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Examining the effects of transphobic discrimination and race on HIV risk among transwomen in San Francisco

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Abstract

Transwomen, in particular transwomen of color (TWOC), are among the most vulnerable populations at risk for HIV. This secondary analysis is organized using a gender minority stress framework to examine the effects of transphobic discrimination and race on HIV risk factors. We describe the sample of 149 HIV– adult transwomen in San Francisco and use binary logistic regression to examine the relationship between levels of transphobic discrimination and TWOC status on binge drinking and condomless receptive anal intercourse (CRAI), controlling for potential confounders. Those with high levels of transphobic discrimination had 3.59 fold greater odds of engaging in binge drinking compared to those who reported a low level of transphobic discrimination (95% CI, 1.284–10.034; $P=0.015$). TWOC had nearly 3 fold greater odds of CRAI compared to white transwomen (95% CI, 1.048–8.464; $P=0.040$). We discuss implications for gender minority stress research and future interventions for this population.

Keywords

Transgender; transwomen; alcohol use; HIV/AIDS; LGBT health

INTRODUCTION

In an unprecedented time for transgender visibility, transwomen are among the most vulnerable populations at risk for HIV and other negative health outcomes (1–4). Studies found that one in five young transwomen were infected with HIV before 25 years of age (4, 5). These rates presage the high HIV prevalence found in adult transwomen – more than one-third in San Francisco (1, 6, 7). While HIV is an important trans health issue (1, 4–7),

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Ethical approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

research has found HIV to disproportionately impact transwomen of color (TWOC) (6). TWOC face poorer access to structural determinants of health such as housing, education and residential stability due to their multiple minority status as a gender and racial minority (8).

Minority stress frameworks have provided a theoretical platform for investigating the impact of stigmatization and chronic stress that minorities, in particular sexual minorities, experience within the context of living in a heterosexist society (9, 10). Research on minority stress has furthered our understanding of the consequences of discrimination, or enacted stigma, on mental health in particular (11). The minority stress framework posits that sexual minorities are exposed to excess stress related to a variety of stigma-related experiences (10). These stigma experiences may include prejudice-related events such as being physically attacked or denied housing, everyday discrimination, self-devaluation and the anticipation of discrimination related to the internalization of heteronormativity and heterosexism (10). Minority stress researchers have gone on to argue that multiple minority statuses, for example minority sexuality and racial identity, exacerbate discrimination and stress and its deleterious effect on health (11).

Transwomen face stigma and systemic oppression directed toward transgender people, known as transphobia. Transphobic discrimination produces gender minority stress and has led to unequal access to education, employment, and subsequently to health disparities. A three-year prospective study in New York City found that transphobic discrimination, in the form of psychological and physical abuse and major depression were endemic among transwomen (12). The National Transgender Discrimination Study (NTDS) found that 47% of transwomen who have ever been incarcerated were victimized while being incarcerated (13). Another analysis of the NTDS found that gender non-conformity, a visible marker of trans identity, was associated with a greater likelihood of experiencing transphobic discrimination (14). Miller and Grollman (2015) found that compared to gender conforming trans people, gender non-conforming trans people faced more discrimination and are more likely to engage in negative health behaviors, specifically attempted suicide, drug and alcohol abuse and smoking (14). A study based on a national sample of trans adults and their non-trans, or cisgender (or cis), siblings found that though trans siblings were more educated than their cis siblings, trans siblings earned lower incomes and were more likely to experience discrimination (15). A study in Colorado found that trans people experienced greater lifetime intimate partner violence compared to their cis sexual minority counterparts (16). Meanwhile, while gender affirmation theories have posited that the need for gender affirmation reinforces sexual risk trajectories, leading to increased HIV risk (17), very few studies have quantitatively assessed the link between transphobic discrimination and HIV risk behavior. One study in San Francisco among young transwomen aged 16–24 found that transphobic discrimination was independently associated with increased odds of drug use, drug use concurrent with sex and concurrent use of multiple drugs (18).

While many scientific knowledge gaps in trans health remain, MacCarthy et al. (2015) advocate for the application and development of theoretical frameworks that address social determinants of health, social stress and intersecting minority statuses (19). This study is organized using a gender minority stress framework to examine the effects of transphobic

discrimination on two risk factors for HIV infection, specifically binge drinking (20–24) and condomless receptive anal intercourse (CRAI) (25, 26).

METHODS

Institutional Review Board Review

All study procedures were approved by the IRB at the University of California, San Francisco. Written informed consent was obtained from all participants.

Eligibility and Procedures

Sampling for the TEACH2 (Transwomen Empowered to Advance Community Health) Study, a cross sectional HIV risk behavior survey among transwomen in San Francisco, was conducted from August to December 2013. Participants were recruited using Respondent-Driven Sampling (RDS), a peer referral sampling method used to recruit members of hard to reach populations (27, 28). In order to begin recruitment, 12 seeds who broadly represented the racial and socio-economic status of the transwomen population in San Francisco were selected. Participants who completed the survey and were eligible to recruit others were given 3–5 referral coupons, which were used to recruit others from their social networks. Eligibility criteria included the following: self-identify as a transwoman, be 18 years old or older, be able to provide informed consent, speak English or Spanish, and live in San Francisco.

250 transwomen were screened for eligibility, 233 were eligible and 233 completed the survey. The final sample of 149 for the current analysis excludes HIV+ participants in order to assess risk for HIV acquisition. Verbal consent was obtained before beginning the survey. The TEACH2 survey was designed in QDS 2.6 (Nova Research) and administered by interviewers using hand held tablet computers. INSTI HIV-1 Antibody Tests were conducted following interviews. Participants who completed the survey and consented to HIV testing were given \$50, and \$10 was given for each coupon that recruited an eligible participant.

Independent Variables

Demographics—Age, race/ethnicity, education, monthly income and health insurance status were reported. Nativity, or being born in the United States, was also reported. We constructed TWOC status by categorizing non-white race as TWOC.

Discrimination and gender minority stress events—Transphobic discrimination was measured by seven gender minority stress events. Distal gender minority stressors included the following dichotomous measures: (1) Have you ever been fired from a job because of your gender identity or presentation?; (2) Have you ever experienced trouble getting a job because of your gender identity or presentation?; (3) Have you ever been denied housing or been evicted because of your gender identity or presentation?; and (4) Have you ever experienced problems getting health or medical services because of your gender identity or presentation? Proximal gender minority stressors included the following dichotomous measures: (1) Have you ever been “clocked” or had your gender identity questioned?; (2) Have you ever been verbally abused or harassed because of your gender

identity or presentation?; and (3) Have you ever been physically abused or harassed because of your gender identity or presentation? These seven gender minority stress events were summed and cut points were made at tertiles to create categories – low, moderate and high levels – of transphobic discrimination.

Dependent Variables

HIV Risk—We assessed HIV risk by measuring the occurrence of any condomless receptive anal intercourse (CRAI) and binge drinking in the last six months. CRAI was measured as a dichotomous outcome indicating if participants reported any CRAI with the last six sexual partners during the last six months. Binge drinking was measured as a dichotomous outcome indicating if participants reported any or no occasion of consuming 5 or more drinks in one episode during the past six months (29).

Analysis

We used univariate and bivariate analyses to determine differences in demographic characteristics, gender minority stress events, binge drinking and CRAI between white transwomen and TWOC. We used logistic regression models to examine the relationship between levels of transphobic discrimination and binge drinking and CRAI, controlling for potential confounders such as age, race/ethnicity and socioeconomic status. Regression models were constructed for each outcome. Stepwise models were built to consider the effects of demographic variables and TWOC status on levels of transphobic discrimination in the model.

RESULTS

Differences in demographics, gender minority stress events, binge alcohol use and CRAI stratified by transwomen of color status are described in Table 1. Of the sample of 149 transwomen, 38 were white and 111 were TWOC. Compared to TWOC, white transwomen were more likely to be 50 years or older ($\chi^2=8.003$, $P=0.046$), have more than a high school education ($\chi^2=6.821$, $P=0.009$), be born in the United States ($\chi^2=10.225$, $P=0.001$), and be insured ($\chi^2=4.439$, $P=0.035$). Compared to TWOC, greater proportions of white transwomen reported ever been denied housing (47.4% vs. 26.1%, $\chi^2=5.5916$, $P=0.015$), and ever having problems with medical care due to their gender identity (44.7% vs. 26.1%, $\chi^2=4.594$, $P=0.032$). Greater proportions of white transwomen reported ever been clocked or had their gender identity questioned (94.74% vs. 83.2%, $\chi^2=4.786$, $P=0.029$), and ever being physically abused due to their gender identity (81.6% vs. 63.1%, $\chi^2=4.444$, $P=0.035$). A greater proportion of TWOC reported any CRAI in the past six months (41.4% vs. 18.4%, $\chi^2=6.546$, $P=0.011$), compared to their white counterparts. About one-third of both white and TWOC engaged in binge drinking, with no significant differences between the two groups.

The results of the multivariable analyses are summarized in Table 2. Transwomen who reported high levels of transphobic discrimination had more than three and a half fold greater odds of engaging in binge drinking in the past six months compared to those who reported a low level of transphobic discrimination [AOR, 3.590 (95% CI, 1.284–10.034; $P=$

0.015)], independent of TWOC status, age, education, nativity, and insurance status. Whereas, TWOC had nearly 3 fold greater odds of CRAI in the last six months compared to white transwomen, controlling for levels of discrimination, age, education, nativity, and insurance status [AOR, 2.979 (95% CI, 1.048–8.464; $P = 0.040$)]. There were no differences in the odds of CRAI based on level of transphobic discrimination.

DISCUSSION

This study found that a high level of transphobic discrimination was associated with recent binge drinking. This is consistent with other research that found that transphobic discrimination was associated with substance use (30). Transphobic discrimination has been linked to increased risk for smoking (31, 32), as well as unsuccessful cessation attempts and never attempting cessation (32). In a study among young transwomen, those who experienced transphobic discrimination had increased odds of drug use, drug use concurrent with sex and use of multiple drugs (18). In models regressing on CRAI, this study suggests race to be a significant predictor while transphobic discrimination was not significant. These findings suggest that while transphobic discrimination and race may indeed have independent deleterious effects on trans health, their impact is not even across all HIV risk behaviors.

This study also contributes to the application of minority stress frameworks among gender minority populations. At the bivariate level, greater proportions of white transwomen compared to transwomen of color experienced transphobic discrimination events that were significantly higher across 4 out of the 7 gender minority stress events measured. A minority stress framework argues that multiple minority statuses – and in this case, identifying as a gender and a racial minority – may exacerbate the effects of discrimination on health. As a result, we initially hypothesized that a greater proportion of transwomen of color would report more transphobic discrimination. However, instead, White transwomen reported greater transphobic discrimination.

This study is not without limitations. First, as with all cross-sectional studies, we cannot determine what behaviors are most likely causing HIV infection in this population. Second, data collection was interviewer administered. Due to the sensitive nature of topics, there is potential for social desirability bias. Future studies using a computer administered survey instrument (CASI) might address this source of bias. We did not assess other measures of substance use in this specific study. Additionally, how we operationalized transphobic discrimination was a crude approach to measuring lifetime exposure of a specific discrimination event and a distal proxy for gender minority stress. At present there are no valid or reliable instruments to assess gender minority stress. Future work in measurement of acute, chronic and everyday gender minority stress is needed. This study did not measure racial discrimination. While transwomen of color did not report higher levels of transphobic discrimination, it is likely that they experienced higher levels of racial discrimination. We are unable to assess the impact of racial discrimination in conjunction with transphobic discrimination on HIV risk behaviors.

CONCLUSIONS

Despite these limitations, this study offers important findings that may inform future directions for the development of trans-specific HIV prevention interventions. While interventions aimed at eliminating transphobic discrimination may negate binge drinking episodes, they may have a limited impact on CRAI. Conversely, interventions informed by racial equity and social justice to specifically target transwomen of color may be effective in preventing URAI.

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Demographics, gender minority stress events, binge alcohol use and condomless receptive anal intercourse stratified by transwomen of color status in San Francisco, 2013.

Table 1

	All (N=149)	Whites (n=38)	TWOC (n=111)	χ^2	P
Age					
18–29	24 (16.1)	5 (13.2)	19 (17.1)		
30–39	27 (18.1)	3 (7.9)	24 (21.6)	8.003	0.046
40–49	49 (32.9)	11 (28.9)	38 (34.2)		
50+	49 (32.9)	19 (50.0)	30 (27.0)		
Race					
White	38 (25.5)	38 (100.0)	0 (0.0)		
Latina	50 (33.6)	0 (0.0)	50 (45.0)	149.00	0.0001
Black	34 (22.8)	0 (0.0)	34 (30.6)		
Other	27 (18.1)	0 (0.0)	27 (25.4)		
Education					
High school or less	82 (55.0)	14 (36.8)	68 (61.3)	6.821	0.009
More than high school	67 (45.0)	24 (63.2)	43 (38.7)		
Nativity					
US born	118 (79.2)	37 (97.4)	81 (73.0)	10.225	0.001
Monthly Income					
0–417	28 (18.8)	5 (13.2)	23 (20.7)		
418–833	24 (16.1)	6 (15.8)	18 (16.2)		
834–1250	57 (38.3)	14 (36.8)	43 (38.7)	2.807	0.744
1251–1667	10 (6.7)	4 (10.5)	6 (5.4)		
1668+	29 (19.5)	9 (23.7)	20 (18.0)		
Missing	1 (0.7)	0 (0.0)	1 (0.9)		
Health Insurance Status					
Insured	125 (83.9)	36 (94.7)	89 (80.2)	4.439	0.035
Ever been fired from a job due to GID					
Yes	47 (31.5)	14 (36.8)	33 (29.7)	0.663	0.415
Ever had trouble getting a job due to GID					

	All (N=149)	Whites (n=38)	TWOC (n=111)	χ^2	P
Yes	82 (55.0)	22 (57.9)	60 (54.1)	0.169	0.681
Ever been denied housing due to GID					
Yes	47 (31.5)	18 (47.4)	29 (26.1)	5.916	0.015
Ever had problems with medical care due to GID					
Yes	46 (30.9)	17 (44.7)	29 (26.1)	4.594	0.032
Ever been "clocked" or had GID questioned					
Yes	125 (83.9)	36 (94.7)	89 (83.2)	4.786	0.029
Ever been verbally abused due to GID					
Yes	128 (85.9)	36 (94.7)	92 (82.9)	3.285	0.070
Ever been physically abused due to GID					
Yes	101 (67.8)	31 (81.6)	70 (63.1)	4.444	0.035
Any binge drinking (last 6 months)					
Yes	49 (32.9)	11 (28.9)	38 (34.2)	0.359	0.549
Any CRAI (last 6 months)					
Yes	53 (35.6)	7 (18.4)	46 (41.4)	6.546	0.011

Binary logistic regression analyses: Binge drinking and condomless receptive anal intercourse among transwomen in San Francisco, 2013.

Table 2

	Binge Drinking (last 6 months)			CRAI (last 6 months)		
	OR	95% CI	P	OR	95% CI	P
Levels of Transphobic Discrimination						
Low	REF			REF		
Moderate	2.732	(0.987, 7.559)	0.053	1.414	(0.533, 3.755)	0.487
High	3.590	(1.284, 10.034)	0.015	2.057	(0.771, 5.489)	0.150
Transwomen of Color Status						
No	REF			REF		
Yes	1.325	(0.517, 3.398)	0.558	2.979	(1.048, 8.464)	0.040
Age						
18–29	2.186	(0.710, 6.728)	0.173	1.040	(0.309, 3.503)	0.949
30–39	1.254	(0.413, 3.803)	0.690	6.368	(2.043, 19.852)	0.001
40–49	1.73	(0.686, 4.363)	0.246	2.172	(0.832, 5.673)	0.113
50+	REF			REF		
Education						
HS or less	0.571	(0.272, 1.200)	0.139	0.623	(0.289, 1.343)	0.227
More than HS	REF			REF		
Nativity						
US Born	REF			REF		
Foreign Born	1.048	(0.392, 2.806)	0.925	0.454	(0.158, 1.303)	0.142
Insurance Status						
Uninsured	0.621	(0.217, 1.773)	0.373	1.537	(0.563, 4.200)	0.402
Insured	REF			REF		