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Stigma and discrimination related to gender identity and vulnerability to HIV/AIDS among transgender women: a systematic review

Estigma e discriminação relacionados à identidade de gênero e à vulnerabilidade ao HIV/aids entre mulheres transgênero: revisão sistemática

Estigma y discriminación relacionados con la identidad de género y la vulnerabilidad al VIH/SIDA entre mujeres transgénero: revisión sistemática

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Abstract

HIV prevalence among transgender women is disproportional when compared to the general population in various countries. Stigma and discrimination based on gender identity have frequently been associated with vulnerability to HIV/AIDS. The objective was to conduct a systematic literature review to analyze the relationship between stigma and discrimination related to gender identity in transgender women and vulnerability to HIV/AIDS. This systematic literature review involved the stages of identification, compilation, analysis, and interpretation of results of studies found in five databases: PubMed, Scopus, Web of Science, Science Direct, and LILACS. No publication time period was determined in advance for this review. The studies were assessed according to the inclusion and exclusion criteria. The review included articles in English, Portuguese, or Spanish that related stigma and discrimination to transgender women's vulnerability to HIV. We found 41 studies, mostly qualitative, published from 2004 to 2018, and categorized in three dimensions of stigma: individual, interpersonal, and structural. The data highlighted that the effects of stigma related to gender identity, such as violence, discrimination, and transphobia, are structuring elements in transgender women's vulnerability to HIV/AIDS. The studies showed a relationship between stigma and discrimination and transgender women's vulnerability to HIV/AIDS and indicated the need for public policies to fight discrimination in society.

Social Stigma; Social Discrimination; Transgender Persons; HIV; Systematic Review

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Introduction

HIV prevalence is disproportionally high among transgender women when compared to the general population [1,2,3]. A metanalysis estimated a prevalence of 19.1% in 15 countries, which is 48.8 times higher than in the reproductive-age population in the same countries [2].

Various studies have explained this disproportionality by a range of complex individual factors: biological (i.e., unprotected anal sex) and behavioral (i.e., lack of condom use, use of psychoactive substances, etc.), together with structural factors such as stigma and discrimination, which also play an important role and can influence behaviors, practices, and attitudes in relation to HIV, limiting access to socioeconomic resources, especially education, work, and prevention services [2,3,4]. Thus, researchers, activists, and health professionals have considered stigma and discrimination two key factors associated with high HIV prevalence rates [5,6,7,8,9].

Gender performances of transgender women are seen as insubordination to the dynamics established by heteronormative society over bodies and social relations [10,11]. As a consequence, transgender women face intense stigmatization due to the expression of their gender identities in predominantly patriarchal and male chauvinist societies [3,10]. When comparing men who have sex with men (MSM) and transgender women, the latter experience more stigma and discrimination [7] and more stressful psychosocial events, revealing the existence of discrimination even within the LGBT community [12]. They also present higher HIV prevalence rates than MSM [13].

Stigma and discrimination due to gender identity are frequently related to the unfavorable social, economic, and psychological context for transgender women [14], which often relates to their involvement in commercial sex, generally as a result of the limited options for accessing the formal labor market [2,3,4,15]. Even so, the current response to the HIV/AIDS epidemic has emphasized biomedical measures to the detriment and less structural issues, which includes the role of activists that are member of the populations most affected by the epidemic [16]. The current article thus intends to conduct a systematic literature review to analyze the relationship between stigma and discrimination related to gender identity of transgender women and their vulnerability to HIV/AIDS.

Methodology

This is a systematic literature review on stigma, discrimination, and vulnerability of transgender women to HIV/AIDS, involving identification, compilation, analysis, and interpretation of the results of selected studies. The review followed the PRISMA guidelines (*Preferred Reporting Items for Systematic Reviews and Meta-Analyses*), which describe the specific requirements for systematic review studies and metanalyses [17].

Search strategies and information sources

Independent reviewers (L. M., M. P.-S.) conducted the study search in PubMed, Scopus, Web of Science, Science Direct, and LILACS, using the following combinations of keywords: "discrimination", HIV, "social stigma" or "stigma" "transgender persons" or "transgender" or "transvestite" (Supplementary Material, Table S1: http://cadernos.ensp.fiocruz.br/site/public_site/arquivo/suppl-e00112718ingles_2106.pdf). The review also examined the reference lists from the relevant studies in order to identify other potentially eligible studies.

In Brazil and Latin America in general, the terms "transvestite" and "transsexual woman" are used more frequently by the communities themselves than "transgender woman". These differences can mark political and/or subjective identities and are fluid depending on the context [18]. The terms convey different levels of performances as a woman and demand their identity's legitimacy beyond binary male-female parameters, adequacy of their physical image and bodies via hormone therapy, use of silicone, and other body modifications, and the fact that they wish to be addressed in the feminine and by the name with which they identify. Importantly, there is transit between identities, which are not fixed or isolated categories, but are always in dispute, negotiation, and constant interaction and movement [19,20,21]. This study used the term "transgender women", since most of the literature consulted in

the review was in English, and it is an umbrella term for a wide range of transfeminine identities that blur the sex-gender borders, although the term "transvestite" was also included in the search strategy.

The publications were managed in the Mendeley app (https://www.mendeley.com) to remove duplicates. Data collection lasted from October 2016 to February 2017 and was updated in June 2018. No publication period was determined in advance for the review.

Eligibility criteria

Inclusion criterion: studies that addressed the relationship between stigma and discrimination due to gender identity and vulnerability of transgender women to HIV/AIDS. There was no exclusion of any methodological approach; both qualitative and quantitative articles were included. The review included articles written in English, Portuguese, and Spanish. No articles were excluded on the basis of geographic location or time frame or for the term used to define transgender women (transvestite, transsexual woman, *aravanis*, *hijras*, *metis*, etc.).

Data extraction

Study selection began by reading the titles and abstracts, based on the inclusion criteria. The full texts of the selected articles were read. After the assessment, the studies were selected for inclusion in the review's corpus. An Excel (https://products.office.com) spreadsheet was organized with the following terms: authors, year of publication, study country, study design/methodology, number of persons in study sample, objectives, study population, and main results.

Assessment of risk of bias (quantitative studies) and methodological rigor (qualitative studies)

Next, the methodological quality was assessed according to the study's nature. Qualitative studies were assessed with the *Research Triangle Institute Item Bank* (RTI-Item Bank) scale, which evaluates risk of bias [22]. RTI-Item Bank contains 29 items to assess studies, 6 of which were applied to the studies included in this review (Supplementary Material, Box S1: http://cadernos.ensp.fiocruz.br/site/public_site/arquivo/suppl-e00112718ingles_2106.pdf): (i) inclusion and exclusion criteria clearly defined; (ii) use of valid and reliable measures to assess inclusion and exclusion criteria; (iii) standardized recruitment strategy for participants in all the groups; (iv) appropriate sample selection; (v) results assessed using valid and reliable measures, implemented consistently for all the study participants; (vi) confounders and effect modifiers considered in the design and/or data analysis [22]. Risk of bias was assessed and classified using the studies' response to the above-mentioned items and classified as follows: high risk of bias – when the study had one or more negative answers to the items; moderate risk of bias – when one or more items were classified as "partially" or "indeterminate"; low risk of bias – when all the items in the scale recorded a positive answer [22].

Assessment of qualitative studies used the instrument proposed by the *Critical Appraisal Skills Programme* (CASP), employed in the critical analysis of reports by qualitative studies. This instrument has ten questions that help the assessor think systematically on the study's rigor, credibility, and relevance, considering: (i) clear and justified objective; (ii) appropriate methodological design for the objectives; (iii) methodological procedures presented and discussed; (iv) sample selection; (v) data collection described, instruments and saturation process explained; (vi) explanation of the relationship between researcher and study subject; (vii) ethical precautions; (viii) dense and well-founded analysis; (ix) results presented and discussed, featuring the issue of credibility and use of triangulation; (x) description of the contributions and implications for the knowledge generated by the study, as well as its limitations [23]. Qualitative studies were classified in two categories: A, for studies with high methodological rigor, since they met at least 9 of the 10 items; B, for studies with moderate methodological rigor, meeting at least 5 of the 10 items [23,24].

Data analysis

The analysis was oriented according to the theoretical references for the concepts of stigma, discrimination, and vulnerability. The study adopted the concept of vulnerability applied to the field of health, specifically to the discussion on the HIV/AIDS epidemic. This concept can be understood by the analysis of three interrelated components: individual vulnerability, aimed at identifying physical, mental, or behavioral factors through risk assessment and/or other approaches; social vulnerability, analyzing the dimensions of culture, religion, morals, politics, economy, and institutional factors, which can determine the means of exposure to diseases and/or injuries; programmatic vulnerability, examining how policies, programs, and services affect persons' social and individual situations [25,26,27,28]. Vulnerability emphasizes the responsibility of government actions and public policies as an integral part of the determinants of the health/disease process [25,26]. In this article, the theoretical-conceptual understanding of this construct expanded the scope of analysis of the articles beyond the behavioral and individual risk issues, including studies that related stigma and discrimination to barriers in accessing health services.

Stigma refers to a person's profoundly depreciative attribute, which is perceived as such through social interaction. The presence of this attribute may confirm or reaffirm the "normality" of specific persons or groups. Stigma highlights a specific trait in individuals, subjecting them to the impossibility of social attention to their other attributes, assigning major discredit to them [29]. Hatzenbuehler & Link [30] recently emphasized the need for progress in the conceptualization and measurement of stigma as a social phenomenon with roots in social structures. The authors define structural stigma as conditions at the broader social and cultural levels and institutional policy norms that construct the opportunities, resources, and well-being of stigmatized individuals. The authors call attention to the intense interaction between the microsocial level, the locus of interpersonal relations, and the macrostructural level. Such structures are not unidirectional and static, but shaped by interpersonal relations and individual factors.

Discrimination can be understood as a practical result of stigma, defined by a conceptual review [31] (p. 34): stigma is a profound attribute of discredit, a *"mark"* or *"socially devalued identity"*; stigmatization is related to a social process that produces devaluation through labels and stereotypes; a label is an officially sanctioned term applied to conditions, individuals, groups, places, organizations, institutions, or other social entities, since the stereotype is related to negative attitudes and beliefs targeted to the labeled social entities; prejudice is an endorsement of negative beliefs and attitudes related to the stereotype; and discrimination involves the actions targeted to the endorsement and reinforcement of stereotypes to place the labeled persons at a disadvantage. In this article, we thus consider studies on discrimination and stigma related to the gender identity of transgender women. Since there is no consensus in the literature on this issue [32], we will use "stigma and discrimination" widely speaking throughout the article, but understanding that there are important theoretical and conceptual specificities [33].

In this analysis, we investigated the methodological issues of the studies analyzed here and established key elements that constituted thematic units [34]. This process identified 65 key elements based on a reading of the articles, which were categorized on an Excel spreadsheet based on the three thematic units in the concept of stigma according to Hatzenbuehler & Link [30] and White-Hughto et al. [14]: individual level (psychological issues such as self-stigma), interpersonal level (person-to-person discrimination), and structural level (state policies that can promote social exclusion).

Results

Characteristics of selected studies

We identified 791 articles in the databases, of which 41 were included in the review. Figure 1 shows the search strategies. The reasons for exclusion of articles were the absence of analysis on stigma, discrimination, vulnerability, and HIV (Supplementary Material, Box S2: http://cadernos.ensp.fiocruz.br/site/public_site/arquivo/suppl-e00112718ingles_2106.pdf).

Most of the articles used qualitative methods exclusively (27/41) (Table 1), there were two articles with mixed methods, and 12 exclusively quantitative studies (Table 2). All were published from 2004 to 2018. We observed an increase in publications in recent years, with a peak in 2016 (11/41). The United States published the most articles (or publications) (13/41), followed by India (5/41), Mexico (3/41), and Brazil (3/41).

Measurement of discrimination and stigma in the quantitative studies

To identify how the studies dealt with the construction of the stigma or discrimination variable, we analyzed 12 exclusively quantitative articles and two with mixed methods. Eight studies dealt with the phenomenon as "discrimination" (experience, perception, etc.) [21,35,36,37,38,39,40,41], three articles analyzed "stigma" (experience, perception, etc.) [6,7,9], one dealt with the phenomenon of "homophobia" [42], one with "transphobia" [8], and one of the mixed-methods articles did not use the quantitative method to assess discrimination and stigma [43]. Many of these studies did not provide a theoretical framework on the distinction between the concepts of stigma and discrimination.

Most of the studies (54%) showed high risk of bias [8,35,37,39,40,41], and only 31% were classified as low risk of bias [6,7,9,21]. Inadequate sample selection and assessment of the study outcome with valid criteria were the items that most contributed to bias scores in the studies analyzed here. In one study it was not possible to apply the scale of bias, since it did not present quantitative methodological elements for the assessment [43] (Figure 2) (Supplementary Material, Table S2: http://cadernos.ensp.fiocruz.br/site/public_site/arquivo/suppl-e00112718ingles_2106.pdf).

The variables related to stigma and discrimination were built on the basis of an unvalidated scale for the population of transgender women, some inspired by previous scales on racial discrimination [40], perception of stigma in MSM [6], and homophobia [8,9], while others were created on the basis of previous studies with this population, or drawing on a review of the literature [7,21,35,36,41]. A few studies used just one or two questions on perceived discrimination [37,39] and did not provide details [42]. Among the studies that used items to assess discrimination or stigma, the majority used Cronbach's alpha to estimate the questionnaire's reliability [6,8,9,40], one used the Kuder-Richardson coefficient [41], one used confirmatory factor analysis [9], one used exploratory factor analysis [7], and another employed latent class analysis [21]. Some did not perform any of these analyses [35,36,38].

Data techniques and analysis in the qualitative studies

The techniques for data production and analysis varied in the qualitative studies. Interviews (semi-structured or in-depth) were the most frequently used [44,45,46,47,48,49,50,51,52,53,54,55,56], followed by a combination of focus groups with interviews [15,57,58,59,60,61,62]. There was a predominance of thematic analysis as a qualitative data analysis technique [5,15,44,46,48,50,52,55,62,63,64,65] (Table 1).

Methodological rigor according to the CASP criteria was classified as B (moderate rigor) in four studies [52,54,65,66]. Non-rigorous data analysis, research ethics procedures not specified in the methodology, and lack of specification of interaction between researchers and participants in the field were the items that scored negatively and contributed to the moderate methodological rigor (Table 1).

Stigma, discrimination, and vulnerability to HIV

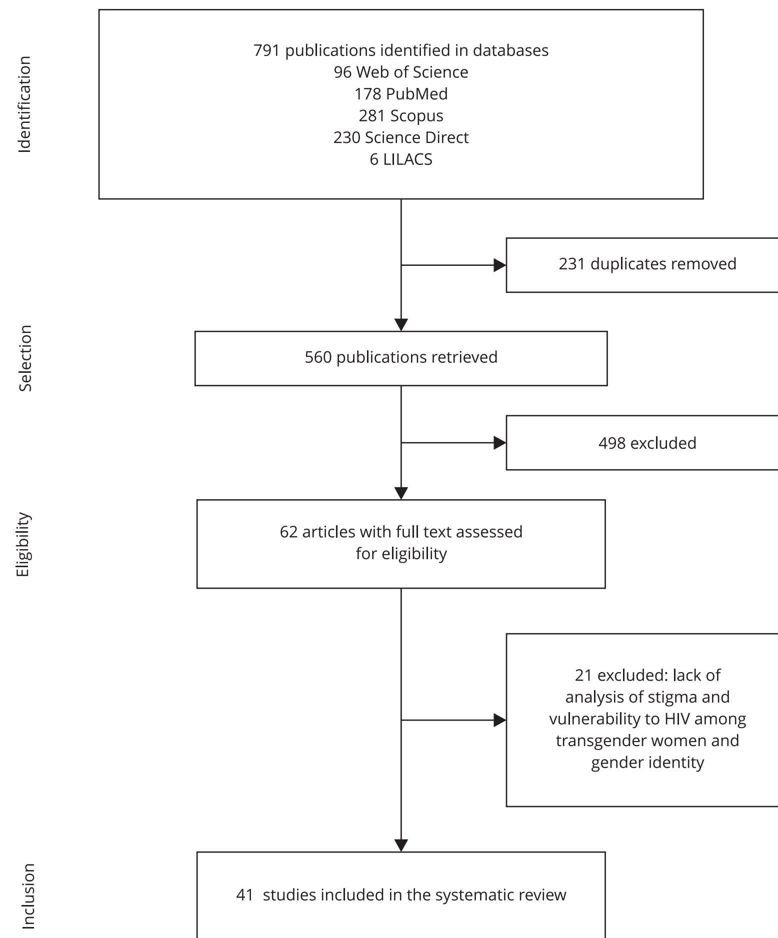
According to the review, stigma produces discrimination and violence at different levels: structural, interpersonal, and individual, which can play a role in the individual, social, and programmatic vulnerability of transgender women to HIV (Figure 3).

Structural stigma

Structural stigma promotes a totally adverse social context for transgender women through transphobia and discrimination [5,42,44,55,56,63,64]. In some countries, especially those with a strong religious tradition, transsexuality, and homosexuality are still legally criminalized, as exemplified in two studies, one in Malaysia [46] and the other in India [60]. In India, section 377 of the Indian Penal Code, known

Figure 1

Flowchart for the systematic article selection process.



as the "Sodomy Law", which criminalizes persons who have sex with non-vaginal penetration, was reinstated by the Supreme Court in 2013, but repealed in September 2018 [60,67]. In India, marriage and procreation, considered key criteria for achieving respect and heterosexual normativity, appear to justify the stigma and violence against groups that do not conform to the hegemonic gender identities [48]. In Lebanon, incarceration on grounds of gender identity or expression has also been reported [38].

Even in liberal countries (from the legal point of view) such as the United States [41,44,53,54], Mexico [51], Japan [68], and Brazil [42], transgender women still suffer discrimination in public spaces and experience difficulty in reassigning their name in keeping with their gender identity [12,54,63].

Family and social stigma was found associated with sex work [7]. It was also reported as an important barrier to access barriers to schooling [43,51,56] and formal employment [5,12,43,46,56,63], which often leaves them in a situation of socioeconomic marginalization [36,61,69] and entry into the sex work market [43,46,56].

Table 1

Characteristics of knowledge production in qualitative studies on the relationship between stigma, discrimination, and vulnerability of transgender women to HIV/AIDS, 2004-2018.

Reference (year)	Country	Study method/ design	Study scope	Objectives	Study population	Study year	CASP score
Nemoto et al. [5] (2004)	USA	Qualitative/ Focus groups	48 transgender women	Explore the social context of drug use and sexual behaviors placing transgender women at risk of HIV infection	Transgender women	1999-2000	9-A
Melendez & Pinto [44] (2007)	USA	Qualitative/In-depth interview	20 transgender women	Examine how stigma and discrimination interact with gender roles to place transgender women at risk of HIV infection	Transgender women	2003	7-A
Koken et al. [45] (2009)	USA	Qualitative/ Semi-structured interview	20 transgender women	Explore transgender women's experiences with their parents and close family members and the relationship with their gender identity	Black transgender women	2007-2008	8-A
Infante et al. [12] (2009)	Mexico	Qualitative/ Participant observation and in-depth interviews	13 transvestites, transgender women, and transsexual women sex workers	Describe the social context in which sex workers live, focusing on sexual identities, sexual practices, and vulnerability to HIV	Transvestites, transgender women, transsexual women, and MSM sex workers	2006-2007	7-A
Estrada-Montoya & García-Becerra [49] (2010)	Colombia	Qualitative/ Interview	18 transgender women	Identify representative forms of portraying and imagining sexuality in the transgender community	Transgender women	Not reported	8-A
Chakrapani et al. [57] (2011)	India	Qualitative/ Focus groups and interview	17 transgender women (*aravanis*)	Identify and understand barriers to free access to antiretrovirals and government treatment centers	Transgender women (*aravanis*) and MSM	2007	8-A
Wilson et al. [50] (2011)	Nepal	Qualitative/In-depth interview	14 transgender women (*metis*)	Explore the social context of stigma among *metis* in Nepal to better understand the risk of HIV infection	Transgender women (*metis*)	Not reported	9-A
Logie et al. [64] (2011)	Canada	Qualitative/ Focus groups	21 transgender women	Understand strategies for confronting stigma among women living with HIV	Transgender women with HIV, cis, lesbian, and bisexual women	2009-2010	7-A

(continues)

Table 1 (continued)

Reference (year)	Country	Study method/ design	Study scope	Objectives	Study population	Study year	CASP score
Beattie et al. [66] (2012)	India	Qualitative/ Focus groups	6 transgender women (*hijras*)	Understand barriers and identify solutions to improve the use of HIV services	Transgender women (*hijras*), cis women sex workers, and MSM (*kothis* and *double-deckers*)	2008	5-B
Cuadra-Hernández et al. [51] (2012)	Mexico	Qualitative/ Semi-structured interviews	26 interviews with transgender women, gays, and other key populations (not specific)	Analyze an intervention to decrease stigma	Transgender women, gays, and other key populations	2009-2010	7-A
Logie et al. [63] (2012)	Canada	Qualitative/ Focus groups	16 transgender women	Explore challenges in daily life and experience with access to HIV services among LGBT women living with HIV	Transgender women, cis, lesbians, gays, and bisexuals	2009-2010	8-A
Boyce et al. [52] (2012)	Guatemala	Qualitative/ Interview	8 transgender women	Identify barriers to access to sexual health services	Transgender women, MSM and others	Not reported	5-B
Wilson et al. [53] (2013)	USA	Qualitative/ In-depth interview	10 transgender women	Identify barriers and facilities for care and support in services for African American transgender women	African-American transgender women living with HIV	Not reported	9-A
Rhodes et al. [58] (2014)	Guatemala	Qualitative/ Focus groups and in-depth interview	20 transgender women	Explore risks for sexual health and HIV infection	Transgender women, transsexual men, gays, and bisexuals	Not reported	9-A
Sevelius et al. [62] (2015)	USA	Qualitative/ Focus groups and interview	58 transgender women	Examine the barriers and facilities for enrollment and retention in HIV services	Transgender women living with HIV	Not reported	8- A
Remien et al. [65] (2015)	USA	Qualitative/ In-depth interview	20 transgender women	Analyze barriers and facilities for enrollment in HIV care	Transgender women living with HIV	Not reported	4-A
Kaplan et al. [56] (2015)	Lebanon	Qualitative/ Semi-structured interview	10 transgender women	Investigate risk behaviors in transgender women	Transgender women	2011	6-A

(continues)

Table 1 (continued)

Reference (year)	Country	Study method/ design	Study scope	Objectives	Study population	Study year	CASP score
Palazzolo et al. [54] (2016)	USA	Qualitative/ In-depth interview	8 transgender women	Explore contextual factors that determine or mitigate vulnerability of Latina transgender women to HIV	Latina or Hispanic transgender women	2013	5-B
Di Stefano et al. [68] (2016)	Japan	Qualitative/ Ethnography with participant observation, document search, and in-depth interviews	3 transgender women	Identify how HIV intersects with other social and health problems in Japan among transgender women and MSM	Transgender women, MSM	Not reported	8-A
Pollock et al. [55] (2016)	Peru	Qualitative/ Interview	50 transgender women	Explore the construction of gender identity and the personal and social contexts of transvestites to elucidate the social context of vulnerability to HIV	Transvestites	Not reported	9-A
Woodford et al. [59] (2016)	India	Qualitative/ Focus groups and interviews with key informants	21 transgender women	Identify barriers and facilities in access to HIV testing among communities with high risk of infection	Transgender women and others	Not reported	6-A
Gibson et al. [46] (2016)	Malaysia	Qualitative/ Interview	21 transgender women	Understand how the identities of trans sex workers influence the patterns in use of health care and harm reduction behaviors	Transgender women, sex workers, and others	2013-2014	9-A
Barrington et al. [69] (2016)	Guatemala	Qualitative/ Interview	11 transgender women	Describe factors that determine the time of diagnosis, linkage to services, and experiences of persons living with HIV	Transgender women and others	Not reported	9-A
Nemoto et al. [61] (2016)	Thailand	Qualitative/ In-depth interview and focus groups	24 transgender women	Describe the sociocultural context of risk behaviors for HIV, exploring characteristics of sex work practices, social support, and role of *karma*	Transgender women	2010-2011	9-A
Ganju & Saggurti [48] (2017)	India	Qualitative/ Interview	68 transgender women	Describe experiences of stigma and violence, and explore coping strategies	Transgender women	Not reported	7-A

(continues)

Table 1 (continued)

Reference (year)	Country	Study method/ design	Study scope	Objectives	Study population	Study year	CASP score
Li et al. [60] (2017)	India	Qualitative/ In-depth interview and focus groups. Quantitative/ Cross-sectional study	11 *hijras*	Examine the experiences of victimization and harassment of MSM and *hijras* in the state of Maharashtra, especially after reinstatement of Indian Penal Code (Section 377)	MSM and *hijras*/ transgender women	2013-2014	6-A
Perez-Brumer et al. [15] (2017)	Peru	Qualitative/In-depth interview, and focus groups	48 transgender women	Assess intersections between social marginalization, multilevel stigma and vulnerability to HIV, and community resilience strategies used by transgender women to mobilize existing resources and link their communities to HIV services	Transgender women	2015	9-A

CASP: *Critical Appraisal Skills Programme*; MSM: men who have sex with men.

As for access to health services, various studies have documented that stigma and discrimination can pose serious barriers for transgender women [12,39,43,46,48,53,54,57,58,59,62,63,64,66,69,70]. Many avoid going to health services because they anticipate discrimination [59,65] and others are denied access even in public services [46,52]. Studies that analyze the use of the public health system in some countries indicate that transgender women prefer to avoid this care and pay for private services or self-medicate, due to the stigma [43,48,49]. Lack of access to hormones [12,46,54] and surgical procedures for body modification and gender reassignment [49] has also been identified in the literature as a barrier to a healthy life.

Stigma and discrimination also pose barriers to access to HIV/AIDS prevention and treatment services, such that many transgender women avoid public healthcare services due to previous experiences of discrimination and mistreatment [46]. From this perspective, many studies report the difficulties of transgender women in access to HIV testing and counseling services [46,59], lack of access to information on prevention [58,63], lack of confidentiality of HIV test results in public healthcare services [12,46], and limited access to condoms [56]. In Brazil, self-perceived discrimination was associated with resistance to HIV testing [37,61]. Even those who have already tested for HIV faced more stigma when accessing HIV testing and care services, when compared to those who had never been tested. Stigmatization can also hinder retention of transgender women in HIV treatment services [9,69].

Interpersonal stigma

The experience of transgender women has been marked by a context of violence and social exclusion in various regions of the world. Violence, both physical [9,12,38,41,43,44,45,48,49,55,56,58], verbal [12,41,43,44,45,48,55,56], symbolic [43,45,64], emotional [12], and sexual [9,36,38,41,48,50,53,54,56,63,66,68] has been extensively documented. In addition, assassinations of transgender women on publicly on the streets have been documented in the literature as the effect of stigma [43].

Exclusion and violence generally begin in the family through family rejection [12,36,38,43,45,48,49,50,55,56,57,58,61,63,65,66], physical and sexual assault by family members [55,68], and expulsion from home [45,48,56,58], so that some end up living on the streets [36,48]. Physical and sexual abuse have been reported as factors associated with HIV risk in transgender women [9].

Table 2

Characteristics of knowledge production in quantitative studies on the relationship between stigma, discrimination, and vulnerability of transgender women to HIV/AIDS, 2005-2018.

Reference (year)	Country	Study method/ design	Study scope	Objectives	Study population	Study year	Risk of bias
Bockting et al. [41] (2005)	USA	Quantitative/ Intervention study	181 transgender women	Present report on the implementation and assessment of the seminar *All Gender Health* and show data on important sexual health measures to help increase the understanding of transgender women's risk context for HIV/STIs	Transgender women	1998-2002	High
Sugano et al. [8] (2006)	USA	Quantitative/ Cross-sectional	332 black transgender women	Examine the relations between exposure to transphobia and risk of engaging in unprotected receptive anal sex	Black transgender women	Not reported	High
Sanchez et al. [6] (2010)	USA	Quantitative/ Cross-sectional	60 transgender women	Compare individual characteristics and risk behaviors among MSM and transgender women in the House Ball community in New York	Transgender women and MSM	2004	Low
Operario et al. [40] (2011)	USA	Quantitative/ Cross-sectional	174 transgender women	Identify factors associated with unprotected anal sex with primary sex partner	Transgender women	Not reported	High
Newman et al. [39] (2012)	Thailand	Quantitative/ Cross-sectional	41 transgender women	Examine and compare sexual risk behaviors and demographic data	Transgender women and MSM	Not reported	High
Martins et al. [42] (2013)	Brazil	Quantitative/ Cross-sectional	304 transvestites	Describe sociodemographic profile and risk behaviors for HIV	Transvestites	2008	Moderate
Boivin [43] (2014)	Mexico	Quantitative and Qualitative	150 transgender, transvestites, and transsexual women	Describe forms, actors, and places of discrimination and stigma suffered in various metropolitan areas in Mexico	Transgender women, transvestites, transgenders, lesbians, bisexuals, and gays	2011	NA
Kaplan et al. [38] (2016)	Lebanon	Quantitative/ Cross-sectional	53 transgender women	Measure and interpret demographic determinants, HIV prevalence, and risk behaviors	Transgender women	2012	Moderate

(continues)

Table 2 (continued)

Reference (year)	Country	Study method/ design	Study scope	Objectives	Study population	Study year	Risk of bias
Logie et al. [9] (2016)	Jamaica	Quantitative/ Cross-sectional	137 transgender women	Examine factors associated with HIV infection and HIV testing	Transgender women	2015	Low
Stahlman et al. [7] (2016)	Ivory Coast, Togo, and Burkina Faso	Quantitative/ Cross-sectional	453 transgender women	Analyze factors that influence sexual risk behaviors and HIV infection	Transgender women and MSM	2012-2015	Low
Pinheiro-Júnior et al. [37] (2016)	Brazil	Quantitative/ Cross-sectional	304 trans women	Identify risk factors associated with resistance to HIV testing	Trans women	2008	High
Rood et al. [35] (2018)	USA	Quantitative/ Cross-sectional	61 transgender women	Assess association between distal and proximal stressors and sexual risk and behaviors in HIV testing.	Transgender persons in general (men and women)	2014-2015	High
Magno et al. [21] (2018)	Brazil	Qualitative/ In-depth interviews and quantitative/ Cross-sectional	127 transvestites and transsexual women	Verify association between gender-based discrimination and unprotected receptive anal sex with stable sex partners and explore experiences of discrimination	Transvestites and transsexual women	2014-2016	Low

MSM: men who have sex with men; NA: not applicable; STI: sexually transmited infections.

Social exclusion due to stigma can cause intense geographic displacement [54] and entry into sex work [5,48,50,51,53,54,56,57,58,62,63]. Sex work in precarious conditions and receiving more money for unprotected sex have been reported in the literature as one of the reasons for unprotected anal sex [56].

These experiences also extend to other interpersonal relations over the life course of transgender women, for example, exclusion from the gay community [12,63,68], rejection by friends [63], partner violence [48,55,62], police brutality [12,43,48,55,59], and violence by neighbors [55].

The experience of gender-related discrimination has been associated with sexual risk behaviors for HIV infection in this population [35], such as unprotected receptive anal sex [8,21]. Many studies also report discrimination against transgender women by professionals in health services [15,39,43,46,48,52,53,57,58,59,62,63,64,66], who refuse to call them by their female social name [4,37,51,55,57,59,62] or to use female pronouns [15], besides leaving them to wait hours to receive care [43,52].

Individual stigma

The combination of interpersonal and structural stigma can cause various negative outcomes in the lives of transgender women, for example, social isolation [48,65] and fear of discrimination [44,52,53,57,59,62,64,66]. The expectation of rejection related to gender was associated with sexual risk behaviors for HIV infection [35].

Experiences of discrimination are reported as important elements in the internalization of stigma, which can cause a range of psychosocial stress [48], such as low self-esteem [48,56,68], and compromise mental health with the occurrence of depression [6,41,46,58,68], suicidal ideation [48,56], and attempted suicide [41,46,56].

Figure 2

Stigma and discrimination based on gender identity and individual, social, and practical vulnerability of transgender women to HIV.

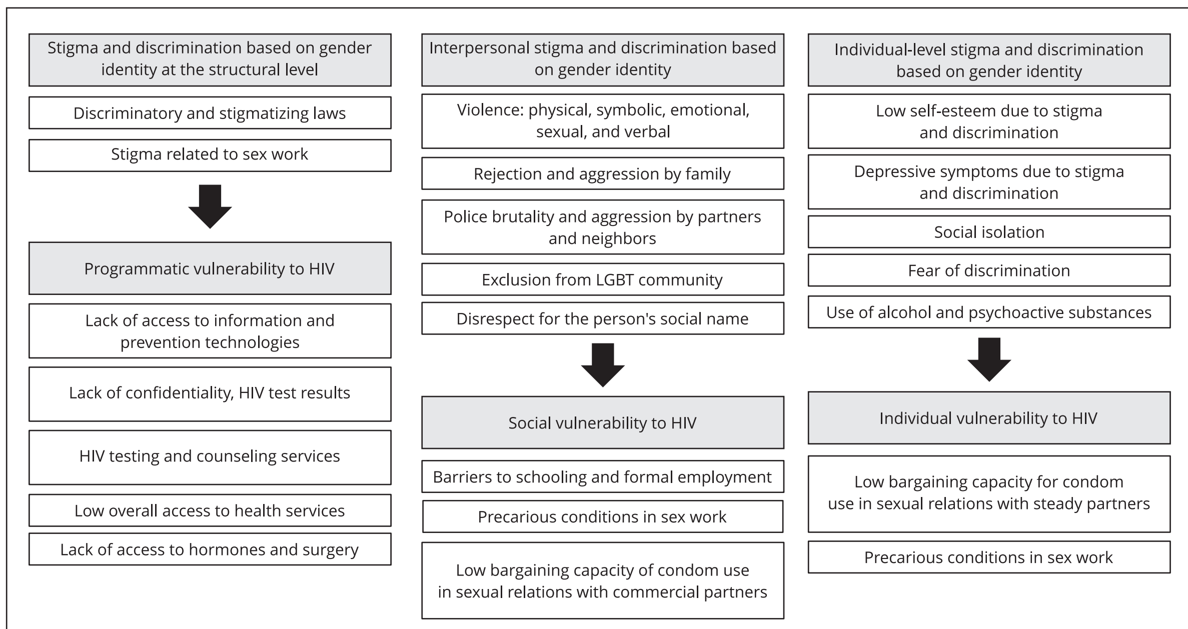
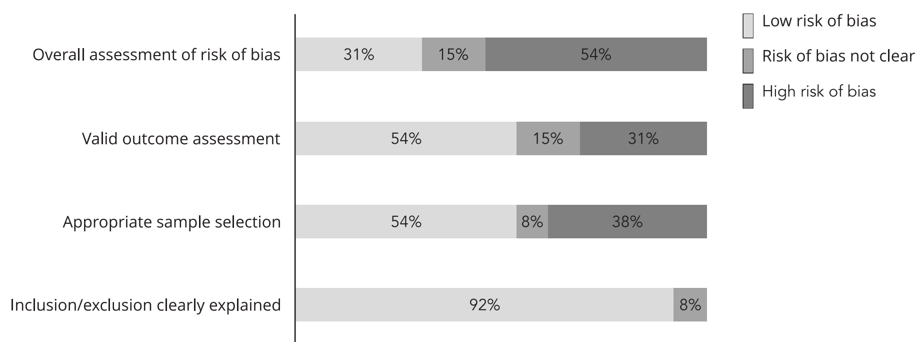


Figure 3

Summary of risk of bias in the selected quantitative studies.



Alcohol use [9,41,57,58,62,68] and use of other drugs [5,9,41,58,62] are reported in contexts in which transgender women experience high levels of discrimination, besides the use of these substances before sexual relations [9] as a practice that increases the risk of HIV infection, mainly through unprotected anal sex [6,40,46].

Stigma and discrimination are identified as factors that can directly influence vulnerability to HIV. A study showed that stigma related to transgender identity was more prevalent in transgender women living with HIV than in those without the infection [9]. The relationship between stigma, discrimination, and HIV infection can be explained by transgender women's low capacity to negotiate condom use, resulting in unprotected anal sex [5,6,12,21,48]. In addition, low self-esteem and depression, caused by intense stigmatization of transgender identities, have been reported as important factors for unprotected sex [56].

Some studies suggest that unprotected anal sex is practiced for validation of female status *vis-à-vis* the male partner [5,46], especially with steady partners such as boyfriends or husbands [21]. A qualitative study in Colombia showed that although transgender women say they use condoms in all their relations, unprotected sex means fulfillment and success in the eyes of their stable partners or husbands. In this context, the risk is even greater in stable relationships due to the "active" sexual role (insertive anal sex) played by the partner, often idealized by some transgender women in that country [49].

Discussion

Analysis of the articles highlighted that stigma due to gender identity, and discrimination, violence, and transphobia, have been identified as structuring elements of the vulnerability to HIV/AIDS among transgender women. Stigma and discrimination were observed wherever the studies were performed, in low, middle, and high-income countries. Nevertheless, some studies documented forms of resistance by transgender women through social activism, participation in support groups, and resilience [48,56,70].

Research on stigma and discrimination has grown exponentially in the last decade, encompassing various areas and becoming increasingly specific and complex [31]. In relation to the studies' methodologies, we found that the majority took qualitative approaches. A plausible hypothesis for this fact is the complexity of operationalizing the concept of stigma in quantitative studies due to the diversity of definitions for stigma. The quantitative studies reviewed here attempted to solve this problem by using scores for variables related to discrimination based on gender identity (at work, in health services, difficulty in obtaining housing) [8,36], by factor analysis [7], or by latent class analysis through the inclusion of specific variables of discrimination (in the family, with friends, with neighbors, at health services, verbal aggression), by adaptation of scales for measuring homophobia [9], or directly by the self-perception of discrimination [37].

Quantitative studies were marked by emphasis on the relationship between experiences of stigmatization and risk of HIV infection. It is important to recall that the initial interpretations of the AIDS epidemic (1981-1984) were marked primarily by a biomedical, epidemiological, and behaviorist focus [26], leading to the identification and stigmatization of population subgroups with the highest likelihood of including persons with the disease when compared to the general population [71]. However, the epidemiological studies reviewed here appear to go beyond a merely behavioral relationship. By reflecting on the concept of stigma, they challenge structural and relational issues that affect analytical dimensions of the concept of vulnerability, producing a shift from exclusively individual issues such as behaviors, attitudes, and risk practices to attention to social factors [26].

Qualitative studies of a sociocultural nature featured significant contributions to the analysis of stigma and vulnerability to HIV, since they were not limited to the dimension of individual behaviors, but expanded the analytical window to include issues related to labeling, distinction, and exclusion, which sustain stigma as a profoundly depreciative attribute. Based on an analysis of narratives and daily social relations, these studies were able to relate the process of stigmatization to transgender women's social and programmatic vulnerability to HIV.

According to Link & Phelan [72], stigma exists when a set of interrelated components converge. The first refers to the fact that persons distinguish and label human differences through a substantial

simplification of differences, as if there were no gradation between the various categories. In this sense, dualism between the categories usually prevails: cis/trans, gay/straight, black/white, etc. An important characteristic of this component is that prominent attributes differ drastically according to time and place. The second component involves the association of human differences – which are labeled – with negative characteristics; the connection between these two properties shapes what the authors call stereotype. The third component of stigma occurs when the social labels promote the separation between two categories of persons: "us" and "them".

We thus observe that stigmatization of transgender women produces discrimination, which materializes as social exclusion and various forms of violence. The effects of stigma may take the form of psychiatric outcomes (e.g., suicidal ideation and depression) and substance abuse. Social exclusion may also be related to low schooling and barriers to access to the work market, which in turn can influence entry into the sex trade and the adoption of risky behaviors such as the use of injecting drugs without medical orientation and unprotected anal sex with steady or casual sex partners or clients.

We also found that at the individual level, transgender women face major social isolation, exacerbated by fear of rejection and discomfort or insecurity in public places, producing high rates of depression and suicide, as observed in various studies [4,73,74]. Substance abuse is also closely related to risk behaviors for HIV infection [1,75]. A study in New York produced strong evidence that gender-based discrimination against young transgender women increased the risk of depression and sexual risk behaviors, which in turn increased the likelihood of HIV infection and other sexually transmissible infections [74].

At the structural level, the studies show that stigma, through discrimination, can affect access by transgender women to health services, including HIV/AIDS testing and treatment services, which is corroborated by other studies that do not focus specifically on the relationship between HIV and stigma [76,77]. A study in Argentina found that 40.7% of transgender women reported avoiding the use of health services because of their gender identity. The study observed that factors related to the stigmatization process were associated with this phenomenon, for example, the report of having experienced discrimination in health services by health professionals or other patients, or having suffered police brutality [78].

The diverse ways of measuring stigma and discrimination in the quantitative studies may hinder the production of future metanalyses on the impact of stigma on the risk of HIV infection. Another important issue is the diversity of uses of the concept of stigma and discrimination in this field of studies. We thus suggest constructing, standardizing, and validating scales to measure the different facets of stigma (individual, interpersonal, and structural) and discrimination (as the action or effect of stigma) in quantitative studies. We found that qualitative studies were the best methodology for analyses intended to address the relationship between the categories of stigma, discrimination, and vulnerability to HIV. Quantitative studies should also consider the sampling processes, since the choice of non-probabilistic procedures is one of the elements responsible for the high risk of bias in the studies analyzed here. We thus suggest that in future studies on the theme, the sample size and selection of participants should be adequate for comparison of the groups and to control confounding.

In the qualitative studies analyzed here, the depth and analytical rigor were procedures that displayed limitations. In qualitative studies, we suggest greater analytical depth and the adoption of different methods for understanding stigma and vulnerability, such as triangulation of methods.

This review study has some limitations. The first is the lack of a metanalysis with the data from the quantitative studies, considering the heterogeneity of the variables they used. There was also difficulty in synthesizing the results of studies with different methodological approaches, since most guidelines for systematic reviews do not consider the integration of qualitative and quantitative studies in the same review. In addition, the current review did not include all of the grey literature from a relevant body of scientific output published online by international organizations, outside the scope of peer-reviewed scientific journals. These limitations notwithstanding, we adopted consistent methodological procedures performed by independent reviewers and assessed the studies that met the eligibility criteria in order to reduce the possibility of bias.

In this review study, we found that stigma and discrimination are related in various ways to individual, social, and programmatic vulnerability to HIV/AIDS. It is necessary to understand how stigma and discrimination operate in society to produce and reproduce social and health iniquities.

Understanding the history of stigma and its consequences for individuals and communities, such as discrimination, can help us develop better measures to fight it or reduce its effects [79]. We thus suggest that health measures and HIV prevention should not be limited to behavioral aspects and risk practices, but should embrace the promotion of a culture of non-discrimination and respect for gender differences.

Contributors

L. Magno participated in the article's conception, systematic literature review, analysis, and writing and final revision. L. A. V. Silva participated in the article's conception and writing and final revision. M. A. Veras participated in the critical revision and approval of the final version. M. Pereira-Santos participated in the data collection and final revision. I. Dourado participated in the study's conception and writing and final revision.

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Resumo

A prevalência de HIV entre mulheres transgênero é desproporcional quando comparamos com a população geral em vários países. O estigma e a discriminação, por conta da identidade de gênero, têm sido comumente associados à vulnerabilidade ao HIV/aids. O objetivo foi realizar uma revisão sistemática da literatura para analisar a relação entre o estigma e a discriminação relacionados à identidade de gênero de mulheres transgênero e à vulnerabilidade ao HIV/aids. Revisão sistemática da literatura, que envolveu as etapas de identificação, fichamento, análise e interpretação de resultados de estudos valendo-se da seleção em cinco bases: PubMed, Scopus, Web of Science, Science Direct e LILACS. Não houve estabelecimento de período de tempo a priori para essa revisão. Os estudos foram avaliados de acordo com critérios de inclusão e exclusão. Foram incluídos artigos em inglês, português ou espanhol, que relacionavam o estigma e a discriminação com a vulnerabilidade de mulheres transgênero ao HIV. Foram encontrados 41 artigos, majoritariamente qualitativos, publicados no período entre 2004 e 2018, e categorizados em três dimensões do estigma: nível individual, interpessoal e estrutural. Os dados permitem destacar que os efeitos do estigma relacionado à identidade de gênero, como a violência, a discriminação e a transfobia, são elementos estruturantes no processo da vulnerabilidade da população de mulheres transgênero ao HIV/aids. Os trabalhos mostraram relação entre estigma e discriminação com a vulnerabilidade de mulheres transgênero ao HIV/aids e apontaram para a necessidade de políticas públicas que combatam a discriminação na sociedade.

Estigma Social; Discriminação Social; Pessoas Transgênero; HIV; Revisão Sistemática

Resumen

La prevalencia de VIH entre mujeres transgénero es desproporcionada cuando la comparamos con la población general en varios países. El estigma y la discriminación, debido a la identidad de género, han sido comúnmente asociados a la vulnerabilidad al VIH/SIDA. El objetivo fue realizar una revisión sistemática de la literatura para analizar la relación entre el estigma y la discriminación, relacionados con la identidad de género de mujeres transgénero y su vulnerabilidad al VIH/SIDA. Se realizó una revisión sistemática de la literatura, que implicó etapas de identificación, registro, análisis e interpretación de resultados de estudios, a partir de una selección en cinco bases de datos: PubMed, Scopus, Web of Science, Science Direct y LILACS. No se estableció un período de tiempo a priori para esta revisión. Los estudios se evaluaron según criterios de inclusión y exclusión. Se incluyeron artículos en inglés, portugués o español, que relacionaban el estigma y la discriminación con la vulnerabilidad de mujeres transgénero al VIH. Se encontraron 41 artículos, mayoritariamente cualitativos, publicados durante el período entre 2004 a 2018, y categorizados en tres dimensiones del estigma: nivel individual, interpersonal y estructural. Los datos permitieron destacar que los efectos del estigma, relacionado con la identidad de género, como la violencia, la discriminación y la transfobia, son elementos estructuradores en el proceso de la vulnerabilidad de la población de mujeres transgénero al VIH/SIDA. Los estudios mostraron una relación entre estigma y discriminación con la vulnerabilidad de mujeres transgénero al VIH/SIDA y señalan la necesidad de políticas públicas que combatan esta discriminación en la sociedad.

Estigma Social; Discriminación Social; Personas Transgénero; VIH; Revisión Sistemática

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