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Anticipated Stigma and Social Barriers to Communication Between Transgender Women Newly Diagnosed with HIV and Health Care Providers: A Mediation Analysis

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Abstract

Purpose: We assessed whether anticipated stigma (i.e., fear of public mistreatment due to gender identity) impacts communication between transgender women (TGW) living with HIV and health care providers.

Methods: This is a secondary analysis of baseline data from *Trans Amigas*, a study conducted in Brazil, 2018. The study population consisted of TGW living with HIV, older than 18 years, residing in the São Paulo metropolitan area. We used multivariable logistic regression ($\alpha=0.05$), mediation, and bootstrapping for the analysis.

Results: One hundred and thirteen participants completed the study. Fear of public mistreatment had an adjusted odds ratio (aOR) of 7.42 ($p=0.003$) for difficulty reporting new symptoms to providers. Concerning fear of public mistreatment, we found that unemployment had an aOR of 3.62 ($p=0.036$); sex work, an aOR of 2.95 ($p=0.041$); and issues related to name change in documents, an aOR of 2.71 ($p=0.033$). For the indirect effect on difficulty reporting new symptoms, mediated by fear of public mistreatment, unemployment had an aOR of 1.52 (confidence interval [CI]=0.88–2.24); sex work, an aOR of 1.48 (CI=0.81–2.52); and name change issues, an aOR of 1.47 (CI=0.96–2.43).

Conclusions: Anticipated stigma was associated with communication difficulties between TGW living with HIV and providers. Our data suggest that structural factors associated with anticipated stigma could indirectly impact on difficulty reporting new symptoms. These findings indicate the importance of considering social contexts that intersect with individual experiences when analyzing communication barriers between providers and patients, and the need to strengthen social policies for TGW in Brazil.

Clinical Trial Registration number: R34MH112177.

Keywords: communication, health care professionals, health care provider–patient relationship, people living with HIV, transgender women, transphobia

Introduction

THE HEALTH CARE PROVIDER and patient relationship, grounded in good communication, is a fundamental strategy to attain good-quality health care. Good communication

favors sharing essential information that enables good diagnostic and therapeutic hypotheses, leading to an increase of the patient's confidence in their provider. Furthermore, horizontal communication that allows the patient agency in their health care tends to increase treatment adherence and self-

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care, and may favor creating alternatives that better address their specific needs. However, to build this provider–patient relationship, the potential for provider bias and discrimination when treating marginalized communities must be acknowledged and addressed.^{1,2}

Transgender women (TGW) are historically discriminated against in societies structured by sexism,^{3,4} such as Brazil, which is often reflected in their relationship with health care providers. Not only are they often mistreated and sometimes even denied proper medical attention,^{5,6} but their existence is pathologized under stigmatizing and outdated diagnostic categories.⁷ Stigma and transphobia, combined with the lack of medical education about transgender health, results in very few health care providers being capable of offering respectful and competent health care to the transgender community.^{5,8,9}

We consider the complexity of transgender health in the context of the provider–patient relationship through the lens of the Gender Affirmation Framework.¹⁰ According to this model, stigma causes social oppression and psychological distress. Social oppression is characterized by transphobia, social marginalization, and barriers to health care, and lessens access to gender affirmation. Psychological distress is characterized by internalized transphobia and anticipated stigma (i.e., fear of being discriminated against), increasing the need for gender affirmation. Decreased access combined with increased need for gender affirmation culminates in identity threat, which may lead to maladaptive defense mechanisms and high-risk contexts and behaviors, such as precarious and neglected self-care.¹⁰

This situation is aggravated for TGW living with HIV, for it intersects with stigma toward a serious chronic condition that, if left untreated, can be lethal. Furthermore, it is a sexually transmitted and blood-borne infection (STBBI),¹¹ which makes it particularly stigmatizing under a morality that condemns free exercise of sexuality and uses it as a parameter to judge one's character.^{12,13}

TGW are more likely to be mistreated in public spaces than the general population, and health care services are no exception to this.^{8,14} Having suffered transphobia, or to fear so, increases the likelihood of postponing health care uptake, both in preventive and curative contexts, frequently resulting in clinical emergency and need of intensive care.^{8,14}

In this article, we aim to (1) assess if anticipated stigma impacts communication between TGW living with HIV and health care providers; (2) identify factors that may be associated with anticipated stigma; and (3) assess if those factors, mediated by anticipated stigma, have an indirect effect on difficulty communicating with providers.

Methods

Study setting and sample

This is a secondary analysis of baseline data from *Trans Amigas: Improving the Health of Transgender Women Living with HIV*,¹⁵ a peer navigation study conducted in São Paulo, Brazil. Survey data were collected between May and November of 2018. Detailed information about the *Trans Amigas* study, methods, and procedures have been published elsewhere.¹⁵

Eligibility criteria were defined as being assigned male at birth but currently identifying as female (as woman, transgender, transsexual or *travesti*); being over 18 years old; living with HIV; and residing in the São Paulo metropolitan

area. All participants signed an informed consent agreement to participate in the study upon enrollment.

Sampling was done in two ways: by (1) recruiting TGW living with HIV that were newly diagnosed or seroconverted during participation in the *Trans National Study* in São Paulo,¹⁶ which used respondent-driven sampling as the sampling method^{17,18}; and (2) recruiting newly diagnosed TGW living with HIV at the Reference Center for Treatment and Follow-up of STIs and AIDS (*Centro de Referência e Treinamento em sexualmente transmitida doença [DST]/AIDS [CRT]*) outpatient and associated services, such as the community testing program *Fique Sabendo* (translation: Find Out), and at Testing and Counseling Centers (*Centros de Testagem e Aconselhamento*).

Measures

After enrollment, participants answered a questionnaire, from where we selected variables related to (1) sociodemographic characteristics (age, race/ethnicity, educational level, employment status, sources of income in the last 30 days, total income in the last 30 days, living situation, marital status); (2) administrative barriers to gender affirmation (change of name in documentation); (3) gender violence experiences within health care settings (feeling discriminated against due to their gender identity, difficulty using the bathroom which they feel most comfortable with, not being called by their preferred name by health care providers); (4) anticipated stigma (fear of being mistreated when going out in public due to their gender identity); and (5) difficulty communicating with health care providers (having a hard time telling their provider about new symptoms). Further details can be found in Table 1.

The variables related to anticipated stigma and difficulty communicating with health care providers were originally designed in Likert scale,¹⁹ with five ordinal categories: from “strongly disagree” to “strongly agree.” Due to the small sample size, they were converted into binary. The categories “strongly agree” and “agree,” and the categories “strongly disagree” and “disagree” were grouped into the new categories “yes” and “no,” respectively. We chose to include the “neutral” category (“neither agree nor disagree”) in the “no” group.

Based on the Gender Affirmation Framework,¹⁰ we built the analytic model. Figure 1 presents a diagram of the results informed by the theoretical framework. Variables related to sociodemographic characteristics, administrative barriers to gender affirmation, and gender violence experiences within health care settings, together, represent variables of social oppression.

Ethics considerations

The study protocol was approved by the Committee for Human Research at the University of California, San Francisco, as well as by the Comitê de Ética em Pesquisa at the CRT DST/AIDS São Paulo, and the Brazilian National Ethics Committee, Conselho Nacional de Ética em Pesquisa. All participants provided written informed consent.

Statistical analysis

Analysis was done in software Stata[®], 13th version,²⁰ using univariate and multivariable logistic regression.²¹ To evaluate direct associations A, B, and C (Fig. 1), we calculated the multivariable odds ratio (OR)²¹ and respective

TABLE 1. RELATIVE AND ABSOLUTE FREQUENCIES OF VARIABLES RELATED TO SOCIODEMOGRAPHIC CHARACTERISTICS, GENDER VIOLENCE EXPERIENCES WITHIN HEALTH CARE SETTINGS, ADMINISTRATIVE BARRIERS TO GENDER AFFIRMATION, ANTICIPATED STIGMA, AND DIFFICULTY COMMUNICATING WITH HEALTH CARE PROVIDERS

Variable	n	%
Age (years)	113	100
18 to 25	32	28.32
26 to 35	44	38.94
≥36	37	32.74
Total income in the last 30 days (Reais)	113	100
≤600	29	25.66
>600 and ≤1000	31	27.43
>1000 and ≤2500	27	23.89
>2500	26	23.01
Race/ethnicity	113	100
White	36	31.86
Racialized	77	68.14
– Black	13	11.50
– Brown	54	47.79
– Other	10	8.85
Educational level (years)	113	100
<12 (incomplete secondary)	73	64.60
≥12 (completed secondary)	40	35.40
Marital status	113	100
Single	71	62.83
In a relationship (dating/living together/married)	42	37.17
Employment status	113	100
Has a job (stable or occasional)/ student/retired	86	76.11
Unemployed	27	23.89
Sources of income in the last 30 days	113	100
Sex worker	48	42.48
Not sex worker	65	57.52
Living situation	113	100
Stable (owned/rented place)	84	74.34
Unstable (lives at work/shelter/homeless/other ^a)	29	25.66
Being called by their chosen name by their health care provider	107	100
Yes	98	91.59
No	9	8.41
Feeling discriminated against due to their gender identity in health care settings	113	100
Yes	38	33.63
No	75	66.37
Difficulty using the bathroom with which they feel most comfortable using in health care settings	113	100
Yes	21	18.58
No	92	81.42
Change of name in documentation	113	100
Have already done it or do not want to	43	38.05
Wish to do it (have not tried yet but intends to/is trying/tried but was not able to)	70	61.95

(continued)

TABLE 1. (CONTINUED)

Variable	n	%
Fear of being mistreated when going out in public due to their gender identity	113	100
Yes	57	50.44
No	56	49.56
Having a hard time telling their health care provider about new symptoms	113	100
Yes	23	20.35
No	90	79.65

^aOther: in a friend’s house; in a temporary home with a friend; in a former employer’s house, without paying any fee; in a house that belongs to an inclusive Pentecostal church.
n, absolute frequency; %, relative frequency.

95% confidence intervals (CIs), setting the alpha at 5% (Tables 2 and 3). In the multivariable models, we included all variables that achieved $p < 0.2$ in the univariate analysis of at least one of the regression models; an exception to this rule is the variable “total income in the last 30 days”: we kept it because it attained a significant result ($p < 0.05$) in a preliminary analysis, in which it was treated as a categorical variable.

To explore an indirect effect (relationship AB), we analyzed A, B, and C’s multivariable coefficients²¹ for each variable of interest, according to the mediation analysis method,²² based on a counterfactual approach (Table 4). For that, we used PARAMED,²³ an extension package from Stata²⁰ that makes the necessary calculation and provides results in OR. To attain the indirect effect’s CI, we used the bootstrapping method,^{24,25} with 1000 replications, and considered the Bias-corrected bootstrap CI. To work with

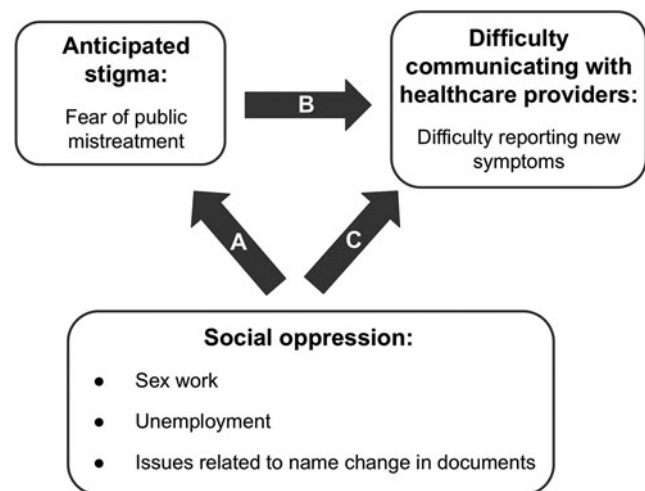


FIG. 1. Diagram of the results informed by the analytic model based on the Gender Affirmation Framework.¹⁰ Axis A: relationship between social oppression variables and anticipated stigma; Axis B: relationship between anticipated stigma and difficulty communicating with health care providers; Axis C: relationship between social oppression variables and difficulty communicating with health care providers.

TABLE 2. FACTORS ASSOCIATED WITH HAVING A HARD TIME TELLING THEIR HEALTH CARE PROVIDER ABOUT NEW SYMPTOMS (UNIVARIATE AND MULTIVARIABLE LOGISTIC REGRESSION MODELS) (N= 113)

Variable	n (%)	OR (CI)	p	Adjusted OR (CI) ^a	Adjusted p ^a
Age	Continuous	0.97 (0.92–1.02)	0.291	0.96 (0.90–1.03)	0.363
Race/ethnicity					
White	3 (8.33)	–	–	–	–
Racialized	20 (25.97)	3.85 (1.06–13.97)	0.040	3.12 (0.71–13.63)	0.129
Educational level (years)					
<12	21 (28.77)	–	–	–	–
≥12	2 (5.00)	0.13 (0.02–0.58)	0.008	0.12 (0.02–0.67)	0.016
Living situation					
Stable	15 (17.86)	–	–	–	–
Unstable	8 (27.59)	1.75 (0.65–4.70)	0.265	1.46 (0.37–5.66)	0.581
Employment status					
Has a job/student/retired	18 (20.93)	–	–	–	–
Unemployed	5 (18.52)	0.85 (0.28–2.58)	0.786	0.38 (0.07–1.99)	0.258
Sources of income in the last 30 days					
Not sex worker	10 (15.38)	–	–	–	–
Sex worker	13 (27.08)	2.04 (0.80–5.16)	0.131	0.70 (0.17–2.74)	0.610
Total income in the last 30 days	Continuous	1.00 (0.99–1.00)	0.757	1.00 (0.99–1.00)	0.676
Marital status					
Single	14 (19.72)	–	–	–	–
In a relationship	9 (21.43)	1.11 (0.43–2.84)	0.827	1.94 (0.59–6.29)	0.269
Feeling discriminated against due to their gender identity in health care settings					
No	13 (17.33)	–	–	–	–
Yes	10 (26.32)	1.70 (0.66–4.34)	0.266	1.03 (0.28–3.66)	0.963
Difficulty using the bathroom with which they feel most comfortable using in health care settings					
No	16 (17.39)	–	–	–	–
Yes	7 (33.33)	2.37 (0.82–6.82)	0.108	1.52 (0.37–6.17)	0.550
Change of name in documentation					
Have already done it or do not want to	10 (23.25)	–	–	–	–
Wish to do it	13 (18.57)	0.75 (0.29–1.90)	0.549	0.44 (0.12–1.54)	0.203
Fear of being mistreated when going out in public due to their gender identity					
No	5 (8.93)	–	–	–	–
Yes	18 (31.58)	4.24 (1.44–12.48)	0.009	7.42 (1.93–28.50)	0.003

^aOdds ratio and *p*-value are adjusted for all variables in this table. Statistically significant values are indicated in bold. OR, odds ratio; CI, confidence interval.

coefficients, variables of “age” and “total income in the last 30 days” were treated as continuous, as they were originally captured; in Table 1, they are described in categories for didactic purposes only.

Results

A total of 113 participants completed the study. Participants’ age varied from 18 to 66 years, with an average of 32.9 years and a median of 30 years. Monthly income varied from R\$40.00 (US\$11.29) to R\$8000.00 (US\$2259.88), with an average of R\$1776.88 (US\$501.94) and a median of R\$1000.00 (US\$282.48); in 2018, the minimum wage in São Paulo was R\$1108.38 (equivalent to approximately US\$313.10 at the time).^{26,27}

Regarding the living situation, four participants answered “other,” and when asked to specify what that meant, they

answered saying: “in a friend’s house,” “in a former employer’s house, without paying any fee,” “in a temporary home with a friend,” and “in a house that belongs to an inclusive Pentecostal church.” Sample characteristics are presented in relative and absolute frequencies (Table 1).

To address our first aim, our analysis of the relationship between anticipated stigma and communication issues with providers (Fig. 1; Axis B) is shown in Table 2. We found in the multivariable analysis (adjusted OR [aOR]) that reporting fear of public mistreatment increased 7.42 times the odds of having difficulty reporting new symptoms. In addition, we found that having more than 12 years of education decreased the odds by 88%.

The analysis of the relationship between social oppression and anticipated stigma (Fig. 1; Axis A), our second aim, is shown in Table 3. In the multivariable analysis (aOR), possible risk factors that may increase the fear of public

TABLE 3. FACTORS ASSOCIATED WITH FEAR OF BEING MISTREATED WHEN GOING OUT IN PUBLIC DUE TO THEIR GENDER IDENTITY (UNIVARIATE AND MULTIVARIABLE LOGISTIC REGRESSION MODELS) (N= 113)

Variable	n (%)	OR (CI)	p	Adjusted OR (CI) ^a	Adjusted p ^a
Age	Continuous	0.96 (0.92–1.002)	0.064	0.98 (0.94–1.03)	0.639
Race/ethnicity					
White	18 (50.00)	–	–	–	–
Racialized	39 (50.65)	1.02 (0.46–2.26)	0.949	0.71 (0.26–1.94)	0.513
Educational level (years)					
<12	41 (56.16)	–	–	–	–
≥12	16 (40.00)	0.52 (0.23–1.13)	0.102	0.53 (0.19–1.46)	0.222
Living situation					
Stable	39 (46.43)	–	–	–	–
Unstable	18 (62.07)	1.88 (0.79–4.47)	0.149	1.72 (0.58–5.12)	0.325
Employment status					
Has a job/student/retired	39 (45.35)	–	–	–	–
Unemployed	18 (66.67)	2.41 (0.97–5.96)	0.057	3.62 (1.08–12.13)	0.036
Sources of income in the last 30 days					
Not sex worker	27 (41.54)	–	–	–	–
Sex worker	30 (62.50)	2.34 (1.09–5.03)	0.029	2.95 (1.04–8.35)	0.041
Total income in the last 30 days	Continuous	0.99 (0.99–1.00)	0.866	1.00 (0.99–1.00)	0.351
Marital status					
Single	40 (56.34)	–	–	–	–
In a relationship	17 (40.48)	0.52 (0.24–1.14)	0.105	0.61 (0.25–1.51)	0.293
Feeling discriminated against due to their gender identity in health care settings					
No	33 (44.00)	–	–	–	–
Yes	24 (63.16)	2.18 (0.97–4.86)	0.056	2.17 (0.78–6.07)	0.137
Difficulty using the bathroom with which they feel most comfortable using in health care settings					
No	45 (48.91)	–	–	–	–
Yes	12 (57.14)	1.39 (0.53–3.62)	0.497	0.66 (0.18–2.32)	0.519
Change of name in documentation					
Have already done it or do not want to	15 (34.88)	–	–	–	–
Wish to do it	42 (60.00)	2.80 (1.27–6.16)	0.011	2.71 (1.08–6.79)	0.033

^aOdds ratio and p-value are adjusted for all variables in this table. Statistically significant values are indicated in bold.

mistreatment were: being unemployed, with odds 3.62 times greater than of those who had a job (stable or occasional)/ were students/were retired; engaging in sex work as a source of income in the last 30 days, with odds 2.95 times greater than of those who reported not doing so; and having not yet changed their name in documentation despite wishing to do so, with odds 2.71 times greater than those who had already done it/did not want to do it.

Furthermore, in univariate analysis (OR), we found that having a monthly income from R\$600.00 to R\$1000.00 was a protective factor against fear of public mistreatment (odds 79% lower; $p=0.006$).

Lastly, in Table 4, we show the results of our third aim, which analyzes the relationship AB between variables of social oppression and communication difficulty mediated by anticipated stigma. Coefficients A, B, and C confirm the results presented in Tables 2 and 3: the variables of social oppression had a direct association with fear of public mistreatment (coefficient A), but not with difficulty reporting

new symptoms (coefficient C); and the fear of public mistreatment had direct association with difficulty reporting new symptoms (coefficient B).

The indirect effects' OR suggest that, mediated by fear of public mistreatment, those variables may increase the odds of having difficulty reporting new symptoms: being unemployed increased the odds by 52%; being a sex worker, by 48%; and not having yet changed their name in documentation despite wishing to do so, by 47%. The CI was not significant in any of the three variables, but the direction of the measurements suggests the existence of an effect over communication issues.

Discussion

In this study, more than 20% of participants affirmed having difficulty reporting new symptoms to providers, which can be challenging for many people living with HIV, due to persisting stigma around this condition.^{11,28} We also

TABLE 4. RELATION A, B, AND C'S COEFFICIENTS AND THE INDIRECT EFFECT'S ODDS RATIO OF VARIABLES OF SOCIAL OPPRESSION OVER HAVING A HARD TIME TELLING THEIR HEALTH CARE PROVIDER ABOUT NEW SYMPTOMS, MEDIATED BY FEAR OF BEING MISTREATED WHEN GOING OUT IN PUBLIC DUE TO THEIR GENDER IDENTITY (N=113)

Variable	Coefficient A (CI)	Coefficient B (CI)	Coefficient C (CI)	OR of indirect effect	BCCI
Employment status	<i>p</i> = 0.036		<i>p</i> = 0.258		
Has a job/student/retired	–		–	–	–
Unemployed	1.28 (0.08–2.49)		–0.94 (–2.57 to 0.69)	1.52	0.88–2.24
Sources of income in the last 30 days	<i>p</i> = 0.041	<i>p</i> = 0.003	<i>p</i> = 0.610		
Not sex worker	–	2.00	–	–	–
Sex worker	1.08 (0.04–2.12)	(0.66–3.35)	–0.35 (–1.72 to 1.00)	1.48	0.81–2.52
Change of name in documentation	<i>p</i> = 0.033		<i>p</i> = 0.203		
Have already done it or do not want to	–		–	–	–
Wish to do it	0.99 (0.07–1.91)		–0.80 (–2.05 to 0.43)	1.47	0.96–2.43

Statistically significant values are indicated in bold. BCCI, bias-corrected bootstrap confidence interval.

found that more than 50% of participants reported fear of public mistreatment due to their gender identity: a justifiable feeling, given existing evidence on open discrimination against TGW in public settings.^{5,6,8,14,29}

Considering that the provider–patient relationship requires establishing trust between patient and provider,¹ and that negative feelings could trigger defense mechanisms, such as avoidance,³⁰ it makes sense that our results demonstrate that fear of public mistreatment could jeopardize this bond, impairing communication with providers. For a person, particularly one living with HIV, to talk freely about new health issues requires a welcoming atmosphere, in which providers are sensitive to the nuances of such experience.¹¹ When living with HIV intersects with being a transgender woman, it should be the health care service's responsibility to guarantee positive experiences with these patients, ensuring the use of affirming language, transparency, accessibility, and privacy.^{29,31}

Identifying contributing factors to the development of this fear and, consequently, of communication difficulties, can be an important tool to help providers to empathize with patients and improve their clinical approach. Factors associated with anticipated stigma in this article—unemployment, sex work, and name change issues in documents—are discussed.

Labor-related issues

Stigma toward transgender identity is responsible for lower educational level rates—school dropout is associated with transphobia at school and poor family support^{32–34}—both combined can reduce TGW's opportunities and access to formal jobs,^{32,35} which can lead them to unemployment, financial instability, poverty, and even homelessness. One of the few remaining options is sex work,¹⁰ which is not regulated and does not offer labor rights, as well as legal and social protection they may need in case they suffer violence and abuse while working.³⁶

According to an official document on violence against trans people (*Dossiê dos assassinatos e da violência contra pessoas Trans em 2020*), published by ANTRA (*Agência Nacional de Travestis e Transexuais*, a national community

organization for transgender people), among trans people murdered in 2020, 72% were TGW sex workers. Among murder attempts against trans people, 100% of the victims were TGW, 94% were sex workers, and 72% of the cases were committed by the victim's client.³⁷ Considering the existing literature suggesting that having suffered transphobia increases the risk of having fear of suffering it again,^{8,14} these alarming data can explain why, in this study, unemployed people and sex workers had a higher odds of fearing public mistreatment.

It is worth noting that TGW who are also sex workers are at the intersection of two key populations in the HIV epidemic: according to the Jointed United Nations Programme on HIV/AIDS, sex workers are 30 times more likely to acquire HIV than nonsex workers, and TGW are 14 times more likely to acquire HIV than cisgender women.³⁸ Literature shows that TGW have more trouble adhering to antiretroviral therapy due to multiple reasons, including negative experiences with health care providers.^{39–42} This makes our findings even more worrisome, since anticipated stigma and impaired communication with providers could further reduce access to much-needed prophylaxis and treatment to people with a high risk of exposure to HIV and other STBBIs.

Names

In recognizing a person's name, we recognize their subjectivity.⁴³ Denying people their right to be called by the name they identify themselves with is to deny them their humanity.⁴⁴ This method has been applied throughout history as an instrument of oppression: when colonizing and enslaving African and Native American people, Europeans took the person's original name and baptized them with a Christian name⁴⁵; in the Nazi concentration camps, the Germans tattooed the prisoners with numbers, and others.⁴⁶ Being so, denying a trans person the recognition of their chosen name is a violation of the Human Right to dignity.⁴⁷

In April 2016, Decree No. 8,727 was approved in Brazil, guaranteeing the right to institutional recognition of transgender people's chosen name, which must be the name by which they will be identified, while the name assigned at

birth must be used only for administrative purposes.⁴⁸ In the studied sample, 91.59% of participants reported being called by their chosen name in health care settings, which shows some progress compared with the recent past.⁴⁹ Even so, almost 10% of the sample had that right disrespected (Table 1), suggesting the need to improve the services' information systems—for them to highlight the chosen name in the identification form and medical record—and the health attendant's training.⁵⁰

Respecting people's chosen name is not enough: when someone is forced to present documentation with a legal name which does not correspond to the one they identify themselves with, they become "othered" and are reminded that they do not belong to the *status quo* in a cisnormative society, precipitating discriminatory behavior from transphobic and/or poorly trained attendants.^{44,50} This may explain why we found that not having changed their name in documentation despite wishing to do so was a risk factor for having fear of public mistreatment. It reaffirms the need to facilitate the name change process, which remains an expensive and bureaucratic procedure, reducing accessibility to what should be a right granted to everyone.⁵¹

Other findings

We found high educational level to be a protective factor against communication issues with health care providers. One possible explanation would be that lower educational level rates may lead to inadequate health literacy levels, which could reduce the patient's understanding of their own health–sickness process.^{52,53}

We acknowledge that, even though racism^{54–56} and transphobia^{57–62} were not associated with any outcome in this sample, these are structural issues in Brazilian society and should be considered in any social analysis concerning transgender and racialized people.

Limitations

This study was a secondary analysis of a broader study, so the questionnaire used was not specifically designed to answer our study question. In our attempt to contribute to the gap in studies focusing on provider–patient relationship in Brazil and on the mechanisms that could interfere in this dynamic, we identified in the *Trans Amigas* questionnaire the variables that could be used to address that question. In addition, since the main study was a pilot project, the sample size was small for such a complex analysis, so we had to treat Likert scale¹⁹ variables as binary. Also, we ought to consider that, as a cross-sectional data analysis, this study does not determine causality.⁶³

Sampling methods are prone to bias. As the recruitment was largely based on indications from health professionals working on reference centers for HIV/AIDS care, participants were probably already linked to care and therefore do not represent the average population of TGW living with HIV. Furthermore, generalizability of our findings is compromised because we selected participants who were newly diagnosed and nonadherent to treatment to attend the purpose of the *Trans Amigas* study, which was to understand factors hampering adherence.

The items we used to measure anticipated stigma (fear of public mistreatment) and difficulty communicating with pro-

viders (difficulty reporting new symptoms) have not been validated for the purposes for which they were used in this study. We recognize that there are other factors that could be interfering in both these situations, which were not measured in our study.

Conclusion

Anticipated stigma was associated with communication difficulties between TGW living with HIV and providers. Sociodemographic and structural factors associated with anticipated stigma were identified in unemployment, sex work, and documentation name change issues and our data suggest that these variables could have an indirect effect on TGW living with HIV/provider communication barriers. These findings indicate the importance of considering social contexts that shape individual experiences when analyzing communication barriers between health care providers and patients, as well as the need to strengthen social policies for TGW in Brazil.

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Authors' Contributions

S.L., M.A.S.M.V., J.S., and G.S.R.S. designed the *Trans Amigas* study, which provided the survey data. I.C.J.A. built the analytic model and conducted further data management—from a database that had been previously used for the *Trans Amigas* study—and analysis with support of M.A.S.M.V. and A.A.M.S. I.C.J.A. led article development with content support from S.L., J.S., G.S.R.S., A.A.M.S., and M.A.S.M.V. All authors have read and approved the final article.

Disclaimer

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Author Disclosure Statement

No conflicts or competing interests to declare.

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