). The states with the highest number of murders were Veracruz (22), the state of México (15) and Chihuahua (14) (EFE, 2017). In 64 of the homicide cases that were followed up by law enforcement only ⅓ had identified suspects (EFE, 2017).

In 2003 the National Council to Prevent Discrimination (CONAPRED) was established in response to the passing of the Federal Law to Prevent and Eliminate Discrimination that included "sexual preference" as a protected category. This agency is handling discrimination complaints by the public against private individuals or federal authorities. It is unclear that the enactment of these laws has resulted in improvements of treatment for the transgender community. For example, it was noted that from January 2012 to April 2013 CONAPRED received 1 official complaint of human rights abuse from a transgender individual, while during the same period there were at least 8 violent murders of transwomen in México City, México (TLC, 2016).

México City is unique in that more legal and healthcare rights have been made for transgender individuals than in other regions of México. México City has the only antidiscrimination policy to explicitly includes gender identity discrimination (in addition to sexual preference), legalized same-sex marriage 6 years before it was legalized in all 31 states of México, and offers free transgender health care access in public health systems (excluding

surgeries) (TLC, 2016). This is a stark difference to the laws passed in other regions of México, such as Tecate's 2002 amendment of its Police and Good Governance Code to prohibit "men dressed as women in public spaces" in order to protect public peace and children, while preventing the spread of AIDS and sex work (TLC, 2016). Such morality law criminalized transgender individuals, increased police harassment, and increased extortion and societal hostility (TLC, 2016). It is also reasoned that legal recognition of the transgender community in México has led to societal awareness and visibility and consequently, backlash in the form of discrimination and violence.

Police and military targeting transgender women specifically are rationalized by "disturbing the peace" for wearing female clothing, being accused of being sex workers, failing to carry a valid health card (even though not mandated by law), allegedly carrying drugs or being gay (TLC, 2016). These and other arbitrary reasons are used as ground for arrest, detention, torture and other human rights violations.

In additional to societal backlash is the internal discrimination within the Lesbian, Gay, Bisexual, Transsexual, Transgender, Transvestite and Intersex (LGBTTTI) faced by transgender individuals. In Mexico, transgender people are "heavily stigmatized and discriminated against, even by members of the gay community" (TLC, 2016).

Transgender Population seeking HIV services

The *Transexual, Travesti and Transgender* (TTT) population is not only lacking trans-specific health services but also HIV related care. Barriers similar to trans-specific services exist

for the TTT population when seeking, accessing and/or obtaining HIV/AIDS and STI testing, prevention and treatment. It is imperative to also review the context of such services as it can underscore challenges the TTT population faces with healthcare systems. Hypothetically it can also serve as an opportunity to engage the TTT population with comprehensive healthcare.

Mexico

In Mexico, the *Transexual, Travesti and Transgender* (TTT) and male sex worker (MSW) population are among the groups most affected by HIV (Infante et al, 2009). Yet, they are often absent from the design of HIV programs and campaigns in addition to suffering from stigma and discrimination (Infante et al, 2009). In a study aimed to provide an account of social context in which MSW's and TTT's sex workers live, by focusing on their sexual identities, sexual practices and vulnerability to HIV. None of the groups remembered being given information about HIV prevention or free condoms by public health services or non-profit groups (Infante et al, 2009). They also reported having to buy their own condoms. Risk perceptions of the groups were high, linked to their sexual practices and were aware of living in a violent or marginalized community (Infante et al, 2009). For TTT's an additional important health need was buying oils and hormones. It was clear from the study that TTT sex workers lacked access to health information about risky sexual practices, specific strategies to negotiate condom use with clients, HIV/STI testing or counseling and health services for the treatment or control of HIV/STI's (Infante et al, 2009).

Mexico's *Centro Nacional para la Prevención y Control del VIH/sida* (CENSIDA) acknowledges sex workers, MSM, and trans women as key populations vulnerable to HIV/AIDS,

causing Mexico to have a “concentrated epidemic” (CENSIDA, 2018, p2). Since Mexico’s first case of AIDS in 1983 until June 30, 2017 a total of 260,815 people have become infected with HIV or have developed AIDS (CENSIDA, 2018, p2). Only 144, 223 people are alive, 100,694 people have died and 15,898 are unaware of their current status (CENSIDA, 2018, p2). The HIV prevalence for Mexico’s population between the ages of 15-49 is 0.3%, while for men who have sex with men it is 17.3%, injection drug users 5.8%, women sex workers 0.7%, MSW 24.1% and transwomen 15-20% in the general population (CENSIDA, 2018, p2). The goal for 2020 is to diagnose 90% of the persons living with HIV (about 225 thousand) and 81% HIV positive persons to engage in the free antiretroviral treatment offered in Mexico (CENSIDA, 2018, p3). In the year 2017 the Secretary of Health reports allocating 73 million pesos for the acquisition of rapid HIV screening tests for key populations, funded 123 projects for HIV prevention and distributed 21.8 million condoms among other efforts (CENSIDA, 2018, p3). The only mention of the trans population in this 2017 report was the recommendation for HIV testing every 6 months. Yet, it is too early to determine the efficacy of these efforts on the TTT population in Mexico City.

Latin America

As mentioned previously, data on the transgender community of the Latin American region mostly focuses on transgender women. This too, applies for trans service related data. Prevention activities in the region for transwomen mainly focus on condom distribution, diagnosis of STI’s and peer education (Silva-Santisteban et al, 2016). These activities are mostly delivered at health facilities with limited community involvement. In Argentina and Uruguay, structural interventions have been implemented to address social inclusion. Argentina, Brazil and

Mexico have adopted early initiation of antiretroviral therapy and treatment as prevention strategies (Silva-Santisteban et al, 2016). The main barriers for transwomen accessing HIV prevention services mirror those for accessing trans-specific services: limited coverage, discrimination and mistrust of health systems (Silva-Santisteban et al, 2016). In other countries, there are no substantial tailored interventions for the trans population. Additionally, they are considered a sub-population of men who have sex with men in data collection and program implementation (Silva-Santisteban et al, 2016).

Internal Migration in México

México's historical emigration to the United States has actually declined, reaching a net immigration rate of zero due to various reasons such as stricter U.S. immigration policies, increased deportations, the 2007-2008 economic crisis in the U.S. and dangers of crossing the border undocumented (Pinedo et al, 2017). This has impacted México's internal migration, so much so that about 18% of the Mexican population are residing outside of their birth state (internal migrants) (Pinedo et al, 2017). However, more is known about migrants in the U.S. than migrants in México. For example, there are research gaps regarding the relationship between internal migration and drug use, but studies have suggested indigenous migrants may have an increased risk for substance abuse and dependence (Pinedo et al, 2017). Some reasons why include the high marginalization of indigenous populations, the unique social, health and structural disparities they face that place them at higher risk for poorer health outcomes and barriers to health (Pinedo et al, 2017). "Large urban tourism destinations, such as Cancun, are characterized as environments with increased exposure and access to drugs and alcohol…[this] expands migrant's opportunity to engage in such behavior, as has been well documented in the

U.S-México migration context" (Pinedo et al, 2017). It has also been found that returned migrants in México show a higher risk of substance abuse and risky sexual practices when compared to non-migrants (Pinedo et al, 2017).

In the early 1900's a total of 75% of Mexicans lived in rural areas where in 2010 nearly 80% lived in metropolitan areas (Meltzer, 2010). Although much of México's migration is rural to urban it is also interstate. For example, internal migration allows Mexicans to take advantage of booming tourist areas without having to face the hardships of adapting to life in the U.S. (Cohen and Ramirez Rios, 2016). Internal migration has been a common practice for rural residents where migration to the U.S. only grew in the 1980's and 1990's (Cohen and Ramirez Rios, 2016).

Demographic changes that played a role in México's transformation included an accelerated increase in the size of population and geographical mobility (Lastra et al, 2000). Changes in the spatial distribution of México's population via constant internal migration led to 1 in 5 Mexicans living in a state that is different from their birth state (Laster et al, 2000). In the 1970's particularly, México City became a zone of attraction due to the growth of cities, the job market and improved communication infrastructure (Laster et al, 2000).

Specifically, in the metropolitan area of México City, migratory dynamics have most impacted its neighbor, the State of México (Graizbord and Mina, 1994). The different types and modes of movement have been metropolitan (from México City), inter-country (within each state) and interstate (between México City and other states) (Graizbord and Mina, 1994). In the

year 2000, México City accounted for 26.4% emigrants, followed by Veracruz with 7.6% (Laster et al, 2000). It was México State that absorbed population mainly from México City (60.7%) and although much less, México City also absorbed population mainly from México State (17%) (Laster et al, 2000). Larger places, where there are 15,000 or more inhabitants, were shown to be more attractive to internal migrants as a place to live (83.1%) and this also applied to areas that had high emigration (89.3%) (Laster et al, 2000). Considering all internal migrants of this time period, 47.9% were male and 52.1% were female however men outnumber women in children under the age of 14 (Laster et al, 2000). México City and the State of México have such an intense exchange due to being the two most important centers of manufacturing industry in the year 2000, there is a large number of administrative districts of México State integrated in México City and both have very little social underdevelopment (Laster et al, 2000).

Theoretical Framework

Theories that were used for the studies framework were the Socio-Ecological Model (SEM) by Urie Bronfenbrenner and Intersectionality by Kimberlé Williams Crenshaw. Bronfenbrenner's SEM was formulated to explain human development within the context of multiple environments, or ecosystems, in order to understand their development. The model has been implemented in public health for exploring health behaviors (McLeroy, 1988) and health promotion (Stokol, 1992) and adapted by classifying five different levels of influence on health behavior and identifying the core assumptions underpinned in the model. The model recognizes the broader interplay of influential factors beyond individual behaviors and demonstrates interaction between and links among, the individual, interpersonal, organizational, community and societal/policy factors. Integral to the experiences of trans participants is their interaction and

connection to various environments that shape their health outcomes. Figure 1 illustrates the study within SEM.

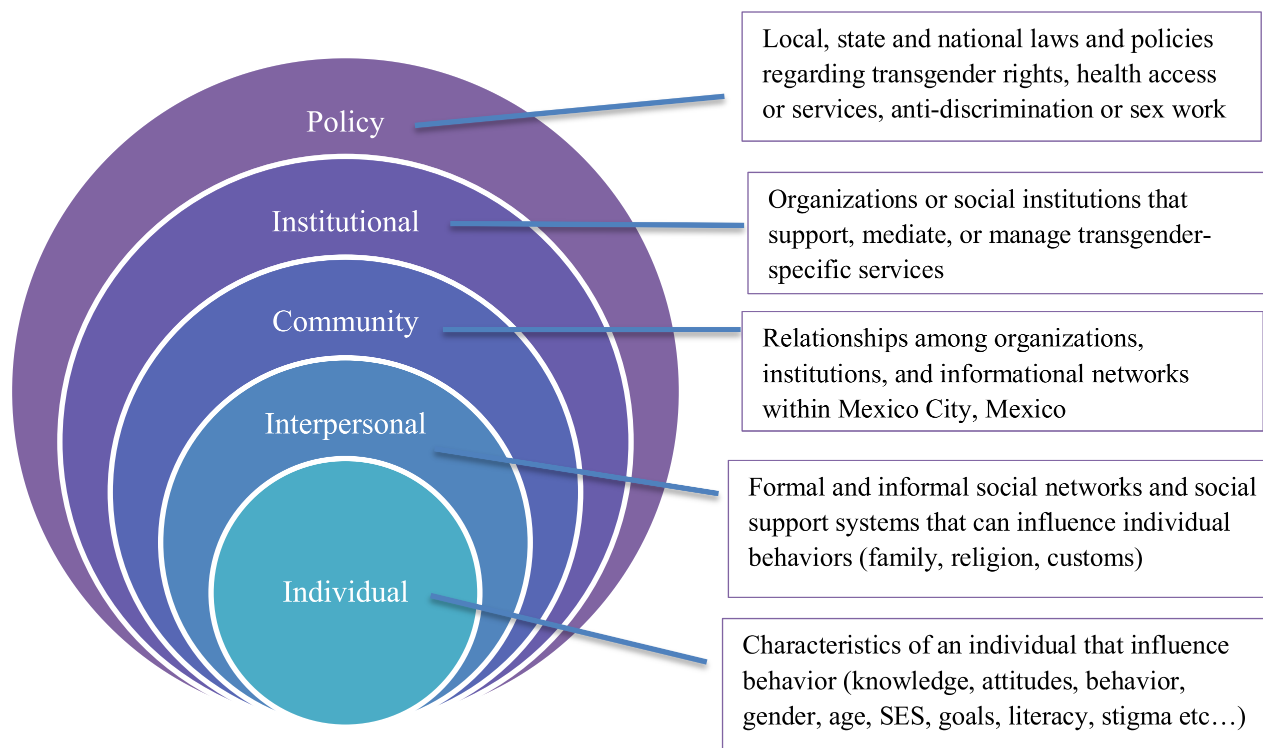

Figure 1*: Social Ecological Model. Adapted from the Centers for Disease Control and Prevention (CDC), The Social Ecological Model: A Framework for Prevention, http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html (retrieved April 21, 2014).*

Kimberlé Williams Crenshaw, a leading authority in the area of Civil Rights, Black feminist legal theory, and race, racism and the law, developed the Intersectionality framework (1989) for understanding the ways that multiple aspects of identity influence one another and compound to make unique experiences, specifically bias and violence against Black women (Utt, 2017). The framework describes the way societal privilege and oppression complicate different parts of one's identity that are privileged or marginalized in society, thus it is not a theory of difference but rather oppression (Utt, 2017). Trans individuals are a marginalized community in Mexico City and experience sex and gender-based discrimination. Their experiences can only be best conceptualized through a framework that allows all aspects of identity to be presented altogether,

without erasure. The Intersectionality framework does away with "either/or" thinking and instead offers the opportunity for multiplicity. Figure 2 attempts to illustrates the study within the intersectionality framework but is not only limited to the identities presented.

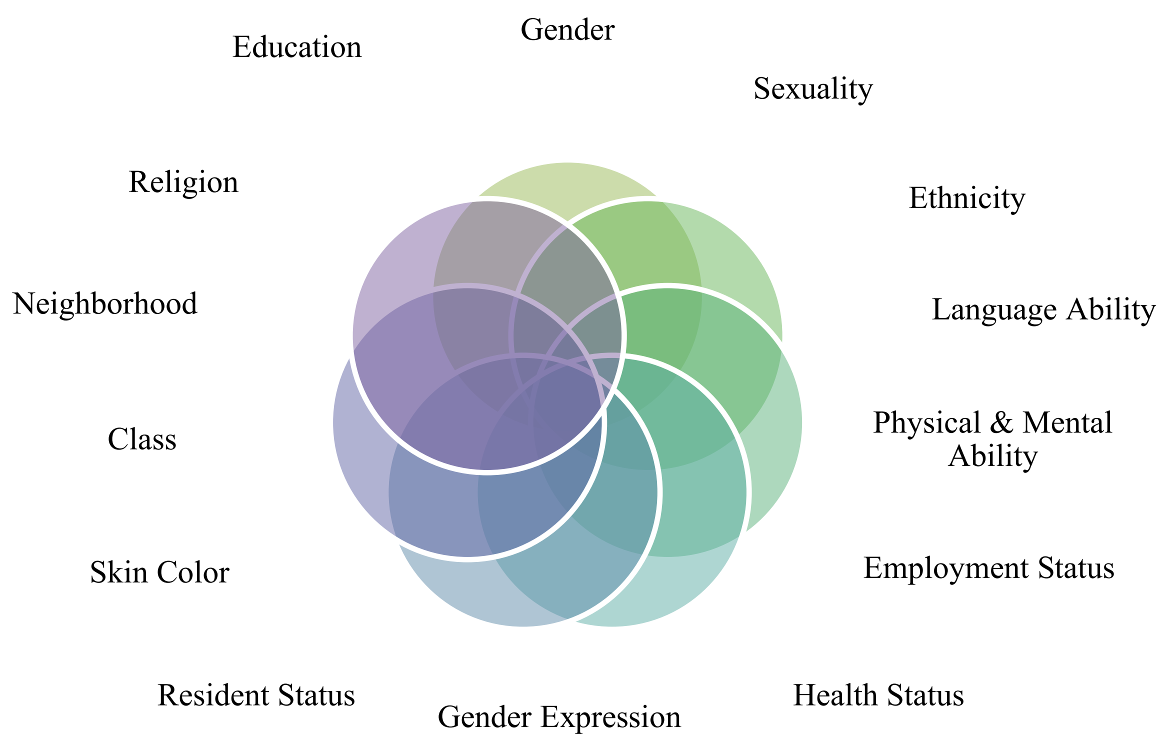

***Figure 2**: Intersectionality Framework applied to study*

METHODS

In order to explore how the trans community in México City learned about, accessed and utilized trans-specific health services, the researcher conducted 13 in-depth qualitative interviews with trans identifying patients of partner organization, the Clínica Especializada Condesa (CEC), and two key informant interviews with providers of the clinic. Recruitment was conducted in collaboration with CEC, the only public-sector site that offers trans health services in México. Thirteen participants agreed to participate however one interview was incomplete. All interviewees consented to participate in the research project and to be recorded, with the exception of one in which the interviewer took handwritten notes. The remaining twelve interviews ranged from 16 minutes to 75 minutes, averaging 25 minutes.

Key Informant Interviews

Two Key Informant interviews (KII) were conducted with CEC providers – an endocrinologist and a mental health provider because both played a critical role as gatekeepers in the initial stage of HRT and ongoing HRT treatment. Both spoke Spanish as their primary language, have professional connections to the LGBTQ community and have worked at the clinic since the formative years when transgender health services were added to its existing HIV treatment and prevention.

Participant Demographics

All 13 participants were ages 18 and older, although the clinic saw patients starting at the age of 16. All interviews were conducted in the CEC site. Four participants identified as transmen and nine as transwomen. All participants spoke Spanish as their primary language and

the majority were born and raised in México City (three were born outside of Mexico City). Only two participants disclosed their HIV positive status and considered it to be an integral part of their healthcare needs. All patients varied in their length of time as patients with CEC and their transition process from three months to five years.

Recruitment

Key informant interviews were also conducted with providers of CEC: endocrinologist and mental health provider. They were recruited by the in-field supervisor prior to recruitment of participants began.

Participants were recruited in person by CEC nurse of the endocrinologist who was familiar with CEC patients and the community. As patients came in for their appointments or with an inquiry, they were invited to participate in the interviews. Recruitment took place during the afternoon and evening hours of the clinic as it was suggested that patients were in less of a rush during these times and more likely to participate than morning scheduled patients.

Eligible participants included adult transgender identifying individuals (18 years of age and older) and residing in Mexico City at the time of study was conducted. Exclusion criteria included being younger than 18 years of age, not living in Mexico City at the time of the study and having severe mental health issues that affected ability to consent.

Data Collection

Key Informant interview guides were developed in both English and Spanish to explore the knowledge of healthcare providers regarding transgender health, clinic protocol, the needs of the transgender community and any challenges faced as a provider at CEC. Questions were informed from the literature and an informal orientation from the clinic director prior to the interviews. The interviews began with inquiries into the providers' connection to the LGBTQ community and their perception of the change in government law of 2009. The purpose was to bridge professional and personal ties to the transgender community and developments since the passing of the law. Questions that followed were specific to services available to the transgender community at CEC, in the public and private sector, the services sought by patients, how protocols were developed and any challenges faced. For example, questions included, "What does a new patient visit look like?", "What guidelines do you follow for transgender health care services?" and "What difficulties have you faced in delivering care?" Institutional knowledge was shared as well as unique insight into the sociocontextual determinants of health affecting the transgender community as a result of the following questions, "In your opinion, what are some of the barriers trans people face in being healthy?" and "How do you feel being in Mexico City, facilitates or hinders the transgender population from reaching their transitioning goals?"

Interviews were conducted in private consultation rooms in CEC. Before each interview, written consent for participation was obtained, and comfortability with recording was discussed. Interviews were conducted during July 2017.

An in-depth interview guide was developed in both English and Spanish to explore the knowledge, access and utilization of transgender health services in México City. Both versions were shared with CEC advisor to ensure questions and translation were accurate and appropriate. The guide was created with initial questions from the literature and later updated as a result of insight gained from the two Key Informant interviews. The Spanish language interview guide was used after review, edits and approval. The guide began with open-ended questions on participants' experiences living in México City and length of residency in México City. This revealed macrosocial factors that affect the participants' livelihood, in additional to macrosocial factors affecting health such as their residential status, origin, occupation and reason for choosing to live in México City. The interview had three parts that focused on the knowledge and attitudes of transgender health services available in México City, the access participants had to the available services and the utilization of such services. For example, "How did you learn about CEC?", "How do you feel being transgender has impacted your health", "What trans-specific health services have you sought out in México City?" The guide focused on all existing services (formal or clandestine) the transgender community can utilize, not limited to the services offered by CEC. The interview closed with any feedback the participants would like to give to healthcare providers and facilities who deliver care to the transgender community and how they imagined the transgender community in México City in the upcoming years.

Interviews were conducted in private consultation rooms in CEC. Before each interview, written consent for participation was obtained, and comfortability with recording was discussed. All but one interview was digitally recorded with participants' consent. Interviews were conducted during the final two weeks of July 2017.

Transcription took place in the months following data collection, in October and November. All interviews were transcribed verbatim in Spanish by the researcher and then de-identified by the researcher. No compensation was given to participants. Informed consents were printed and read in Spanish language for patients. All data transcription and analysis were performed in Spanish.

Ethics

Prior to recruitment of participants the research study and its instruments were reviewed and approved by CEC advisor and Emory University's IRB. México City specific IRB approval was not sought as the CEC advisor and research coordinator determined the Emory University's IRB approval was sufficient.

Analysis

Following transcription, all de-identified transcripts were imported into MAXQDA2018 (Verbi Software GMBH, Berlin, Germany) for analysis. Thematic analysis was used to analyze the 13 in-depth interviews and two key informant interviews. Transcripts were read and annotated with memos to capture broad themes and describe preliminary findings of described participant experiences. Memos informed the creation of the codebook which included deductive (based on the literature review) and inductive (derived from the data) codes. The coding process was completed by the author alone and discussed with thesis advisors for feedback.

Codes were developed prior to analysis and refined after initial coding; the codebook was finalized after three rounds of coding and adjusting code definitions. For example, the code for "Internal Migration" at first included participants moving to the City of México for transgender specific services. However, in the data many participants also mentioned "Staying Put" due to transgender specific services only being offered in the City of México. Therefore, the code definition was adjusted to include both experiences. Additional codes included "Social Support Network" for persons who served as support for the participant in seeking, establishing or continuing trans health care; "Impact of trans identity on health" for perceptions of trans identity impacting overall health; and "Learning of trans services available" which included processes or sources (any physical or virtual space) that have impacted knowledge of trans health services available. Due to the small sample size of the participants, saturation of knowledge was not reached. According to Guest et al. (2006) 12 interviews of a homogenous group is all that is needed to reach saturation. However, the transgender population is heterogeneous and required more than the thirteen interviews conducted. Due to delayed IRB approval there was not enough time to administer more than the collected interviews.

The thematic analysis consisted of constructing themes inductively from codes, categories and subcategories. Variables were developed for length of time as a CEC patient, obtaining health services at private, public or clandestine establishments, already having surgeries/body modifications, having an accepting support network, and HIV + status. Maps were created using the MAXMaps function to examine code co-occurrences and two-case models for transwomen and transmen experiences. Comparisons were made across participants based on the three research questions: how participants learned about the clinic or transgender

services in general, the barriers or facilitators related to service access, and what motivated or deterred participants from continuing use of services. Regularities, patterns, and contradictions were examined across all participants and stratified by gender identity.

RESULTS

Jaime is a transman who was born and raised in Mexico City and has been a patient of the CEC for a year and one month. He shared his experiences transitioning in Mexico City with the support of his sister and mother as well as internet groups. His story demonstrates the generational shifts in learning about trans health services assisted by the growth of technology and the importance of including family members in the transition process for youth. His story highlights the discrimination, transphobia and stigma faced when accessing and utilizing services in the public sector amidst the growing awareness of the trans community in Mexico City.

Jaime learned about the clinic through a transmen's internet group after a member mentioned the clinic and its free services. Since learning about the clinic, he has left the internet groups because members were further along in the transition process than he was and when others would ask questions it was not received positively. Jaime says the members were discriminatory, tried to make fun of him or call him arrogant for posting about his experience transitioning but mainly having his mother's support. He himself has a YouTube channel where he shares his experiences in order share information that he never had access to. He feels there are others in similar position as him and he wants to offer support through his videos and posts.

During his first visit at CEC, he remembers being treated friendly and contrasts his experience to others who were clinic patients but told him weren't treated well. In his experience, he was asked how he wanted to be addressed, pronouns, preferred name. Comparing his first visit to his most recent over the last year and a half, he notices personnel that are trans competent treat him well but not everyone at CEC reflects that. He recalled the first, and last time, he tried to make an appointment with the dermatologist (same building as CEC). He overheard the personnel say that HIV positive persons and trans patients shouldn't use dermatology services, so he never returned. It has not affected his ongoing HRT services, but only goes to CEC for his 3-month visits with the endocrinologist.

Overall, Jaime feels being trans has positively impacted his health especially his mental health. Jaime when coming to identify as trans, felt confused, different, *señalado*, and more than anything because of the (lack of) acceptance from family. He mentions his father specifically perpetuating machismo in that he says he understands and accepts Jaime as his son but continues to use feminine pronouns and says Jaime is lesbian because he dates women although Jaime identifies as heterosexual. In the same regard, family and friends impact his ongoing use of trans health services. His middle sister was the first to support him and attributes his motivation, ability to move forward and excelling to her. His immediate family is accepting (acknowledging his father's lapses) but prioritizes his mother's acceptance above everyone else's. Although his mother accepts Jaime she does not feel positively about the HRT treatment saying, the HRT will cut years of his life. This has caused Jaime to avoid the topic of health altogether with his immediate family.

Jaime's transition goals are to see himself as he has always wanted, since he was boy. Before HRT he wanted to get rid of his female features and have everything be masculine, specifically, his soft voice. He now has those results including a beard he desired but wishes he could stop taking HRT because he has reached all the changes he wants. He knows in the long run HRT may damage his organs but also knows the changes are reversible.

Themes

Social Networks

Jaime's story exemplifies the many generational shifts in the trans population in Mexico City, which include using social networks for learning about available trans services in formal medical institutions, affirming trans identity and having a supportive community. Key Informant Interviews gave context to the social networks discussed by CEC patients which were crucial in how the transgender population learned about trans health services. Yet, Key Informants only discussed social networks as avenues for obtaining clandestine trans services and not necessarily learning about formal trans health services offered in Mexico City. This was in part due to the fact that about 70% of CEC patients utilize trans health services offered by friends or peers. The use of clandestine services was more frequent in transwomen than transmen. A total of about 15% of transmen arrive to clinic already having undergone HRT but the majority not having self-medicated. For transwomen, 65-70% arrive to the clinic previously self-medicating. In Mexico it

is easy to obtain hormones from pharmacies since they are not regulated, and it only depends on the ability to pay. Another issue for transwomen is the injection of biopolymers that are very commonly learned about and administered in the trans community. There has been a visible generational shift in that before, patients would arrive having started the transition process if not already completed it. Now, younger trans patients are arriving accompanied with family members, not having self-medicated and without surgeries. Key Informant's attribute this change to the increased awareness of the LGBTTI population and the availability of free trans health services through the CEC.

Social networks were identified as family, friends and virtual spaces. Unlike Jaime, there were four of the 13 participants that stated not having support from family and/or friends regarding their trans identity. Maria, a transwoman from Mexico City and having three years as a CEC patient, said not having familial or friends support highly affected her emotionally: "*Psychologically, it affects the physical. I have morally frequent falls. I do not have the energy to get up, to do things.*" However not all participants said that lacking family or friend support affected their decision to initiate and continue receiving trans health services. Sonia, a transwoman from Mexico City and a year and a half as a CEC patient said:

> *Since I am a person very distant from friends I have very few, those that I do have, we do not touch the topic of my transition. Much less services, right? of health. And in regard to my family, because my family is very distant, so like there is really no support from either side.* *-Sonia*

The nine remaining participants stated having support from a key family member or the members that were most important to them. Jennifer, a transwoman who migrated to Mexico City for services and six months as CEC patient, did not find out about the clinic herself. Instead it was her mom who sought help from a local priest. Still, Jennifer felt she needed her family's approval to start treatment:

> *I mean, I have a lot of confidence in my family and if I'm going to make a decision to come or take the treatment or not take I,t first I talk to them. Obviously, I am very confident in the endocrinologist who is treating me and in the clinic. But like I said, I'm very attached to my family. So, if my family says no ... well, even if I wanted to [laughter] I wouldn't.* *-Jennifer*

Although participants had family support it did not mean participants shared all aspects of their health issues. For example, Jaime had his mother's acceptance but she was concerned about HRT so he did not like to discuss overall health issues with her. Others like Ximena, a transwoman from Mexico City and two years as a CEC patient, did not disclose her HIV positive status with her family or son.

> *My family does not know that I am seropositive. And not because I'm afraid of my family's reaction if I'm being honest. It's that they are not ready to hear such news. I do it for them not for me… I can talk about it when it is necessary, but it is not right now. At least when they find out they will know that I gave it all my worldly effort, that I am taking care of myself and that there are doctors behind me and that even the country itself is supporting me and giving me care.* *- Ximena*

Two participants explicitly named CEC as social support network, especially for Ximena who is older (48 years old) and wanted to re-engage with the trans community in Mexico City. After recognizing that she had not experienced the same level of discrimination as her friends and has

ignored their struggle, she saw the clinic as an avenue to become more involved and build a supportive network.

> *I want to meet more people [laughter] the truth is I want to know my doctor and be part of this. I am an adult aged person, entering a very mature age where I said, well this is the fact of the matter, it doesn't matter that I entered my life feeling 100% a lady, a woman integrated into my society when my community is going through this - I want to be part of it because this is where I came from.* *-Ximena*

Four participants had found internet communities that served as support networks and sources of learning. They were YouTube channels, Facebook groups, forums and chat groups. Jaime's experience highlights how internet spaces that are intended to be supportive yet fail to be for all members. Ximena uses her Facebook group as a place to encourage other transwomen to get engaged in clinical care.

> *I am in a Facebook group of transwomen, and if they ask a lot of questions. I say, "girls, come, come over here I have some time as a patient. They gave me emotional therapy, they gave me this and that, for the prevention of HIV…Don't be afraid." Then they say, "oh it's because I don't know anyone," so I tell them, "doesn't matter, come to my house and I'll take you."* *-Ximena*

Ximena also highlights the gap of familial support that transwomen do not receive, leading to a desire to fill in that gap through other avenues. Transwomen participants referred to the "promiscuity" of the trans community and consequently the need to have a primary care provider. However, Ximena provided an in-depth analysis of how the lack of social networks makes the trans population prey to promiscuous people.

> *For many reasons people who are more promiscuous approach us, people who do not take care of themselves, and it is easier for us to fall into that because many of us want much attention and love. It comes from family. And sometimes we become the pillars of the family, supporting them financially, and we feel that the love they give us is reciprocal. It is very easy for them to talk to us beautifully, we fall into their hands thinking that they really like us and if they like us maybe there is someone who loves us. I do not doubt it, because I have had wonderful people in my life. But not all are like that...And we are prey to very promiscuous people, very dirty, very exploitative. And I do not want to justify the carelessness of my friends and maybe also mine, that ends up with an infection or one thing and another. For the simple fact of saying "it's because you did not take care of yourself." No, my life is very complicated, for someone to take care of herself when she does not have her integrity whole. They talk to you beautifully, they talk to you about love and you do not want to put anything on, because you want to let yourself be loved. You stop protecting yourself and you think you are making love. And in reality, you are putting your life at risk…we are very vulnerable to the issue of affection, to anyone that does not offer it. We become victims without wanting to.*
>
> *-Ximena*

Social networks served as a place for affirming trans identity, for learning about trans health services and achieving personal growth. While both transmen and transwomen varied in their experience with creating and engaging with social networks, family and friends were rarely completely onboard with no issues. Certain family members were key for participants to have support from, and they in turn also influenced the eventual support and/or acceptance of the rest of the family as we see with Jaime. For those that lacked the support it did not deter their use of trans services but it did make the transition process more difficult.

Discrimination, Transphobia and Stigma

Jaime shared his experience with discrimination when seeking specialty care in dermatology and he was not the only one from the 13 participants interviewed. Five participants confirmed experiencing discrimination or transphobia in and out of healthcare settings, of whom all were born and raised in Mexico City (three = transwomen, two = transmen). Four participants reported not directly experienced discrimination or transphobia (four = transwomen). From the four, one respondent migrated to Mexico City for trans health services. Ximena was one of the four and differentiated from being directly targeted versus when she was out with girlfriends and was denied entry into a group for being trans. This made her aware of her privilege of passing but she still states that she has not directly experienced discrimination. Four participants did not explicitly share they experienced discrimination or transphobia (two = transmen, one = transwoman). Of these four participants, two were born in Mexico City and two migrated to Mexico City for trans health services.

When discrimination and transphobia were experienced personally, it took place in the city streets, when seeking healthcare services and in the employment sector. When Ana, a transwoman from Mexico City and a CEC patient for a year, was seeking trans health services in other health facilities she was laughed at and it delayed her seeking care thereafter.

> *I went to ask for information at a health center and a nurse mocked me. And like, I was uncomfortable and did not want to return. And I lasted about two months in looking for something.* *- Ana*

Maria shared her interview experience when she was looking for a job but ultimately not gaining employment because her employer assumed she was trans. She discusses how limiting job options are for a trans person because of transphobia.

> *The types of jobs are not enough and they do not want to hire a trans person. They make excuses for not hiring trans people. I had anxiety and I was nervous in the interview because even though I was qualified for the job they did not give it to me because I was trans. I do not need to divulge but they assumed I was and then they asked.*
>
> *- Maria*

All participants mentioned the difficulty in developing or obtaining a professional career as a trans person. Sex work and beauty stylists are the traditional types of jobs that trans persons, particularly transwomen are forced into. Ximena was the only participant who went in-depth on the discrimination transwomen sex workers face and how they are incorrectly judged.

> *Because of simply having short skirts that does not mean they are not productive. Sometimes there are families who depend on these girls cutting hair, doing work only to take bread home, feed their little brothers, feed their mom. […] I mean, it's a pity that people discriminate against them and see them badly, hey they are the heads of their families because they had the pants to confront and go out into the streets being as they are and bringing food to their house. They aren't even begging for money, they are not stealing from you, they are working. At minimum they deserve medical attention. If there was no demand, the girls wouldn't have work or no? You contribute to this, you use that service, if you did not use it "oh how disgusting, what a fag" Shhh look, be quiet, you do not know who is behind you and who is doing it, but he will not tell you. But if the girls did not work and there was no demand they would not earn money and wouldn't be doing it. They would have gone to a normal job, working hard as shit like everyone else."*
>
> *-Ximena*

There were not specific conversations about the types of jobs transmen had or are forced into based on discrimination or transphobia. All participants talked about the importance of place - Mexico City. All participants that migrated to Mexico City (2 = transwomen, 1 = transman) for trans health services compared their home cities to Mexico City and mentioned the many opportunities for trans people.

Living in Mexico City is an experience with many contrasts because there are people who have a very relaxed vision of any aspect, in regard to social aspects, ethnicity, sexual preferences but there are also people who are very closed. And since many people of different ages live here, from different cultural areas, it's like a very broad experience.
-Rosa

Participants who were born and raised in Mexico City were aware of the more open environment compared to other places in the country. They expressed valuing the opportunities they had and wanting it to be widespread in the country.

Come here. I will not guarantee that they will not see you badly. But opportunity- there is. You go out on the street and you find three or six, five travestites, that and another [...] We do not give importance to what you are doing. It's not that we're going to accept you… it's that we do not care what you're doing. So, come here and take care of your health. *-Ximena*

However, Mexico City residents were the only ones to mention the internal discrimination in the trans community in the city. Jaime shared his experience about the internet forums, distancing

himself from toxic friends but his friend Carlos brings internal conflicts within the trans community into the conversation:

> *… being from the same community, they attack you. I do not know who, if they are heterosexual people from birth many times they do not break with social norms and of telling you things. And also, being* transexuales *or from the same community they still do it, so it's as if you don't know who to trust [laughter].* *-Carlos*

Additionally, Alex highlighted that although there are health providers in Mexico City that know about trans health it does not mean they don't have personal biases, judgements or prejudices against trans people.

> *Because we are a* machista *country then to understand that someone wants to change how they were born to how they feel is complicated, because there are many doctors who at the end of the day maybe say you do not stop being a man […] I think there are many people who, although they know the topic, their prejudice rejects it. And when you put the issue in the context of health, well if people, let's say who are "normal", struggle a lot to find care, then for a topic that is stigmatized I perceive it to be twice as complicated outside this clinic.* *- Alex*

In regards to stigma, Ximena mentioned having to combat clinic stigma from other trans identifying persons because she was a patient of the clinic. Since the clinic was first associated with providing HIV care, many associated CEC patients with having HIV or being mentally ill. This was in part due to the trans community learning about the gender dysphoria diagnosis being used and how gender identity was pathologized in Mexico City.

Nobody likes to go to the doctor. But if you see I'm very happy, it's great. Even when they ask me, "where are you going?", "I have my appointment with my endocrinologist", "hey that's great, where do you go?", "The Clinica Condesa", "isn't it for sick people?" "I'm sick" I said [laughter] I'm sick. It's not that I'm simply getting treatment, I have to be taken care of and I like to be monitored. *- Ximena*

She found out why many perceived patients of CEC as sick. When she was in a consultation with CEC she found out about the gender dysphoria diagnosis.

[…] they told me that they saw us as almost disabled, us transwomen […] and they say, it's because you suffer, suffer from gender dysphoria. And respond that I do not suffer [laughter] I do not suffer, I do not consider it an illness because I'm not sick. They make me feel sick, that is different […] I do not consider myself a mentally handicapped person since I became a very productive person in my youth, I created employment for many people and I contributed to the growth of my country, I put in my two cents. So, if I were a disabled person I would not do that. However, I am incapacitated by people who do not believe me to be capable – that is very different. *-Ximena*

While not all, nor the majority, experienced discrimination or transphobia directly all participants are aware of its existence even in more accepting cities like Mexico City. Sex work and aesthetic jobs were known to all participants as the only job options that transwomen get forced into and how it has impacted the perspective of the trans community as a whole (i.e. promiscuous, ill population). Participants then shared nuances of discrimination and transphobia in medical personnel, within the trans community and Mexico City. Stigma was discussed by one participant in relation to the CEC's reputation in the community for providing HIV treatment and care.

Barriers and Facilitators to Care

Jaime identified his family's support and the CEC existing as facilitators to care but also discrimination and transphobia as a barrier. Key Informant's list the lack of HIV testing and information, high expectations for transition, and transphobia as barriers for the trans population in Mexico City. Participants on the other hand, identified a lack of information, high cost, lack of public health funded surgeries, lack of trans competency and knowledge coupled with discrimination.

Key Informants list the lack of HIV testing as a barrier because it impacts CEC patients who avoid visits if they involve HIV testing. From the 1,800 patients at the clinic about 350 are HIV positive. From the 1,800 patients about 20% are transmen and none are HIV positive. Transwomen make up the reminder 80% and only 1,100 have been screened for HIV. From the tests that have been done, about 30% are HIV positive (one in every three transwomen). Of this group 87-88% are on antiretrovirals and adhering. Of this treatment group, 80% are undetectable. HRT has functioned as an incentive to get tested for HIV and undergo treatment if positive. This fear was real for four participants who explicitly said they were afraid of finding out they had STI's or HIV, for example, Sonia, *"At first I was very scared, I even considered not starting the treatment to avoid getting tested for HIV. I already thought I had HIV."*

However, participants did not just focus on HIV services or even only trans health services when discussing barriers. Instead they focused on general issues faced by the trans community in Mexico City and in the health sector. Although participants recognized the increase in accessibility of information with technology, Mexico City and the health sector could

improve in sharing CEC specifically as a resource. Only one participant said information on trans health services was not a problem for him. For participants who had sought health services (both trans and non-trans specific) in other facilities, they were never referred to CEC. They mentioned no campaigns or a central source of information in the health sector that share information about CEC.

Cost was a barrier for participants in the past and present even as patients of CEC where services are free. In the past, participants sought services in the private sector, paid out of pocket for consultations and medications or delayed care because of the costs. Current CEC patients need to purchase medications at an external pharmacy when medication runs out at CEC and this does create issues for participants.

> *If I have the resources I buy it. I mean, I try not to run out of treatment. But there were times when, for example, maybe I can only get two boxes and I need seven. Then, I'm out of five of them… sometimes it's a bit difficult to get them and also to get the money to buy all the treatment. And for example, at the next consultation, obviously they do not recover your missed medication, it is not like that.* -Jennifer

Although there are some instances when the clinic pharmacy runs out of medication, CEC as a fundamentally free clinic serves as a facilitator as well. Ximena values the fact that the services are given without strings attached and incorporate mental and emotional well-being:

> *[I am] very grateful because I see the price of the medicine and I say wow, I could not afford it. I would have to work solely to be able to afford medications. I think what they are giving me for free is the best. They do not know if I have a future or not, if am a productive person or not.* -Ximena

Patients initiating care at CEC see a mental health provider first to discuss the process of identifying as trans, how they have or have not received support from family, what changes they have achieved and not achieved, and how their adolescence was (post puberty when secondary sex characteristics developed). For example, a question asked is, “did it bother you or does it bother you to menstruate?” The final part of the conversation is on expectations of transition. Mental health is not placed as the first service trans patients engage with because being trans is a mental illness but because there is great diversity in the trans community and the health providers want the patients to be prepared for the transphobia that exists in Mexico. At the start of the clinic it was not required to be living in one’s identity for six months, but they saw when HRT was given without this previously required time frame, patients would discontinue care. So, the objective is to evaluate the life experiences identifying as trans and if they don’t have it, offer support in how to do so, offer accompaniment through a social network for the six months. Additionally, HRT impacts emotions and the nervous system so if there is some type of disturbance the providers are able to catch it and provide care. Some patients that are not eligible for HRT (i.e comorbidities, cancers etc..) say they prefer to die with HRT than to wait and die without it, showing the high need for comprehensive care for the trans population and how much CEC was needed.

Key Informant’s said it was possible that there were some patients that discontinued care because they did not want to wait the six months. The estimated percentage that decided to stay in care is above 80% and the Key Informant’s believe that it is because it is the first time these services are being offered so the wait is tolerated. The remainder that do not want to wait are usually transwomen; it is rare for transmen. The number is a small percentage because now many are

aware of the protocol, whereas before there may have been more that left before engaging in HRT care. Through the in-depth interviews, Flor, a transwoman from Mexico with a little over a month as a CEC patient, was the only respondent who felt that mental health services are unnecessary for trans people but also felt more adjusted in body and mind.

The existence of CEC was the most common facilitator to care, yet since the CEC does not offer surgery, this gap in care was identified by all participants as a barrier to care. Not including gender affirming surgeries in the public sector was unknown to the Key Informants as it was before their time and did not involve them in the decision-making process. Key Informants were aware that this is a highly demanded service and hope in the future there may be changes. Only two participants reported having a previous surgery and the remainder desired it. However, out of pocket costs deterred them momentarily or permanently.

> *In Mexico, right now, I do not know if there is a specific place for a vaginoplasty procedure. I know they have done them, but to be honest, of all the ones I know they have done, I don't know if any of them were a success right? So, I feel that there is so much lacking in that aspect here in Mexico, the only place I know that exists in having great specialists for everything of feminization, face, body or in vaginoplasty is in Thailand. It is very expensive [laughter] super, super expensive. Since obviously you need to process your visa, obviously you need to have your passport, you have to pay for your surgery, obviously the recovery time that you will be in the hospital and another time for you to remove everything you are putting in. Yes, it's an investment.* *-Jennifer*

The possibility of having to travel to undergo surgery was not an immediate goal for the participants. All were content with the HRT and mental health services offered but would revisit surgery in the future. The fact that clandestine surgeries are available at very low costs were a barrier to living healthy lives was noted by Alex. She highlights the differences in surgery prices

and how the low costs motivate some transwomen to prostitute themselves to be able to afford the procedures.

> *[Surgery] would be very great, unfortunately I think that for many transwomen operations or physical changes in your body, it would be very great if they would be much more accessible right? In other words, an operation that you want costs you between 40 and 50 thousand pesos. It's not that we want it for free but that they… could give you half the price, a plan for breasts and you can give it in 9 or 10 thousand pesos or make a financial plan. I think that if it would be wonderful because at the end of the day if you do not have a good job, a good income or the support of your family, unfortunately what happens is a lot of prostitution to earn that money and be able to change physique, right?* *-Alex*

Lack of trans competent providers and discriminatory care is a barrier in Mexico City across the health sector. Key Informant's recognized the lack of trans health curriculum in both of their specialties and having to learn on the job, but they both felt supported in providing services to the trans population, seeking help if needed, and obtaining the resources needed to provide better care. While they did not start out feeling this way, the doubts and lack of training were mediated by workshops and trainings offered by external civil associations outside of Mexico. After it was determined that the CEC would offer trans health services, there were a series of clinic-wide sensitivity training on trans identity, competency, and importance of using correct gendered language. The clinic followed a protocol that was developed after researching many existing protocols; it is perceived as a living document that will be subject to changes as needed. These trainings however, were particular to CEC and not across the health sector. Two participants (both transwomen) who have been patients of the private sector expressed a lack of general knowledge in trans health and sensitivity.

I have not left the country to obtain other trans services but I have gone to the private sector, but they lack sensitivity and knowledge. They see us as objects, like an animal and do not know information themselves, only hormone treatment services. *-Maria*

All participants noted the CEC's personnel's sensitivity, knowledge and respect as a facilitator to care. Another factor was that the care offered was holistic - physical, mental and emotional. Family support specifically was stated as a facilitator by two of the participants (one = transwoman, two = transman) but only one was dependent on their approval for her care. Ivan highlighted the importance of feeling welcomed by personnel, confident in their abilities and feeling they were knowledgeable about trans health services.

Well, I think that part is fundamental because when you live a different situation like what you're used to the street, you feel like you're on exhibit all the time, right? And part of what they take is that you are a normal person, so you start having confidence. Speaking to you with respect, talking to you as if they understood you, right? Knowing that they are not trans but they understand the process and that helps a lot. The part where they also take the time to ask you how you are, I mean not just as a patient, just another one in the clinic, there is a lot of communication with the doctor that is here right now and there is this trust that I feel. *-Ivan*

Lastly, one participant explicitly stated that there were legal barriers for obtaining residency in Mexico City and becoming a CEC patient. While three participants in total migrated for health services, it is important to highlight the legal barriers that still exist even though laws have been passed. Ana had logistical, distance and discriminatory barriers to obtaining her document changes.

For example, when I went to get my birth certificate, it cost me a lot of work and I had to go to [hometown] three times in one day. They made me go three times in a day. I could not work because I did not have my papers and it was very difficult. In fact, the judge who attended me, when I told him it was to change my name he said no, no, no that is very difficult, better not waste your time. *- Ana*

When participants were asked about barriers they listed a lack of information, high costs for medications as a CEC patient, or high costs in the private sector, lack of public health funded surgeries, and lack of trans competency and knowledge. Legal barriers also still exist for participants even though not every participant that migrated experienced them. The facilitators for accessing care and continuing their use has been in the treatment of patients, in the knowledge of providers, and the trust established between personnel and patient. The fact health services are provided free of cost is a huge facilitator, but they will not be as well accessed or utilized if there is a lack of knowledge, maltreatment and distrust from the trans population.

Trans Identity Impact on Health

Jaime mentioned being trans having a positive impact on his health. Although he struggled with his father correctly addressing him at home, he felt he has, since starting HRT, surpassed the confusion, feelings of difference and not belonging. Hormone Replacement Therapy, surgical and mental health services (individual and/or family) are the most demanded services according to the Key Informant Interviews. They shared that adolescence is when trans patients face many challenges because of puberty and body changes. Additionally, there are internal, familial and friend conflicts. When participants were asked, “how does being trans impact your health?” Nine of the participants stated being trans has positively impacted their health. Some went based off physical changes from HRT, emotional or mental health status or

relationships with self. Only one participant, Diana, felt that there was no impact since she always lived her life as a woman:

> *Personally, it has not affected me at all. I know myself, I have always recognized myself as a different person, I have always recognized myself as a person [pause] …I would not see it as transsexualism."* *-Diana*

Eight of the nine respondents that stated a positive impact due to improvements in mental or emotional health. The remaining participant stated only physical changes. Jennifer mentions both aspects being part of her positive health outcomes.

> *Actually, I feel better […] before I was very impulsive, very angry, like they would do anything to me and it irritated me or made me angry. And since I started coming, and they have been controlling all of the hormones and anti-androgens and lowering testosterone, and up taking all that the female hormones…it has benefited me in terms of having a better quality of life, having better communication as a family, in my house.*
> *-Jennifer*

Jennifer mentions the improvement of her relationships as well as her emotions but because she has only been on HRT for six months, she feels she has not completed the physical changes. The remaining three respondents were more neutral in that there were 1) no physical changes, 2) they hadn't had any problems to date 3) continued to discuss living with the consequences of self-injections and entering an older age group such as Ximena. She injected biopolymer when she was younger and was at the moment getting it removed. Ximena became HIV positive in the past 10 years and discusses how self-injections and HIV have impacted her health.

> *I think that at this stage of my life, after 40 being trans has impacted [my health] more because I know that after a whole life of hormonal treatment it has its consequences. My legs are filled with varicose veins because of so much estrogen in my body. I have not taken them for two years and they have cleared, that's great, but there has been some damage. Certain infections arose obviously. Sometimes I wonder if this could have been avoided if I just protected myself… I want to believe that yes. I want to convince myself that it was my carelessness that go me infected, but it is incredible that in a woman's circle, the ones that surround us the most are sick people. I do not want to generalize but 89% -90% of people I think are sick. - Ximena*

Ximena and Alex are also the only two participants who discussed the societal pressures of body modifications on transwomen and this specific impact on health:

> *But as we feel disadvantaged for not having breasts, for not having a butt, we feel less like women because of that. We feel a sense of approval to see ourselves in the mirror to see our breasts with big butts…and it's only what you care about…that's why I tell you that if you live in a society that never tells you that if you lack a butt - you lack breasts, then you're not a woman, we wouldn't have to do this. A woman has breasts, a woman has a butt, you do not have that, then you are not a woman...I think I did it to integrate myself into a society in order to feel integrated in it right? Now I pay the consequences. I pay surgeries to extract biopolymer in order to keep me alive. -Ximena*

Below, Alex describes the various services transwomen seek and use in order to reach their transition goals. Alex says that some transwomen are not content with just injections or surgeries and undergo both types of modifications in unsafe ways.

> *…and it would be great if our stereotypes of beauty were not so high right?...You will always want that part of the feminine 100%. Those who inject substances it won't be too much on my body but why can't we say, with this type of surgery I will have some*

> *impressive hips, right? So yes, there are many things that the trans woman wants to achieve at the end of the day.* -Alex

All participants varied in their responses to how their identity as trans has impacted their health. The immediate answers were either physical changes (or lack thereof), mental, emotional and relationship improvements, and harmony between mind and body. One participant felt being trans has not impacted her health and she would not identify as *transexual* since she has always felt and grew up as a woman. Two participants placed the impact of transitioning within the context of societal pressures that women face and even more so, transwomen.

Self-advocacy

The change in law was instrumental in establishing CEC because it required trans services to be offered and allowed them to be demanded. Two participants, Alex and Ximena, explicitly shared sentiments of self-advocacy during their interviews especially when it came to utilizing trans health services. In the potential case of being denied services, Alex demonstrated self-advocacy and exercising her right to services that legally need to be provided. When asked what some reasons Alex may have avoided going to the doctor, she said there were none:

> *Well, no reason really, I'm like if you do not like it, I'm leaving. It is not something that afflicts me or if they reject me, in fact if they reject me I can do twice as much. That is, I fight for my rights for equality...I am not just anyone that you can say…I am going to deny you services, no, no, no. I'm paying, you give it to me. If it's free, you respect the people who you are giving it to because at the end of the day you are provide a service and you owe them respect...if it bothers you stay home, do not work. So, I'm like an empowered woman.* -Alex

On a similar note, Ximena views the CEC trans health services as a right and feels she is being given what has already belonged to others and now finally, her too:

> *You are giving me what belongs to me as a woman. All women have different medical needs ... I need it because I am going through a transition. A transition that far from needing it biologically or necessarily, I do it because I need it to adapt to a society.*
>
> *- Ximena*

Although only Alex and Ximena explicitly stated sentiments of self-advocacy they highlighted an important factor in utilization of services. Self-advocacy was positioned within barriers to care that all patients named which were legal processes, past discrimination, experiences with and transphobia.

Internal Migration & "Staying Put"

Unlike Jaime, there were three participants who were not born in Mexico City and migrated to obtain trans health services. According to Key Informant's, the requirements for becoming a CEC patient are to have an address in the City of Mexico and possess a *cédula de gratuitad de medicamentos y salud de la Ciudad de Mexico* – a paper which certifies the person is a resident of Mexico City and does not have social services and thus has the right to receive health services from Mexico City. In order to obtain the *cédula* you basically need a residence. If a non-Mexico City resident seeks healthcare services at CEC it is given to them but at a cost (for labs and medical treatment) the consultation will not be charged. Initial labs range in cost from three-five thousand pesos ($160 - $270 US dollars), ultrasounds are from 300-600 pesos each ($16 - $32 US dollars), HIV, hepatitis and syphilis tests 500 pesos ($27 US dollars), and treatment. For a transwoman monthly treatment costs approximately one-three thousand pesos

($54 - $162 US dollars) and transmen is 500 pesos ($27 US dollars) average. With all fees together, it is estimated that a trans person spends seven to ten thousand pesos a month, at least for trans health services ($380-550 US dollars). Because the CEC is only available in Mexico City it is known that trans persons and their families move to Mexico City to obtain services. Not all participants were asked if the fact that CEC was only in Mexico City impedes their traveling or living elsewhere because it was only realized after participant #4 that internal migration was occurring. It also prompted the question, if the CEC being in Mexico City also had an impact on residents of Mexico City. From the participants that were asked, Jaime and his friend Carlos (transmen) said it did not affect them because they would just seek a private specialist. Whereas, five participants said it encouraged them to "stay put" in Mexico City. Ximena elaborated the most on how it impedes her ability to move.

> *But it does prevent you from leaving the country, I definitely do not see myself living anywhere else than in Mexico City […]. If the treatment is also going to be given to me in the U.S. – I have a friend who is being treated there, and I asked if she was being treated, she said yes and I asked if I arrived as a Mexican citizen and asked for your treatment, will they give it to me? Of course, they will give it to you, she said. I said wow. Interesting. But if it does limits you a bit. You have to ask permission, put together your documents. But look, I'm very comfortable in Mexico City. I am grateful and very comfortable, honestly, for the care that is given to me.* *-Ximena*

The rarity of the CEC in Mexico is well known and has demonstrated to be a pull factor for other Mexican residents to move to Mexico City. Those that call Mexico City home vary in their feelings of being tied to the clinic services since the services do not exist elsewhere in the country.

DISCUSSION

It is important to note that the study relied on convenience sampling of patients of the CEC, so it is not a representative sample of the larger transgender population in Mexico City. CEC patients are residents in Mexico City or have completed legal processes to obtain it; they learned about the clinic and were willing and able to engage with trans healthcare services. Nevertheless, the study illustrated how the sources of learning about the clinic, the limited trans health services throughout the rest of Mexico City's health sector (public and private), and the past and present barriers to learning, seeking and engaging with available trans healthcare services shape actual access to care.

Social Networks

Participants learning of trans health services were self-initiated and supported by social networks. Across all participants the increase in technology was recognized as a facilitator to learning about the clinic yet is was still considered difficult to learn about services. Both health sectors do not refer patients to the CEC, do not share information about the clinic nor initiate campaigns to increase its awareness. Similar to Infante et al (2009), TTT population are recognized to be marginalized groups, but are not explicitly included in the design of programs and campaigns; the TTT population does not recall ever being given information about HIV prevention or free condoms. In the same vein, CEC patients did not recall a campaign or any centralized source for learning about trans health services. Social networks not only shared CEC as a resource but also provided affirmation of identity and encouragement to seek and continue with trans health services.

The literature highlights the existing transphobia and violence against the transgender population in Mexico City outside of the health sector (citation), but results show there is also internal discrimination within the trans community social networks. This has strained the involvement of some trans individuals in the virtual and physical spaces created by and for trans individuals. Within the family structure, there were key family members that participants highly valued for their support. It was surprising that only a small number of participants reported not having a supportive social network. It may be that there is a growing awareness and acceptance of the transgender population in Mexico City and this is reflected in the laws and public healthcare system. While this does not eliminate the 108 reported murders of transwomen from 2014-2016 (EFE, 2017) it does imply a possible shift in the interpersonal relationships of transgender individuals. Mexico and other Latin American countries that are seeking to increase knowledge, access and utilization of trans health services can utilize technology and include the transgender population in campaign design to increase knowledge about services. Additionally, it is advantageous to include support networks in the provision of health services for transgender individuals and efforts to encourage health seeking and continued engagement in services.

Transgender Identity Impact on Health

Comprehensive transgender health services that include physical, mental and emotional well-being have positive impacts on the trans population. Having a multi-disciplinary team makes the patients feel they have support through their transition process and throughout the life course. The literature highlights that trans health care is highly specialized to endocrinologists, urologists and plastic surgeons across Latin American and Mexico (CEC, 2013; Diehl et al, 2017; Perucchi et al, 2014). In fact, in Peru, Chile, Colombia, Brazil and Mexico, psychologists,

medical providers and even judges have been identified as gatekeepers to accessing trans health services (Fraser, 2016; Aguayo-Romero et al, 2015; Riquelme, 2017; Tagliamento and Paiva, 2016). Results of the current study illustrate that specialists do not satisfy all the healthcare needs of the transgender population. Neither is it beneficial to confine transgender health needs to medical facilities and services when legal processes exist that require non-medical providers involvement. Uruguay and Ecuador exemplify this understanding through their social support services which include food assistance programs, focus on trans persons living in extreme poverty, partnerships with academic institutions to improve understanding, and legislation such as "family diversity" that applies to transgender sex workers who act as a single economic and social unit (Santisteban et al, 2016; AWID, 2013). Mexico and other Latin American countries, with or without gender identity laws, can establish multi-disciplinary teams and offer services that are comprehensive and include support for adolescents and older adults in medical facilities. Further, they can and should build partnerships with the legal sector to eliminate barriers in obtaining changes in identity documents that are needed to obtain care.

Barriers to Care

Instances of discrimination, transphobia and stigma emerged from the current study. Mexico is considered the second country with highest count of transgender violence from October 1st 2016 and September 2017 (TGEU, 2017). Although the National Council to Prevent Discrimination (CONAPRED) was established to handle reports of discrimination, only one official complaint of human rights abuse from a trans person was received during the same period that at least eight murders of transwomen occurred in Mexico City (TLC, 2016). Yet, in the current study, four participants stated having experienced discrimination, transphobia or

stigma. Mirroring the literature, all participants were transwomen. However, it is important to note that all participants stated that they know it exists in Mexico City even they may not have directly experienced it. This may be attributed to the increasing awareness and acceptance of the transgender community in Mexico City, or as some participants said, their ability pass and thus not be targeted.

In alignment with the literature, this study showed that trans persons experienced being ousted from their homes at young ages and excluded from employment services, which had the effect of forcing them into sex work and beauty styling as the primary source of employment for transwomen (TLC, 2016; Lavers, 2014; Alliance, 2012; He, 2016). Results from the current study illustrate the persistence of employer discrimination starting from the interview process. Some participants expressed high appreciation for employers that were accepting or allowed them to take time off to undergo the transition process because they knew it was rare. It may be that some sectors of employment are more accepting than others; there also seems to be a shift in leadership and education systems that are more accepting of the transgender population.

Stigma towards sex workers was prevalent in key informant interviews and participant interviews where they were identified as being the least engaged in healthcare services. Transwomen have the highest HIV prevalence in both the population of Mexico City (15-20%) and the CEC patient population (30%) (CENSIDA, 2018, p2; CEC, 2013). They are a target population for CENSIDA and the Secretary of Health strategies yet have not been effectively engaged with as demonstrated by Infante et al (2013). This can be attributed to the clinics reputation as solely an HIV clinic, as well as the pervasive fear of being infected by STD's, HIV

or AIDS. Further, legal processes pose perceived and real threats to being able to change identity documents, particularly for marginally housed individuals, as they must have a residential address in order to complete the process.

Transgender youth continue to be expelled from their homes, but young CEC patients interviewed here were sometimes accompanied by family members to their visits and they sought family therapy services. This may be due to an increase of adolescents' willingness to come out as trans due to the increase in awareness, and the availability of free services in Mexico City which diminishes the needs to seek clandestine services. Similarly, there may be an increase in support from family who are willing to move with the transgender individual and/or accompany them to visits. Mexico and other Latin American countries with high instances of societal and healthcare system discrimination, transphobia and stigma can take an active approach to managing and preventing incidences. Results show the opportunity to report experiences are beneficial but not sufficient. Also needed are awareness campaigns in the labor and healthcare sector, so employers and providers can be held accountable and transgender individuals can feel safe and motivated to file reports. Including transgender sex workers in the design and implementation of outreach initiatives focusing on comprehensive health and not just HIV or STD's can increase engagement with the healthcare system. Once again, it is also important to collaborate with the legal system to eliminate barriers in changing identity documents, and with family members to continue their positive involvement in their relative's health.

Facilitators to Care

Creating clinics similar to the CEC improve the trans populations' engagement with healthcare, however offering free services is vital. Results show that many changed their care from private specialists to the CEC due to cost or when medications constitute a financial burden. Contrary to the literature, participants in this study did not show a high use of clandestine services or self-medication (PAHO, 2011). This may be due to the very existence of CEC, as it provides a safe, comprehensive and inexpensive avenue to trans services. It may also be that patients who have self-medicated want to continue transitioning with the support of a medical team. The increase in trans awareness and acceptance may also be motivating trans individuals to search for formal services due to the decrease in stigma and increase in recommendations through social networks.

Results show the value of limiting the conditions required to initially receive services and continuing their use. The existence of free trans services and facilities is beneficial, however it is clear that they are highly utilized when the personnel has trans competency and sensitivity, but most importantly knowledge. The current study results echo the literature regarding transphobia and lack of knowledge on gender identity in medical facilities (EBD, 2015). In particular, when doctors lack proper training on hormone treatment, many trans persons wait until situations are dire before seeking consultation (Telesur, 2017). Results confirm that a welcoming environment, correct use of name and pronoun, and overall respect for transgender persons facilitate the process and encourage continuation of care. Clearly there are some specialists in Mexico City that offer trans healthcare services, however some not all follow protocol or lack critical

knowledge. Specialists for general health services do not demonstrate trans competency or sensitivity and these services are requested to be included at CEC (i.e. gynecology).

Results demonstrate the confidence and trust in CEC personnel for their protocols, transparency in consultation, and thorough testing at each consultation. Transgender participants noted that obtaining healthcare services requires that they feel safe, human and not stereotyped. The CEC accomplished this through training all CEC staff and medical teams, establishing a rigorous protocol, and being willing to adapt the protocol as they are made aware of changes that are needed. It is important to note that the private and public sector vary in their ability to provide services. Mexico and other Latin American countries can replicate the CEC model and protocols for their facilities and personnel training, as well as comparing processes and health outcomes with countries like Argentina, Uruguay and Brazil which have similar laws and facilities.

Internal Migration and Staying Put

Results show that the existence of the CEC caused participants to move from other parts of Mexico to Mexico City, as well as influencing residents to stay in Mexico City in order to be eligible for services. According to the literature 18% of Mexican population is residing outside of their birth state, and since the 1970's, Mexico City has been attractive due its growing job market and improved communication infrastructure (Pinedo et al, 2017; Laster et al, 2000). All participants recognized the need to expand clinics like CEC across the country. They also noted that Mexico City encompasses a unique blend of progressive perspectives, *machismo* and Catholicism. Thus, Mexico City as a place had an influential role in the unfolding of the

CEC, trans awareness and acceptance, and health of the trans population. Results also demonstrated a confinement to Mexico City because of the CEC eligibility requirements, the greater opportunities Mexico City offers, and the social advancements in trans inclusivity. Data also shows that participants migrated to Mexico City due to limiting or non-existent trans health services in their home communities, as well as a lack of knowledge of trans issues and the high costs for limited services. Emigration did not always include the entire family, but instead key members who were supportive of trans identity. In addition to continually improve services and engagement with all seeking care, Mexico and other Latin American countries should also identify and collaborate with other high need areas.

Self-Advocacy

Results show that transwomen exemplified self-advocacy in accessing trans health services, whereas transmen did not during the in-depth interviews. This finding was surprising, however, it can be hypothesized that transwomen are more subject to discrimination, transphobia and violence compared to transmen, and this may encourage them to develop a stronger sense of self-advocacy. This is not meant to deny the experiences of transmen, however the literature supports that transwomen have seen multilevel targeting by laws, state officials, police, military, medical providers, educators and society (TLC, 2016), including morality laws, arbitrary grounds for arrest, detention, torture, and other human rights violations (TLC, 2016). Additionally, some research focuses more on transwomen than transmen due in part to the higher prevalence of HIV rates for transwomen in Latin America and Mexico. Transwomen in this study felt they were exercising their legal rights in using trans health services and were empowered to react to instances of being discriminated against. In this study, transwomen who

shared experiences of discrimination, transphobia or stigma in connection with their advocacy in the healthcare system when trans health services are required by law. It is important to note that the two transwomen who expressed self-advocacy are also HIV positive and were the only ones who disclosed their status. Results also suggest that some transwomen may feel disenfranchised in accessing trans health services based on conversations with other transwomen in their social networks. The participants that did not echo these sentiments expressed that they thought they had to be realistic, that having limited services was better than having none. They also showed differences in transition goals or did not have the money to be able to pay out of pocket for surgeries. The current laws of Mexico support these sentiments because surgery is not covered; it is not considered to be medically necessary. The private sector offers surgeries however all costs are out of pocket. Mexico and other Latin American countries can benefit from adding patient advocates and navigators to their existing models of care and facilities. Additionally, partnerships with community organizations can involve support groups for trans individuals and trainings on patient rights even for individuals who are not engaged in care. This will engage the general trans population with medical facilities and encourage enrolling as a patient and feeling more confident in navigating the legal and healthcare system.

Limitations

Study limitations include the small sample of participants, which prevented saturation being reached. The convenient sample excluded residents of Mexico City that were not engaged with healthcare services and did not include additionally marginalized trans populations such as sex workers or migrants/refugees from Central America or South America and the Caribbean seeking inclusive trans health services.

APPENDICES

APPENDIX I: Consent Form

Study No.: IRB00095934 *Emory University IRB* IRB use only Document Approved On: 7/6/2017

ES INVITAD* A PARTICIPAR EN UN ESTUDIO DE INVESTIGACION

¿Que es un estudio de investigación?

El propósito principal de un estudio de investigación es para adquirir conocimiento que puede ser usado para ayudar a otros. Estudios de investigación no tienen el propósito de beneficiarle directamente, aunque unos estudios si pueden.

¿Tengo que participar?

No. Participar en el estudio es voluntario. Si decide participar y despúes cambia de opinión y desea retirarse del estudio lo puede hacer.

La participación en el un estudio es independiente de su atención médica. La decisión de participar o no, no afecta su estatus como paciente.

¿Qué es este documento?

Esta forma es un documento que contiene información detallada y sirve como consentimiento informado. Describe los riesgos del estudio, los procedimientos y cualquier costo para usted.

Este documento también es una autorización de la ley de Responsabilidad y Portabilidad del Seguro de Salud. Describe como su información médica será usada y por quien.

Al firmar esta forma usted acepta que está dispuesto a participar en el estudio y permite el uso de su información médica.

¿Cuáles son los siguientes pasos?

1. Leer esta forma o pedir que alguien se la lea
2. Asegurarse que el doctor o los empleados del estudio le expliquen la investigación
3. Haga preguntas (p. ej. Compromiso de tiempo, palabras desconocidas, procedimientos específicos etc.…)
4. Si va tener un tratamiento, saber cuáles tratamientos son parte de la investigación y cuales son tratamientos regulares
5. Tome tiempo para considerar el estudio y hable con su familia y amigos.

Universidad de Emory
Consentimiento para ser participante de investigación / Autorización de Responsabilidad y Portabilidad del Seguro de Salud

Título: Conocimiento, acceso, y utilización de servicios de salud de la población transgenero, transexual y travesti en la Ciudad de México, México
Investigador Principal: Isabeth Mendoza, departamento de salud global, Dra. Karen Andes, departamento de salud global y ciencias de comportamiento y educación para la salud
Patrocinador: Premio de experiencia global (GFE) de la universidad de Emory, escuela de salud pública Rollins Emory y Jack Boozer y Hermann Noether puesto de interno en ética social y servicio comunitario

Introducción
Gracias por su interés en nuestro estudio de investigación. Esta forma es diseñada para informarl* de todos los aspectos del estudio antes de que tom* una decisión. Su participación es voluntari*. Si cambia de opinión después y decide retirarse del estudio lo puede hacer. La decisión de participar o no, no afecta sus beneficios médicos.

¿Cuál es el propósito del estudio?
El propósito del proyecto de investigación es aprender de los conocimientos personas transgenero, transexual y travesti tienen sobre servicios de salud específicamente trans* y sus experiencias accediendo servicios de salud.

¿Cuánto durara el estudio?
El estudio durara aproximadamente tres meses para completar. Se espera que participantes sólo participen una vez durante los tres meses de estudio.

¿Que se me pedirá?
La participación en el estudio requiere compartir su conocimiento de servicios de salud, su experiencia accediendo y utilizando tales servicios de salud en la Ciudad de México por medio entrevista profunda o una encuesta. La entrevista profunda durar aproximadamente una hora y cubrirá temas relacionados a su conocimiento de servicios de salud trans*, la disponibilidad de tales servicios en la Ciudad de México y sus experiencias en acceder tales servicios. La encuesta durar aproximadamente veinte minutos and cubrirá temas relacionados a sus experiencias en la búsqueda de servicios de salud, facilitadoras y barreras para acceder tales servicios, y fuentes formales o informales de servicios en la Ciudad de México.

¿Cuáles son los posibles riesgos y molestias?
La Participación en el estudio conlleva algunos riesgos, mayormente estrés, vergüenza, y/o malestar general por la información revelada de experiencias y opiniones. Incumplimiento de confidencialidad también es un riesgo potencial en participar (en este caso la entrevista/transcripciones y encuestas). Sin embargo, toda la información y opiniones reveladas durante la entrevista y encuesta permanecerá estrictamente confidencial; nombres reales no serán usados en las transcripciones o cualquier otro material escrito. Todos los materiales se mantendrán bajo estricta seguridad y solo los miembros del equipo de estudio tendrán acceso a cualquier material e información de identificación.

¿Me beneficiare directamente del estudio?
Este estudio no es designado para beneficio directo. Esta designado para aprender más sobre las experiencias de personas transgenero, transexual, y travesti en acceder y utilizar servicios de salud en la Ciudad de México, México. Los resultados del estudio pueden ayudar a otros en el futuro.

¿Cómo protegerá mi información privada que va a obtener en el estudio?
Siempre que sea posible se usara un numero de estudio en lugar de su nombre, va ser usado en los registros de estudio. Su nombre e información de identificación no aparecerá cuando presentemos o publiquemos los resultados.

Los registros del estudio pueden ser abiertos por orden judicial. También pueden ser proporcionados en respuesta a una citación o una solicitud para la producción de documentos.

Costo
No habrá ningún costo por su participación en el estudio. No se le cobrara por las actividades del estudio.

Retiro del estudio
Tiene el derecho de retirarse del estudio en cualquier momento sin penalización.

Los investigadores tienen el derecho de discontinuar su participación en el estudio sin su consentimiento por cualquier razón, especialmente si creen que es en su mejor interés o si se opusiera a futuros cambios que se pueden hacer en el plan de estudio.

Información de salud protegida
Este estudio no usara o compartir alguna información de salud que lo identifique.

Información de contacto
Comunicarse con: Isabeth Mendoza al teléfono 323-599-7344

- Si tiene preguntas sobre este estudio o su participación en el estudio
- Si tiene preguntas, inquietudes o quejas sobre la investigación

Comunicarse a la Junta de revisión institucional de Emory a 404-712-0720 o 877-503-9797 o por correo electrónico a irb@emory.edu:

- Si tiene preguntas sobre sus derechos como un participante de investigaciones
- Si tiene preguntas, inquietudes o quejas sobre la investigación
- También puede informar al IRB sobre su experiencia como participante de investigaciones por medio de nuestra encuesta de participantes de investigaciones: http://www.surveymonkey.com/s/6ZDMW75.

Consentimiento y autorización

¿Tiene alguna pregunta sobre algo que acabo de decir?

¿Había alguna parte que no estaba clara?

¿Está de acuerdo en participar en el estudio?

Participante acepta participar: Si No

ESTA PARTE COMPLETAD* POR PARTICIPANTE

Por favor escriba su nombre, firma y la fecha si está de acuerdo en participar en el estudio principal. Firmando este consentimiento y autorización, no renuncia a ninguno de sus derechos legales. Le daremos una copia del formulario para su referencia.

Nombre

Firma (18 años o mayor y capaz de dar el consentimiento) **Fecha** **Hora**

DEBERIA SER COMPLETADO POR EQUIPO DE ESTUDIO SOLAMENTE

Nombre de la persona conduciendo el consentimiento informado

Firma de la persona conduciendo consentimiento informado **Fecha** **Hora**

APPENDIX II: In-Depth Interview Guide

IRB Study #00095934 Document Approved: 06JUL2017
Version: 06JUL2017

In-Depth Interview Guide

Experiences of Transgender Individuals in Mexico City, Mexico

Preguntas para determinar elegibilidad:

- ¿Tienes entre 18 y 65 años de edad?
- ¿Vives en la Ciudad de México?
- ¿Te identificas como transgenero, travesti o transexual?
- ¿Está interesado en completar una breve encuesta después de la entrevista?

Introducción

Hola, mi nombre es Isabeth Mendoza. Soy estudiante de la universidad Emory, en Atlanta Georgia, EEUU. Estoy conduciendo entrevistas profundas con personas transgenero, transexual y travesti (TTT), y proveedores de salud trans, en la Ciudad de México.

El propósito del proyecto de investigación es aprender de los conocimientos personas trans tienen sobre servicios de salud específicamente trans y sus experiencias accediendo servicios de salud. La entrevista va durar una hora y va cubrir temas relacionados a su conocimiento de servicios de salud trans, la disponibilidad de tales servicios en la Ciudad de México y sus experiencias en acceder tales servicios.

Si usted está de acuerdo en participar, no necesita contestar ninguna pregunta que no se sienta cómoda respondiendo y podemos tomar un descanso cuando es necesario. Si alguien se acerca tanto como puede escuchar nuestra conversación o interrumpe la entrevista, cambiare el tema de conversación inmediatamente para proteger su privacidad. No hay respuestas correctas o incorrectas. Estoy interesada en escucar sus experiencias personales entonces siéntase libre en hablar abiertamente sobre sus opiniones.

Quiero enfatizar que la entrevista y los datos adquiridos no tendrán su nombre y serán confidencial. La entrevista será transcrita y de-identificado por este propósito. Me gustaría grabar la entrevista para asegurarme que no pierda ninguna información. Inmediatamente después de la entrevista voy a subir la grabación a mi computadora protegida con contraseña y borrarla del registrador digital. Una vez el estudio está finalizado se destruirá la grabación. Ningún otro estudiante, proveedor, personal de la clínica que no está asociado con el proyecto escuchará la

grabación o tendrá acceso a la transcripción. Los datos adquiridos serán usados para mi tesis de maestría y podrán ser publicados en el futuro.

También voy a tomar notas para anotar preguntas de seguimiento y las preguntare al final. Si no gustaría que la entrevista se grabe, tomare notas durante la entrevista para capturar la información.

¿Está de acuerdo en participar en la entrevista?

¿Tengo su permiso para grabar la entrevista?

¿Tiene alguna pregunta antes de comenzar?

[Prueba grabador. Si funciona, empieza la entrevista]

Preguntas para empezar:

Primero me gustaría empezar con unas preguntas acerca de usted.

1. ¿Como es vivir en la Ciudad de México?
2. ¿Por cuanto tiempo ha vivido en la Ciudad de México?
   Explorar: razones por escoger a la Ciudad de México, status residencial, ciudadanía, trabajo

Preguntas clave:

Objetivo 1: Identificar el conocimiento y actitudes de la población transgenero, travesti y transexual en la Ciudad México acerca los servicios médicos

Ahora voy a preguntar sobre cómo te cuidas y cuando decides ir al médico.

3. ¿Cuáles son tus necesidades de cuidado a la salud?
   Explorar: ¿te sientes en la capacidad a poder solicitarlos?
4. ¿Como siente siendo trans ha impactado su salud?
   Explorar: influencia en recibir o pedir servicios
5. ¿Cuales servicios de salud trans puedes acceder en la Ciudad de México, México?
   Explorar: servicios proporcionado por el estado, sector privado y lo que no se puede acceder en el estado
6. ¿Como aprendiste sobre la clínica condesa?
7. ¿Como era tu experiencia la última vez que fuiste al médico?
8. ¿Que ha sido tu experiencia en recibir servicios de salud específicamente trans?
   Explorar: diagnosis médica, terapia de hormonas, salud mental
9. ¿Por cuanto tiempo ha estado recibiendo servicios de salud específicamente trans?

10. ¿Cuales otros lugares visitas para recibir servicios de salud?
    Explorar: mercado negro, redes sociales y/o procedimientos clandestinos y calidad de servicios de tal
11. ¿Con quien consulta a cerca sus necesidades de cuidado de salud?
    Explorar: redes sociales, instalaciones médicas formales, redes basadas en el internet, organizaciones comunitarias etc. ¿Cuáles específicamente?
12. ¿Qué tan difícil es aprender sobre servicios de salud trans en la Ciudad de México?

Si participante es migrante:

13. Cuales servicios de salud trans están disponible en su país de origen?
    Explorar: proporcionado por el estado, sector privado y servicios clandestinos
14. Cómo aprende la comunidad trans sobre estos servicios?
15. ¿Durante la migración, tuviste acceso a estos servicios?
    Explorar: pedir medicamentos por adelantado, asistencia por organizaciones sin fines de lucro, familia o amigo/as
16. Que es el proceso para hacerse residente de México para poder usar servicios de la Clínica Condesa?
    Explorar: cuales procesos legales ha completado o considerado

Objetivo 2: Determinar el acceso de la población transgenero, travesti y transexual a servicios de salud específicamente trans en la Ciudad México

Ahora le voy a preguntar sobre su capacidad para acceder a los servicios de atención medica en la Ciudad de México y sus experiencias.

13. ¿Cuales son unas de las razones que ha evitado ir al médico por servicios trans?
    Explorar: estigma, barreras financieras, miedo, seguranza, transportación, status residencial
14. ¿Cómo paga por sus servicios médicos?
15. ¿Que tan cerca está el hospital o la clínica más cercana a usted?
    Explorar: servicios ofrecidos en sitio, transportación disponible, costo de servicios
16. ¿Como fue su primera consulta médica de salud trans en la Ciudad de México?
    Explorar: estigma, acoso, violencia, vergüenza, exclusión de servicios, influencia en buscar futuro servicios, ¿influyo acceder servicios en el futuro?
17. ¿Que contribuye a que se sienta seguro y cómodo en acceder servicios de salud trans?
    Explorar: aspectos de la Ciudad de México acerca el género, normales sociales, culturales, religiosos, y políticos

Si participante es migrante:

18. Durante la migración ¿que tipos de servicios médicos estaban disponible?

Explorar: uso de Seguro Popular del gobierno que permite uso de migrantes, clínicas o hospitales cerca, curanderos etc.

19. Cómo recibe servicios de salud en la Ciudad de México?

    Explorar: uso de Seguro Popular del gobierno que permite use de migrantes, clínicas o hospital cerca, curanderos etc.

Objetivo 3: Cuantificar la utilización de servicios específicamente trans en la Ciudad de México

Ahora voy a hacer preguntas sobre los servicios que ha usado mientras estando en la Ciudad de México.

18. ¿En un ano, con que frecuencia va al médico por servicios de salud específicamente trans?

    Explorar: ¿Ha cambiado con el desarrollo de identidad?

19. ¿Está satisfecho con los servicios ofrecidos en la Ciudad de México para la población trans?

    Explorar: amplitud de servicios, competencia cultural, accesibilidad, conocimiento de proveedores

20. ¿En un tiempo a obtenido servicios que al momento no son disponibles en la Ciudad México por la secretaria de salud – como electrolisis, planificación familiar para personas trans, cirugía, terapia para modular la voz?

    Explorar: fuente de servicio, costo, satisfacción, referencia a servicio

21. ¿Cuales son algunos servicios de salud que usted desea tener acceso a?
22. Si no puede obtener esos servicios en la Ciudad de México, ¿que planea hacer?
23. ¿Cuáles son sus metas para la transición?

    Explorar: ¿Como siente que estando en la Ciudad de México facilita alcanzar esas metas? ¿Impide alcanzar esas metas?

24. ¿Cómo le afecta el apoyo de familia y/o amigo/as en su uso de servicios trans?

Si participante es migrante:

25. ¿Que espera obtener de la migración?
26. ¿Cuáles son sus planes para el futuro?

    Explorar: quedarse en México, continuar a los estados unidos

27. ¿Ha considerado aplicar por asilo?

    Explorar: por qué si o por qué no?

Preguntas de cierre:

Nos estamos acercando al final de la entrevista, pero tengo tres preguntas finales que preguntar.

25. ¿Que les diría a los proveedores que sirven la población transgenero, travestí y

transexual en la Ciudad de México?

26. ¿Hay algo que deseé que las instalaciones de salud hicieron para la población transgenero, travestí y transexual en la Ciudad de México?
    Explorar: servicios de salud mental, asistencia financiera, disponibilidad
27. ¿Cómo imagina la población transgenero, travestí y transexual en la Ciudad de México en los próximos años?
    Explorar: lo primero que se le venga a la mente o integración social, servicios públicos/salud/educación etc..

Si participante es migrante:
28. ¿Cómo siente que el proceso migratorio ha afectado su salud?

Termine con todas mis preguntas. Gracias por compartir su historia y experiencias conmigo.

28. ¿Hay algo más que le gustaría compartir conmigo?
29. ¿Tiene interés en los resultados de la investigación?
Si es así, ¿cuál es la mejor manera en comunicarme con usted?

Encuesta:
¿Todavía está interesado en completar una encuesta de veinte minutos?

La encuesta durará aproximadamente veinte minutos y cubrirá temas relacionados a sus experiencias en la búsqueda de servicios de salud, la facilitadoras y barreras para acceder tales servicios, y fuentes formales o informales de servicios en la Ciudad de México.

[Para la grabación. Asegúrate que la entrevista fue grabada bien. Si el participante comparte algo después de parar la grabación, anota información en las notas de campo]

Conclusión:
Gracias por su tiempo. Sé que hablamos de algunos temas delicados y agradezco su disposición a compartir.

[Comparte recursos de salud mental de la Clínica Especializada Condesa y organizaciones comunitarias]

Si tiene alguna pregunta, puede comunicarse con las personas designadas en el formulario de consentimiento.

[Complete el resume de entrevista, sube la grabación a computadora y Emory Box y varios otros sitios antes de borrar de registrador digital]

APPENDIX III: Key Informant Interview Guide

Introducción

Hola, mi nombre es Isabeth Mendoza. Soy estudiante de la universidad Emory, en Atlanta Georgia, EEUU. Estoy conduciendo entrevistas profundas con personas transgenero, transexual y travesti (TTT), y proveedores de salud trans, en la Ciudad de México.

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Si usted está de acuerdo en participar, no necesita contestar ninguna pregunta que no se sienta cómoda respondiendo y podemos tomar un descanso cuando es necesario. Si alguien se acerca tanto como puede escuchar nuestra conversación o interrumpe la entrevista, cambiare el tema de conversación inmediatamente para proteger su privacidad. No hay respuestas correctas o incorrectas. Estoy interesada en escuchar sus experiencias personales entonces siéntase libre en hablar abiertamente sobre sus opiniones.

Quiero enfatizar que la entrevista y los datos adquiridos no tendrán su nombre y serán confidencial. La entrevista será transcrita y de-identificado por este propósito. Me gustaría grabar la entrevista para asegurarme que no pierda ninguna información. Inmediatamente después de la entrevista voy a subir la grabación a mi computadora protegida con contraseña y borrarla del registrador digital. Una vez el estudio está finalizado se destruirá la grabación. Ningún otro estudiante, proveedor, personal de la clínica que no está asociado con el proyecto escuchará la grabación o tendrá acceso a la transcripción. Los datos adquiridos serán usados para mi tesis de maestría y podrán ser publicados en el futuro.

También voy a tomar notas para anotar preguntas de seguimiento y las preguntare al final. Si no gustaría que la entrevista se grabe, tomare notas durante la entrevista para capturar la información.

¿Está de acuerdo en participar en la entrevista?

¿Tengo su permiso para grabar la entrevista?

¿Tiene alguna pregunta antes de comenzar?

[Prueba grabador. Si funciona, empieza la entrevista]

<u>Preguntas</u>

1. ¿Como está conectado a la comunidad trans?
2. ¿Qué opina sobre cambios en la ley que requiere ofrecer servicios de salud a personas trans?
3. ¿Cuales servicios de salud son solicitados por pacientes trans?
4. ¿Como proveedor se siente apoyada en ofrecer servicios de salud a pacientes trans?
   <u>Explorar</u>: colegas, protocolos de clínica, recursos, leyes
5. ¿Cuales servicios de salud son ofrecidos?
   <u>Explorar</u>: diagnosis médica, hormonas, cirugía, electrolisis, planificación familiar, salud mental, terapia de voz
6. ¿Cómo varían los servicios de salud trans en el sector privado y público?
7. ¿Se siente cómodo y bien informado en proveer servicios de salud trans?
8. ¿Que protocolo o directrices usa como referencia?
9. ¿Cuál ha sido su experiencia en proveyendo servicios de salud trans?
10. ¿Que retos ha enfrentado en la prestación de servicios de salud?
11. ¿Que pasa durante una visita iniciativa con un nuevo paciente?
12. ¿Cuales son unas alternativas para una persona trans en obtener servicios médicos?
    <u>Explorar</u>: mercado negro, redes sociales, procedimientos clandestinos
13. ¿En su opinión, cuáles son unas de las razones que personas trans evitan ir al médico para recibir servicios de salud trans?
    <u>Explorar</u>: estigma, barreras financieras, miedo, seguranza, transportación, residencia
14. En su opinión, ¿cuales son algunas barreras que las personas trans enfrentan en ser saludables?
15. ¿Como puede pagar una persona trans por sus servicios de salud?
16. ¿Existe un programa de asistencia financiera que ayuda pagar por servicios de salud?
17. ¿Cuales recursos desea tener que no tiene actualmente?
18. ¿Como siente estando en la Ciudad de México, facilita o impide la población trans en alcanzar sus metas de transición?

Esas son todas mis preguntas. Gracias por su tiempo y por compartir sus experiencias conmigo. ¿Hay algo más que le gustaría compartir conmigo?

[Para la grabación. Asegúrate que la entrevista fue grabada bien. Si el participante comparte algo después de parar la grabación, anota información en las notas de campo]

Si tiene alguna pregunta, puede comunicarse con las personas designadas en el formulario de consentimiento.

[Complete el resume de entrevista, sube la grabación a computadora y Emory Box y varios otros sitios antes de borrar de registrador digital]

APPENDIX IV: Code Definitions

Code	Definition
Learning of trans services available	The process or source (any physical or virtual space) that has furthered or prevented knowledge of trans health services available. This includes states and countries outside of Mexico City, internet communities, family, friends, formal or informal establishments, private and clandestine sectors of health
Internal Migration/"Staying Put"	Moving to Mexico City with the purpose of obtaining trans health services or feelings related to being unable to return home or leave for risk of not continuing trans care
Attitudes about trans identity	Any feelings regarding the current perception or treatment of the trans community in society or healthcare settings; feelings regarding the available or unavailable trans health services in Mexico City through formal or informal channels
Barriers to living fully as trans	Barriers that relate to a trans person obtaining, accessing or utilizing trans health services that are essential to living a full life. Included can be health services, features of the built environment, financial costs, stigma, discrimination, prior health issues, social network support or lack thereof
Facilitators to trans health services	Facilitators that relate to a trans person obtaining, accessing or utilizing trans health services that are essential to living a full life. Included can be health services, features of the built environment, financial costs, stigma, discrimination, prior health issues, social network support or lack thereof
Social network support	Persons who serve as support for the participant in seeking, establishing or continuing trans health care
Discrimination & Stigma	Specific instances where participants experienced discrimination relating to their trans identity. This includes within health establishments, with employers, family, friends, healthcare providers or hospital/clinic staff, or community members. Feelings of stigma related but not limited to specific experiences of discrimination
Transition goals	Participants expressed desires for their transition goals that may or may not be directly related to medical services
Legal processes	Participants experiences obtaining residency in order to establish care at the clinic or when seeking to obtain a legal name change
STI's and/or HIV	Participants discussion of their own or peers STI and/or HIV perception and attitudes, testing and stigma
Lack of trans health services	Participants referring to an absence in health services, medical competency, sensitivity, trans health information, trans health facilities in CEC or Mexico City; also in employment opportunities and societal rights that impact participants ability to seek, obtain or utilize healthcare services
Experience as a patient at CEC	Participants journey as a patient at CEC after learning about the CEC's existence. This includes feelings before and during first visit, treatment from clinic staff/providers, attitudes about protocol and process, and their continued engagement in care
Impact of Trans identity on health	Participants perception on how their trans identity has impacted their overall health
Self-advocacy	Participants call for rights to health services, social services or experiences, employment opportunities etc....

REFERENCES

Sanchez, Mayela. (2016, December 18). Transgender People in Mexico City Resort to Dangerous Unsupervised Procedures. Retrieved from https://globalpressjournal.com/americas/mexico/transgender-people-mexico-city-resort-dangerous-unsupervised-procedures/

Lavers, Michael K. (2015, January 5), 'It's okay to be gay' in Mexico City. Retrieved from http://www.washingtonblade.com/2015/01/05/okay-gay-mexico-city/

Robles et al. (2016, July 26). Removing transgender identity from the classification of mental disorders: a Mexican field study for ICD-11. Vol 3: 850 – 859. Retrieved from http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30165-1/abstract

Woodman, Stephen. (2016, August 22). Mexican police turn blind eye to murders of transgender women, say activists. Retrieved from https://www.reuters.com/article/us-mexico-transgender-violence/mexican-police-turn-blind-eye-to-murders-of-transgender-women-say-activists-idUSKCN10X1TY

The Lancet. (2016, July 26). The Lancet Psychiatry: First field trial supports removing transgender diagnosis from mental disorders chapter within WHO classification [Press release]. Retrieved from https://www.eurekalert.org/pub_releases/2016-07/tl-tlp072516.php

Diehl, Alessandra et al. (2017). Social stigma, legal and public health barriers faced by third gender phenomena in Brazil, India and México: Travestis, hijars, and muxes. *International Journal of Social Psychiatry*. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/28552025

Clinica Especializada Condesa (CEC). (2011). Transgénero. Retrieved from http://www.condesadf.mx/transgenero.htm

Pan American Health Organization (PAHO). (2011). Elementos par el desarrollo de la atención integral de personas trans y sus comunidades en Latinoamérica y el Caribe. Retrieved from http://www.paho.org/arg/images/gallery/Blueprint%20Trans%20EspaÃ±ol.pdf

Lipka, Michael. (25, June, 2015). Same-sex marriage makes some legal gains in Latin America.

Religion in Latin America. Retrieved from http://www.pewresearch.org/fact-tank/2015/06/25/same-sex-marriage-makes-some-legal-gains-in-latin-america/

Berkman, Alan et al. (2005, July). A Critical Analysis of the Brazilian Response to HIV/AIDS: Lessons Learned for Controlling and Mitigating the Epidemic in Developing Countries. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449335/

He, Lucia. (16 November 2016). Latin America: the most deadly region for transgender communities. *Equal Times*, human rights. Retrieved from https://www.equaltimes.org/latin-america-the-most-deadly#.WiGu-LaZOgQ

Santisteban, Silva Alfonso, et al. (2016). HIV Prevention among transgender women in Latin America: implementation, gaps and challenges. *Journal of the International AIDS Society*. Retrieved from https://www-ncbi-nlm-nih-gov.proxy.library.emory.edu/pubmed/27431470

AWID, Women's Rights. (4, January, 2013). Transgender Rights in Ecuador: A Legal, Spatial, Political and Cultural Acquittal. Retrieved from https://www.awid.org/news-and-analysis/transgender-rights-ecuador-legal-spatial-politicL-and-cultural-acquittal

Fraser, Barbara. (23, July, 2016). Peru's Transgender Community: the battle for rights. The Lancet, World Report. Retrieved from https://www-ncbi-nlm-nih-gov.proxy.library.emory.edu/pubmed/?term=Peru's+transgender+community%3A+the+battle+for+rights

Aguayo-Romero et al. (2015). Gender Affirmation and Body Modification Among Transgender Persons in Bogota, Colombia. *Routledge*. Retrieved from https://www-ncbi-nlm-nih-gov.proxy.library.emory.edu/pubmed/?term=Gender+Affirmation+and+Body+Modification+Among+Transgender+Persons+in+Bogota%2C+Colombia

Riquelme, Michel. (27, June, 2017). Gender Identity Recognition in Chile. ARC International. Retrieved from http://arc-international.net/blog/gender-identity-recognition-in-chile/

Tagliamento, Grazielle and Paiva, Vera. (18, August, 2016). Trans-Specific Health Care: Challenges in the Context of New Policies for Transgender People. Retrieved from https://www-ncbi-nlm-nih-gov.proxy.library.emory.edu/pubmed/?term=Trans-Specific+Health+Care%3A+Challenges+in+the+Context+of+New+Policies+for+Transgender+People

Perucchi et al (2, June, 2014). Brazil's Unified Health System (SUS) and Its Treatment for Transgender People. *Psychology*. Retrieved from http://www.scirp.org/journal/psych http://dx.doi.org/10.4236/psych.2014.59121

Telesur. (11, August, 2017). Ecuador Transpeople Fight for Better Healthcare During Transition. *News, Latin America*. Retrieved from https://www.telesurtv.net/english/news/Ecuador-Transpeople-Fight-for-Better-Healthcare-During-Transition-20170811-0028.html

Lavers, K. Michael. (18, September, 2014). Peru "is not Uganda" on LGBT rights. Washington Blade. Retrieved from http://www.washingtonblade.com/2014/09/18/peru-uganda-lgbt-rights/

Health Policy Project (HPP) and Futures Group. (30, September, 2015). Transforming Care: Tools to understand and meet the health needs of transgender people in Latin America and the Caribbean. Retrieved from https://www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubId=778

Transgender Law Center (TLC) & Cornell University Law School LGBT Clinic. (2016). Report on Human Rights Conditions of Transgender Women in México. Retrieved from https://transgenderlawcenter.org/wp-content/uploads/2016/05/CountryConditionsReport-FINAL.pdf

World Bank. (2018). Seguro Popular: Health Coverage for all in Mexico. Projects & Operations. Retrieved from http://www.worldbank.org/en/results/2015/02/26/health-coverage-for-all-in-mexico

México: Ley publicada en la Gaceta Oficial del Distrito Federal [Mexico],17 September 2009. H. Asamblea Legislativa del Distrito Federal, IV Legislatura. Retrieved from http://www.paot.org.mx/centro/leyes/df/pdf/LEYES_AMBIENTALES_DF_PDF/LEY_SALUD_17_08_2012.pdf

México: Ley de 2010 de Refugiados y Protección Complementaria [Mexico], 28 January 2011, Retrieved from http://www.refworld.org/docid/4d4293eb2.html

Clinica Especializada Condesa (CEC). (2013). Distrito Federal. Estadisticas. Descargue el *Informe Epidemiológico del VIH/SIDA en la Ciudad de México, 2013*. Retrieved from http://www.condesadf.mx/distrito-federal.htm

México Transgender Center (MTC). (2016). Your Body Your Decision. Retrieved http://www.mexicotransgendercenter.com/Default.aspx

Mendoza, Gardenia. (17, June, 2017). Así se preparan en México para una cirugía de cambio de sexo. *La Opinion*. Retrieved from https://laopinion.com/2017/06/07/asi-se-preparan-en-mexico-para-una-cirugia-de-cambio-de-sexo/

Duron, Luis. (2017). Cirugía transexual: Ángel con esencia de Ángela. *Zocalo, Ruta Libre*. Retrieved from http://www.zocalo.com.mx/new_site/articulo/cirugia-transexual-angel-con-esencia-de-angela-1460991142

El Big Data (EBD). (5, February, 2015). Cambio de sexo, una cirugía de alto riesgo. *El Big Data*. Retrieved from https://elbigdata.mx/diversidad/cambio-de-sexo-una-cirugia-de-alto-riesgo/

International HIV/AIDS Alliance (Alliance). (2012). Impunity and violence against transgender women human rights defenders in Latin America. Retrieved from https://www.aidsalliance.org/assets/000/000/405/90623-Impunity-and-violence-against-transgender-women-human-rights-defenders-in-Latin-America_original.pdf?1405586435

Gillette, Hope. (3, April, 2013). Violence Against Transgender Women In Latin America Thwarts HIV Efforts. Latino Voices, Huffington Post. Retrieved from https://www.huffingtonpost.com/2013/03/04/transphobia-latin-america-thwarts-hiv-efforts_n_2805976.html

Transgender Europe (TGEU) and Liminalis. (April 2009). Trans Murder Monitoring (TMM). Transrespect vs Transphobia (TvT). Retrieved from https://tgeu.org/tmm/

Transgender Europe (TGEU). (20, November, 2017). Trans Day of Remembrance (TDoR) 2017, Press Release. *The Vicious Circle of Violence: Trans and Gender-Diverse People, Migration, and Sex Work*. Retrieved from http://transrespect.org/en/tmm-update-trans-day-remembrance-2017/

EFE. (18, May, 2017). More than 200 members of LGBT community killed in Mexico over three-year period. *Al Dia, Politics*. Retrieved from http://aldianews.com/articles/politics/more-200-members-lgbt-community-killed-mexico-over-three-year-period/48171

Infante, Cesar & Sosa-Rubí, Sandra & Cuadra, Silvia. (2009). Sex Work in Mexico: Vulnerability of Male, Travesti, Transgender and Transsexual Sex Workers. Culture, Health and Sexuality. 11. 125-137. 10.1080/13691050802431314

Centro Nacional para la Prevención y Control del VIH y el sida (CENSIDA). (23, March, 2018). Boletin Mundial del sida, Mexico 2017. Retreived from https://www.gob.mx/censida/articulos/convocatoria-publica-2018-para-la-implementacion-estrategias-de-prevencion-focalizada-del-vih-y-otras-its-149338?idiom=es

Perez-Salgado, Maria et al. (10, December, 2014). Satisfaction with healthcare services and adherence to antiretroviral therapy among patients with HIV attending two public institutions. Revista de investigacion clinica. 2015; 67:80-8. Retrieved from http://www.medigraphic.com/pdfs/revinvcli/nn-2015/nn152b.pdf

Pinedo et al. (1, January, 2017). An exploratory study of internal migration and substance use among an indigenous community in Southern México. *Fam Community Health*. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/26605952

Meltzer, Josh. (2010). Internal Migration. *University of Miami.* Thesis. Retrieved from http://www.joshmeltzer.com/migration/migration_small/site_english_small.html

Cohen H. Jeffrey and Ramirez Rios, Bernardo. (27, November, 2016). Mexicans are migrating, just not across the US border. *The Conversation*. Retrieved from http://theconversation.com/mexicans-are-migrating-just-not-across-the-us-border-68959

Lastra et al. (2000). Internal Migration in México in the year 2000. Retrieved from http://eprints.uanl.mx/8781/1/Internal%20Migration%20in%20Mexico%20in%20the%20year%202000.pdf

Graizbord B, and Mina A. (1994). The geographic scope of migration in México City. *Estud Demogr Ubranos Col Mex.* Retrieved from https://www-ncbi-nlm-nih-gov.proxy.library.emory.edu/pubmed/12291775

McLeroy, Kenneth et al. (1, December 1988). An Ecological Perspective on Health Promotion Programs. SAGE Publications. Volume 15 issue 4: 351-377. Retrieved from http://journals.sagepub.com/doi/abs/10.1177/109019818801500401#articleCitationDownloadContainer

Stokols, D. (January 1992). Establishing and maintaining healthy environments. Toward a social ecology of health promotion. American Psychology. 47: (1) 6-22. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/1539925

Crenshaw, Kimberle (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. University of Chicago Legal Forum: Vol. 1989, Article 8. Retrieved from https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Utt, Jamie. (2017, April 24). "We're all just different!" How Intersectionality is Being Colonized by White People. Thinking Race Blog. Retrieved from https://thinkingraceblog.wordpress.com/2017/04/24/were-all-just-different-how-intersectionality-is-being-colonized-by-white-people/