Adapting a multi-level intervention to promote HIV care and promote wellbeing for transgender sex workers in the Dominican Republic

Barrington, Clare
Davis, Dirk
Perez, Martha
Gomez, Hoisex
Donastorg, Yeycy
Kerrigan, Deanna

1. Gillings School of Global Public Health, Department of Health Behavior, Chapel Hill, USA, cbarring@email.unc.edu
2. Instituto Dermatológico y Cirugía de Piel Dr. Huberto Bogart Díaz, Unidad de Vacuna e Investigación, Santo Domingo, Dominican Republic
3. American University, Department of Sociology, Washington DC, USA

Abstract:
Introduction: Transgender women are disproportionately affected by HIV and experience many intersecting forms of stigma and discrimination. To address the multi-level factors that affect transgender women’s experiences with HIV care, there is a need for holistic, stigma-free services. Objectives: We adapted the Abriendo Puertas (AP) multi-level intervention for female sex workers living with HIV for transgender sex workers in Santo Domingo, Dominican Republic. AP includes: individual counseling, navigation, provider capacity-building and community mobilization. Methods: We first consulted with transgender women about their needs and assets with regard to HIV care and treatment. We then adapted the content of the AP individual counseling component. We used a mixed-methods approach to assess experiences of 30 trans women in the pilot including structured surveys and qualitative in-depth interviews. Results: Among the 30 women who enrolled, 26 participated in all 6 individual counseling sessions with high levels of satisfaction. The sexual health session required substantial revision to address experiences related to participants’ biological sex and the consequences of hormone use and transition processes. With the navigation component, participants requested having navigators who were peers in terms of sex work and HIV but not transgender women as they were perceived to be vulnerable to the same stigma and discrimination. Conclusions: The adapted AP intervention was acceptable to trans women living with HIV. Due to lack of trust and limited cohesion, community mobilization activities are still nascent but will be critical to sustainability and addressing structural factors such as discrimination, lack of employment, and poverty.

Key words: transgender, HIV, Dominican Republic, adaptation, navigation, multi-level intervention
I. INTRODUCCIÓN

HIV Disparities among Transgender Women

Transgender women across the globe experience dramatic HIV disparities. One historical limitation of much HIV surveillance data and research has been the classification of transgender women as a subgroup of the epidemiological category of ‘men who have sex with men’ (MSM), which leads to a lack of specificity and precision in the knowledge about distinct populations (1, 2, 3, 4). Increasingly, data are being collected with greater attention to the fluidity of identities related to both sexual orientation and gender. Despite the messiness of categories and potential bias in sampling transgender women for surveillance (1, 5), compelling empirical data exist documenting a substantial and disproportionate HIV burden among transgender women across the globe. Baral et al. (1 2013) conducted a meta-analysis documenting a global HIV prevalence of 19% among transgender women. Additionally, these authors found that transgender women in low and middle income countries have 50 times the risk of HIV infection as compared to non-transgender adults of reproductive age. In the Latin American and Caribbean region, HIV prevalence among transgender women is estimated to be 17.7% (6). There is a small but growing literature suggesting that transgender women living with HIV also experience sub-optimal care and treatment outcomes compared to other populations (7, 8, 9, 10). Individual behaviors alone cannot explain the HIV prevention, care and treatment disparities experienced by transgender women nor can individually-focused behavioral interventions fully address these disparities, which are the products of broader social and structural forces.

Theoretical Frameworks for Understanding HIV Disparities among Transgender Women

The anthropological concept of syndemics has been used to frame and measure HIV vulnerability among transgender women (11, 12). Singer refers to a syndemic as, ‘a set of enmeshed and mutually enhancing health problems that, working together in a context of deleterious social and physical conditions that increase vulnerability, significantly affect the overall disease status of a population’ (13). A critical component of Singer’s definition that is relevant for understanding HIV vulnerability among transgender women is the recognition of the ‘context of deleterious social and physical conditions’. Multiple, overlapping health problems do not occur in isolation but rather are the products of the context and conditions in which people live (12). Of note, the concept of syndemics has been applied to both the health outcomes as well as the determinants that drive those outcomes. In the application of the concept of syndemics to transgender health, overlapping health problems such as HIV, mental health, substance use, and violence are directly connected to overlapping social and structural determinants such as stigma and discrimination, poverty, and social exclusion (3,5,11,12). Embedded within both applications of the concept is recognition and appreciation that any attempt to address syndemics – whether outcomes or determinants – requires research and intervention at multiple levels.

Brennan et al. (2012) created a syndemic index for young transgender women in two cities in the US based on four factors including: self-esteem; polysubstance use; victimization; and intimate partner violence. These authors report an additive relationship between the syndemic index and both HIV infection and unprotected sex whereby the associations become stronger with the addition of each factor. In a recent study in India, Chakrapani et al. (2017) (14) also used an additive measure of three syndemic psychosocial factors including alcohol use, depression and victimization. They found that over half of their sample (55%, n=300) experienced 2 or 3 of these factors and, like Brennan, that the factors were additively associated with sexual risk behaviors. One critique of these additive measures is that they do
not capture the synergistic interactions of the determinants, which has been interpreted as the intention of syndemic theory (15, 16). There is also still limited understanding of the processes that create such extremely heightened HIV vulnerability within this population.

Highlighting current gaps in the understanding of the synergistic determinants of health disparities, including HIV, among transgender women, Reisner and colleagues (5) state:

For transgender people, health inequities are hypothesized to arise from systematic exposure to multiple, intersecting social stressors, including legal and other structural factors that are a result of being part of a socially marginalized group. Social and economic exclusion are therefore conceptualised as causal pathways to adverse health—however, we found very few studies actually linking these social stressors to health indicators. (Reisner et al. 2016: 17)

In response to these intersecting social stressors, we adapted a multi-level intervention for female sex workers living (FSW) with HIV called Abriendo Puertas (AP). Starting in 2012, we developed AP through an intervention research process to improve HIV outcomes among a cohort of 250 female sex workers living with HIV in Santo Domingo (17). The AP intervention includes: individual health education and counseling, peer navigation and partner referral, provider sensitization, and community mobilization. In the initial evaluation of AP, we found the intervention to be highly acceptable with 90% retention over 10 months (18). We also found high levels of intervention exposure, reflecting salience of the intervention content in the lives of FSW living with HIV. With regard to outcomes, we found significant improvements in treatment adherence (72% to 89%, p<0.001) and protected sex (71% to 81%, p<0.002). Across analyses, substance use and violence were identified as key determinants of HIV care and treatment outcomes.

Based on the initial experience with AP, in addition to scaling up the intervention with FSW we also adapted the model for transgender women sex workers. The purpose of this paper is to describe that adaptation process and initial outcome among a small cohort of transgender women sex workers living with HIV (n=30).

II. METHOD

We describe three key of the adaptation and evaluation including:

1) Participatory formative assessment:
The first phase of the adaptation was a participatory formative assessment where we consulted with key informants, leaders from the transgender community, and transgender women sex workers to identify key themes to address in the intervention and the most effective strategies. We facilitated 2 workshops with transgender women to present and collaboratively review findings from the formative assessment. We also conducted a secondary analysis of existing interview data from previous research to improve understanding of the experiences of transgender women in Santo Domingo.

2) In-depth review of individual counseling sessions:
Following the assessment, we conducted an in-depth review of the content of the 6 individual counseling and health education sessions. We iteratively piloted each session and made revisions
as needed. These sessions were presented to a local transgender group, COTRAVED, for review and approval.

3) Qualitative assessment of the intervention experience:
We conducted qualitative in-depth interviews to explore the experience of participants and inform future iterations of the adaptation process.

III. RESULTS

A. Key findings for the adaptation

Individual Counseling
Each session was revised based on the formative assessment. Self-esteem was a major cross-cutting theme that was emphasized across sessions. The most substantial revision was to session 5, which is focused on sexual and reproductive health, and was revised to address the following content:

- Prostate cancer
- Options for artificial insemination and adoption
- Andropause
- Sex re-assignment surgery
- Implants
- Use and abuse of hormones
- Injecting practices

Another focus area that was added to the adapted model was attention to the medication practices of transgender women to provide accurate information and guidance to avoid negative outcomes related to unsafe injections and misuse of medications and hormones. Information on the effects of hormone use on erections was also added in response to participant interest. Other topics integrated into the counseling and health education included healthy nutrition, support and referrals for substance use and alcohol, and general information on HIV and other STI, which was found to be lacking.

In the qualitative interviews, participants identified the close and trusted relationship with their counselor as a strength of the AP intervention. They appreciated being treated warmly and with respect, which greatly contrasted their daily experiences in their communities. They also appreciated the relaxation exercises as a way to cope with stress. As one participant commented about her counselor,

She’s so warm and loving. She tries to explain things to you so that you understand it, she makes you feel good and really improves your self-esteem and I absolutely love the sessions with her.

Participants suggested added additional sessions focused on relationships with family, more attention to substance use and how to manage stigma and discrimination.

Peer Navigation
Due to tensions and lack of cohesion within the transgender community, participants expressed a desire to have navigators who were female sex workers and/or people living with HIV, but not transgender women. Their concern was that transgender women navigators would experience the same stigma and
discrimination, which would limit their ability to provide support and advocacy, two key functions of a navigator. As one participant explained,

“The trans community does not work with peers, they destroy each other.”

This finding went against the assumption that transgender women would prefer to have navigators from their same community and reflects the importance of consulting with target populations in the design of interventions. Participants have a strong need for support on how to manage the daily intersecting forms of stigma and discrimination to which they are exposed.

While participants were pleased with their navigators overall, they expressed a desire for more contact and more support from them moving forward.

[I want] them [navigators] to follow-up more with people that they recruited, to give them more support, to call them more, to know more about the project, and to find better ways to find us and take us to the events, because it’s not just taking us and leaving us there, it’s giving more support, that would feel better.

Casas abiertas (open houses)

The content of the casas abiertas was tailored to the interests of transgender women. There was emphasis placed on creating a safe space in the open houses and working to improve trust and social cohesion. In the interviews at the end of the intervention, participants commented on how they appreciated the opportunity to spend time with other transgender women in a safe space, as one participant explained,

Wow, coming here, with the way that they treat me... because it’s the first time in my life that I go to a Dominican center and that they treat us with such love and sweetness, they’re so peaceful, this love that they show to us, this is what has had the biggest impact on me, in the Casas Abiertas, in everything. I’ve never received, in the projects or the programs, no discrimination or arrogance or anything like that. To the contrary, I feel happy, and I never want to leave the event, or go back to that world outside, where there’s nothing but suffering. Here I feel happy.

They also appreciated the sessions on income-generating activities as most identified poverty as a major barrier to their retention in HIV care and general wellbeing. As recommendations, they suggested improving the notification process for open houses and also suggested doing more team building activities to further develop cohesion and support among trans women.

There was always some sort of gossip, a discord, a tyranny, you said this, she said that, there always was something like this...the talks would always begin well, but in the end there was always some sort of drama between them [trans], always.

IV. CONCLUSIONS

Overall, the adapted model was highly acceptable and the majority of participants completed all of the individual sessions and participated in open houses. Formative assessment was essential to inform the adaptation of the intervention and make it appropriate and relevant for transgender women sex workers living with HIV. Additionally, qualitative interviews with participants at the end of the interview provide critical inputs for additional expansion and implementation. Future expansion should ad-
dress the need to improve trust and cohesion with the trans community as a key factor in promoting positive HIV outcomes and general wellbeing.

V. REFERENCIAS