



## SHORT COMMUNICATION

# Short report: Characterizing HIV care among a clinical sample of transgender women living with HIV

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## Funding information

This study was funded by a Canadian Institutes of Health Research Foundation Grant (grant no. 1017493) and by Gilead Sciences Canada, Inc

## Abstract

**Introduction:** This study aimed to characterize and identify factors associated with HIV care among transgender (trans) women living with HIV (TWLWH) in two urban centres in Canada.

**Methods:** Retrospective data were collected from clinic charts of TWLWH aged 16 years and older across seven family medicine, endocrinology and/or HIV clinics in Montreal and Toronto, Canada, from 2018 to 2019 ( $n = 86$ ). We assessed the proportion of individuals being ever engaged in HIV care [defined as having any recorded antiretroviral therapy (ART) regimen and/or viral load], current ART use, and most recent viral load (suppressed [ $<200$  copies/ml] vs. unsuppressed) overall and compared across subgroups using  $\chi^2$  tests.

**Results:** All TWLWH in our sample [100.0%, 95% confidence interval (CI): 95.8–100.0%] were engaged in HIV care; most (93.0%, 95% CI: 85.4–97.4%) were currently using ART and most (93.4%, 95% CI: 85.3–97.8%) with complete data ( $n = 71/76$ ) were virally suppressed. A higher proportion of trans women of colour (100.0%) reported current ART use compared with white trans women (76.9%,  $p = 0.017$ ). A higher proportion of those with no documented history of injection drug use (IDU; 96.6%) were virally suppressed compared with those with a history of IDU (66.7%,  $p = 0.022$ ). Although not statistically significant, 96.2% of those currently reporting feminizing hormone use were virally suppressed, compared with 85.0% of those not reporting use ( $p = 0.202$ ).

**Conclusions:** Once engaged in HIV care, TWLWH in Canada appear to have excellent ART use and viral suppression. Findings can be leveraged to identify target populations to enhance HIV care and to further explore the relationship between gender-affirming medical care and HIV care.

## KEYWORDS

antiretroviral therapy, gender affirmation, HIV care cascade, transfeminine, transgender women, viral suppression

## INTRODUCTION

Globally, transgender (trans) women experience a disproportionate prevalence of HIV [1]. A recent meta-analysis identified an HIV prevalence of 14.11% among trans women across 13 US studies [1], whereas the US national HIV prevalence is approximately 0.36% [2]. Equally concerning are analyses of US cohort and surveillance datasets which have shown trans women living with HIV (TWLWH) have less access to HIV care across the HIV care cascade compared with cisgender people living with HIV, including lower retention in care [3], initiation of antiretroviral therapy (ART) [4], adherence to ART [5] and viral suppression [6].

The US and Canada have differences regarding health-care organization and human rights protections for trans people. Canada has a universal, publicly funded health-care system designed, in theory, to reduce socioeconomic barriers to care [7]. Further, gender identity and expression were added as prohibited grounds of discrimination to the Canadian Human Rights Act in 2017 and various provincial and territorial protections previously existed; by contrast, the Human Rights Campaign has noted that 2021 will officially be the ‘worst year in recent history for [lesbian, gay, bisexual, trans, and queer] LGBTQ state legislative attacks’ within the US [8]. Thus, HIV care and associated factors among LGBTQ people living with HIV may look different across the two countries.

Trans identities are not routinely collected nor reported in national estimates of HIV incidence or prevalence in Canada. The most recent HIV prevalence estimates come from the Trans PULSE Ontario study (2009–2010), which reported an HIV prevalence of 2.9% among trans women. Although this prevalence is lower than global estimates, it is much higher than the 2019 Ontario provincial prevalence of 0.18% [9,10]. Analyses from a subset of TWLWH ( $n = 50$ ) participating in the first wave of the Canadian HIV Women’s Sexual and Reproductive Health Cohort Study (CHIWOS) (2013–2015) showed gaps in HIV care – particularly with respect to ART uptake – among a community sample of TWLWH [11]. However, CHIWOS remains the only published study characterizing the HIV care cascade among TWLWH in Canada to date. Characterizing access to HIV care, including factors associated with access among a clinically engaged group of TWLWH, may help researchers and clinicians to understand and enhance optimal HIV health outcomes among trans women within universal healthcare settings. The main objectives of this study were to: (1) characterize HIV care (ever engaged in HIV care, current ART use) and HIV health (viral suppression) among TWLWH in two Canadian urban centres; and (2) explore factors associated with current ART use and viral suppression.

## METHODS

Data were collected from clinic charts of 1495 trans women aged  $\geq 16$  years, across seven family medicine, endocrinology and/or HIV clinics in Montreal and Toronto, Canada, between July 2018 and December 2019. These clinics represented the primary clinical care sites for the majority of TWLWH in Montreal and Toronto. These analyses draw on the subsample of 86 TWLWH (5.7% of total sample). Year of HIV diagnosis ranged from 1999 to 2019.

### Data collection

Standardized data collection forms were developed by the clinician, researcher and community member research team, piloted at two clinics, and refined. Clinic and linking logs were used to identify and merge patients receiving care at multiple sites. Study data were collected and managed using Research Electronic Data Capture (REDCap), a secure electronic data capture tool [12] hosted at Women’s College Hospital in Toronto where research ethics approval was obtained (no. 2018-0140-E). Central ethics approval was obtained from the University of Toronto, Toronto (no. 36003).

HIV care indicators were ever engagement in HIV care, current ART use and most recent viral load. Ever engagement in HIV care was measured as having any recorded ART regimen and/or viral load in the dataset (yes vs. no). Current ART use was defined as having one or more ARTs indicated in the chart, with indication of being ‘ongoing at this dose’ considered current ART use. Most recent viral load was based on the most recently reported/recorded viral load (dichotomized as suppressed vs. unsuppressed). Suppressed viral load was defined as  $< 200$  copies/mL.

Sociodemographic factors utilized in these analyses included age (continuous and categorized as  $< 30$ , 30–39, 40–49, 50–59, and 60+), race/ethnicity (white vs. person of colour), legal status in Canada (Canadian citizen/permanent resident vs. refugee/refugee claimant), birthplace (Canada vs. outside of Canada), relationship status (legally married/common law/in a relationship vs. single/separated/divorced/widowed, and other), employment status (employed vs. unemployed), receiving social assistance (yes vs. no). Mental health, physical health and substance use factors included: ever being diagnosed with a mental health condition (excluding gender dysphoria), any other current chronic medical diagnoses and a history of injection drug use (IDU) (each yes vs. no). Healthcare access and utilization factors included: having an endocrinologist, current feminizing hormone use (FHU) and planned or completed gender-affirming surgery (each yes vs. no).

## Data analyses

All variables were summarized as median and interquartile ranges (IQRs) for continuous variables and proportions for all categorical variables, as well as 95% confidence intervals (CIs) for ever engagement in HIV care, current ART use and most recent viral load. The prevalence of ever engaging in HIV care, current ART use and most recent viral load were reported overall and compared across subgroups for current ART use and most recent viral load using  $\chi^2$  tests.

## RESULTS

Trans women living with HIV in our sample had a median age of 38 years (IQR: 27–47). Nearly one-half (44.2%,  $n = 38/86$ ) were TWLWH of colour, with 13/86 (15.1%) being white and 40.7% ( $n = 35/86$ ) missing race/ethnicity data (Table 1). Almost half were born outside of Canada (47.7%,  $n = 41/86$ ), with approximately one-fifth (19.8%,  $n = 17/86$ ) born in Canada and another 32.6% missing birthplace data ( $n = 28/86$ ). Most TWLWH in our sample received social assistance (69.8%,  $n = 60/86$ ). Three-quarters of TWLWH in our sample had ever been diagnosed with a mental health condition (76.7%,  $n = 66/86$ ). Most TWLWH in our sample (68.6%,  $n = 59/86$ ) were currently using FHT, while 38.4% ( $n = 33/86$ ) had planned or completed gender affirming surgery.

All TWLWH in our sample (100%, 95% CI: 95.8%–100.0%,  $n = 86/86$ ) were ever engaged in HIV care. Most (93.0%, 95% CI: 85.4%–97.4%,  $n = 80/86$ ) were currently using ART. Among those with complete data, most (93.4%, 95% CI: 85.3%–97.8%,  $n = 71/76$ ) were virally suppressed at the most recent viral load, while 82.6% (95% CI: 72.8%–89.9%,  $n = 71/86$ ) were for the entire cohort. The most recent documented viral loads ranged in last recorded date from 2013 to 2018.

Given sample size limitations and missing data, few factors demonstrated a statistically significant association with HIV care (Table 1). Race/ethnicity was significantly associated with current ART use, such that a higher proportion of trans women of colour reported current ART use (100%,  $n = 38/38$ ), compared with white trans women (76.9%,  $n = 10/13$ ) and with 91.4% ( $n = 32/35$ ) of those who were missing race/ethnicity data ( $p = 0.017$ ). Among 76 TWLWH in our sample with complete viral load data, a higher proportion with no documented history of IDU (96.6%,  $n = 28/29$ ) were virally suppressed at most recent viral load measurement compared with those with a history of IDU (66.7%,  $n = 4/6$ ) and with 95.1% ( $n = 39/41$ ) of those missing a history of IDU data ( $p = 0.022$ ). Finally, 100.0% ( $n = 36/36$ ) of those reporting having no planned

or completed gender-affirming surgery were virally suppressed, compared with 90% ( $n = 27/30$ ) of those reporting planned or completed gender-affirming surgery and with 80% ( $n = 8/10$ ) of those with missing gender-affirming surgery data ( $p = 0.049$ ). Although not statistically significant, 96.2% of TWLWH currently reporting FHT were virally suppressed compared with 85.0% of those not reporting current FHT.

## DISCUSSION

Our findings suggest that once engaged in HIV care, TWLWH appear to have excellent uptake of ART and viral suppression. Although not directly comparable given differences in operationalization of measures, our estimates appear higher than those identified among people living with HIV in a retrospective population-based cohort study in Ontario, Canada, which identified that 87% (95% CI: 81–87%) were engaged in HIV care, 81% (95% CI: 70–82%) were currently using ART, and 80% (95% CI: 67–81%) were virally suppressed [13]. Our estimates are also higher than those emerging from the US. For example, a recent US study utilizing national administrative data ( $n = 6534$  trans women) reported that 79.0% of TWLWH were virally suppressed [3]. Also contrary to data emerging from the US indicating racial disparities between cis and trans WLWH [14], a higher proportion of TWLWH of colour were currently using ART compared with white TWLWH in our sample. These findings are consistent with Canada's CHIWOS data, which reported that women of African/Caribbean/Black race/ethnicity have lower odds than those of white race/ethnicity of having a gap in comprehensive care [15], and lower odds of attrition at retention, initiation of ART and viral suppression [16]. Authors of these studies note the high proportion of CHIWOS participants of colour who have immigrated, for whom a move to Canada may increase access to HIV care within a universal healthcare system. These findings point to the importance of understanding local contexts and histories associated with diaspora communities when examining the HIV care cascade and potential interventions.

Our findings corroborate other research suggesting that IDU is a barrier to HIV care within systems that stigmatize people who use substances. This information should be more routinely collected in affirming ways, taking into consideration best practices (e.g. self-administered questionnaires), and be informed by intersectional considerations such as concerns about confidentiality and disclosure, particularly among trans women with precarious immigration status [17]. Gender-affirming support for substance use is also urgently needed. One promising intervention is Seeking Safety, an evidence-based

**TABLE 1** Bivariate analyses of factors hypothesized to be associated with HIV care among transgender women living with HIV in clinical care

	<b>Total sample (n = 86)</b>	<b>Current ART use (yes) (n = 86)</b>		<b>Most recent viral load (suppressed) (n = 76)</b>	
	<b>n/N (%)</b>	<b>n/N (%)</b>	<b>P value</b>	<b>n/N (%)</b>	<b>P value</b>
<b>Age (years)</b>					
< 30	17 (19.8)	15/17 (88.2)	0.818	14/15 (93.3)	0.789
30–39	20 (23.3)	19/20 (95.0)		15/17 (88.2)	
40–49	22 (25.6)	21/22 (95.5)		19/20 (95.0)	
50+	27 (31.4)	25/27 (92.6)		23/24 (95.8)	
<b>Race/ethnicity<sup>a</sup></b>					
White	13 (15.1)	10/13 (76.9)	0.017	9/10 (90.0)	0.642
Person of colour	38 (44.2)	38/38 (100)		33/36 (91.7)	
Missing	35 (40.7)	32/35 (91.4)		29/30 (96.7)	
<b>Legal status in Canada</b>					
Canadian citizen/permanent resident	31 (36.1)	28/31 (90.3)	0.690	26/28 (92.9)	0.142
Refugee/refugee claimant	12 (14.0)	11/12 (91.7)		8/10 (80.0)	
Missing	43 (50.0)	41/43 (95.3)		37/38 (97.4)	
<b>Birthplace</b>					
Canada	17 (19.8)	14/17 (82.4)	0.117	12/14 (85.7)	0.430
Other	41 (47.7)	40/41 (97.6)		36/38 (94.7)	
Missing	28 (32.6)	26/28 (92.9)		23/24 (95.8)	
<b>Relationship status</b>					
Legally married/common law/ in a relationship	22 (25.6)	20/22 (90.9)	0.963	19/20 (95)	0.742
Single/separated/divorced/ widowed	49 (57.0)	46/49 (93.9)		41/45 (91.1)	
Other	1 (1.2)	1/1 (100)		1/1 (100)	
Missing	14 (16.3)	13/14 (92.9)		10/10 (100)	
<b>Employment status</b>					
Employed	30 (34.9)	30/30 (100)	0.174	27/28 (96.4)	0.236
Not employed	39 (45.4)	35/39 (89.7)		30/34 (88.2)	
Missing	17 (19.8)	15/17 (88.2)		14/14 (100)	
<b>Receiving social assistance</b>					
Yes, any	60 (69.8)	55/60 (91.7)	0.715	49/52 (94.2)	0.698
No, none	4 (4.7)	4/4 (100.0)		4/4 (100.0)	
Missing	22 (25.6)	21/22 (95.5)		18/20 (90.0)	
<b>Ever diagnosed with a mental health condition</b>					
Yes	66 (76.7)	62/66 (93.9)	0.350	57/60 (95)	0.420
No	16 (18.6)	15/16 (93.8)		12/14 (85.7)	
Missing	4 (4.7)	3/4 (75)		2/2 (100)	
<b>Other current medical diagnoses (chronic condition)</b>					
Yes	57 (66.3)	54/57 (94.7)	0.175	47/52 (90.4)	0.291
No	26 (30.2)	24/26 (92.3)		22/22 (100.0)	
Missing	3 (3.5)	2/3 (66.7)		2/2 (100.0)	

TABLE 1 (Continued)

	Total sample ( <i>n</i> = 86) <i>n/N</i> (%)	Current ART use (yes) ( <i>n</i> = 86)		Most recent viral load (suppressed) ( <i>n</i> = 76)	
		<i>n/N</i> (%)	<i>n/N</i> (%)	<i>P</i> value	<i>n/N</i> (%)
History of injection drug use					
Yes	7 (8.1)	6/7 (85.7)	0.731	4/6 (66.7)	0.022
No	32 (37.2)	30/32 (93.8)		28/29 (96.6)	
Missing	47 (54.7)	44/47 (93.6)		39/41 (95.1)	
Having an endocrinologist					
Yes	25 (29.1)	24/25 (96)	0.552	22/22 (100)	0.335
No	22 (25.6)	21/22 (95.5)		19/21 (90.5)	
Missing	39 (45.4)	35/39 (89.7)		30/33 (90.9)	
Current feminizing hormone use					
Yes	59 (68.6)	56/59 (94.9)	0.032	51/53 (96.2)	0.202
No	21 (24.4)	20/21 (95.2)		17/20 (85.5)	
Missing	6 (7.0)	4/6 (66.7)		3/3 (100.0)	
Planned or completed gender-affirming surgery					
Yes	33 (38.4)	32/33 (97)	0.281	27/30 (90.0)	0.049
No	41 (47.7)	38/41 (92.7)		36/36 (100.0)	
Missing	12 (14.0)	10/12 (83.3)		8/10 (80.0)	

Abbreviations: ART, antiretroviral therapy

<sup>a</sup>Further race/ethnicity breakdown is as follows: white (*n* = 13/86, 15.1%), black (*n* = 15/86, 17.4%), indigenous (*n* = 2/86, 2.3%), Asian (*n* = 2/86, 2.3%), South Asian (*n* = 4/86, 4.7%), Latina/x (*n* = 8/86, 9.3%), other (*n* = 7/86, 8.2%), missing (*n* = 35/86, 40.7%).

intervention that combines substance use and treatment for post-traumatic stress disorder, adapted for use with TWLWH [18]. Mental health disparities and unmet mental health needs among trans women are also well documented [19]. As over three-quarters of TWLWH in our study were diagnosed with a mental health condition (excluding gender dysphoria), gender-affirming mental health support is also urgently needed.

Although not all trans women access gender-affirming medical care, professional organizations recognize that access is medically necessary to support the health and well-being of those who desire it, with many positive psychosocial effects [20]. Our data found high current FHU, but low uptake of gender-affirming surgery. These findings corroborate a previous study suggesting that TWLWH may experience unique barriers to gender-affirming surgery (e.g. HIV stigma, financial barriers, social isolation) [21]. The non-significant yet interesting finding that a higher proportion of those reporting current FHU were virally suppressed compared to those not reporting FHU is consistent with research suggesting that access to gender-affirming medical care may facilitate uptake of HIV care [11]. This finding appears in conflict with our finding that TWLWH who had not undertaken gender-affirming surgery had better HIV outcomes, which may be related to our small sample size and repeated comparisons. However,

our previous research showed that viral suppression was either a stated or perceived prerequisite for gender-affirming surgery for TWLWH [21], as, frequently, is sustained use of FHT. Thus, it is possible that either TWLWH who have not undergone gender-affirming surgery may be motivated to maintain HIV health to acquire surgery or that TWLWH have not undergone gender-affirming surgery because of a detectable viral load. More research is needed to examine these associations further and to continue to develop integrated HIV and gender-affirming care models for TWLWH.

Our study was limited in ways that led to necessary assumptions, and the serious limitations of our outcome measures must be understood to contextualize our results properly. Both current ART use and most recent viral load were based on what was most recently documented in the patient's chart. While we documented whether the recorded ART was ongoing in the chart, it is still possible that some patients may have discontinued ART use. It is also possible that viral load of patients may have changed since their most recently recorded viral load. Future studies with larger sample sizes should take into consideration physician guidelines that recommend assessing viral load every 3–6 months [22]. Missing values may reduce our confidence on the validity of the comparisons across subgroups of covariates. We created



a missing category for the covariates with missing values to maintain the statistical power of the comparisons. Lastly, given the lack of research about TWLWH in Canada, we have no data to assess how representative our sample of TWLWH in Montreal and Toronto are of TWLWH in other urban centres. It is possible that TWLWH in other urban centres may have different levels of engagement with HIV care. We are also further limited in our assessment of generalizability by the lack of routine and comprehensive collection gender identity in national HIV surveillance data or cohort studies. Systematic data collection of gender identity including within trans identities (e.g. trans women, trans men, non-binary people) would better inform clinical care of TWLWH and directions for future research.

## CONCLUSIONS

Despite these limitations, these preliminary findings can be leveraged to support TWLWH by identifying target populations (e.g. TWLWH with a history of IDU) and developing specific strategies (e.g. increasing access to gender-affirming medical care, particularly FHU) to increase engagement in HIV care. Moreover, these findings suggest the importance of future research on TWLWH in universal care settings, particularly those that consider the multi-faceted determinants of health affecting TWLWH, including gender affirmation.

## ACKNOWLEDGEMENTS

We would like to thank all the team members who offered their insight into these analyses, all of the community members involved in the Trans Women HIV Research Initiative, as well as the research coordinators and assistants, partnering clinics and funders who made this study possible. We would also like to thank Chris Battiston, the Women's College Hospital REDCap Database Administrator, for his time and effort with data management.

## CONFLICT OF INTEREST

The authors have no conflicts of interest to declare.

## AUTHOR CONTRIBUTIONS

AL-D, YP, AU, NM, PC and ML conceptualized the study. PC, RF, LYLC, GA, AB and QN led the study at participating sites. MW, MG, LTK and AAB collected data at participating sites. MS led the data analyses. AL-D and MS led the first draft of the manuscript. All co-authors reviewed the manuscript, provided written feedback and approved the final version.

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**How to cite this article:** Lacombe-Duncan A, Shokoohi M, Persad Y, et al. Short report: Characterizing HIV care among a clinical sample of transgender women living with HIV. *HIV Med*. 2022;23:324–330. doi:[10.1111/hiv.13261](https://doi.org/10.1111/hiv.13261)