Behaviors and Sexual Patterns leading to HIV risk among young transgender women in Coastal Kenya; a qualitative Study.

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***Abstract*- Background**:
Transgender women are globally ranked as a high risk population for their high HIV prevalence compared to other key population and 49 times higher than cisgender populations. Studies have cited many conditions and situations that contribute to these high HIV risks including stigmatization and discrimination and occlusion to access to universal health care. This study however aims to access the behavioral and sexual tendencies of the transgender women that predispose them to HIV risk. This paper informs on the sexual and behavioral risk factors predisposing the transgender women to a high HIV prevalence.

Methods: The study enrolled 200 transgender women aged between 18-24 years. An interviewer administered questionnaire was used to capture the sociodemographic, behavioral and sexual characteristics of the young transgender women.

Results: There are five main behavioral characteristics and sexual tendencies that render the young transgender women vulnerable and at risk of HIV; preference of physical hotspot as recreational site, early initiation into sex work, engaging in sex under the influence of drugs, multiple partners, and condom less and/or non-lubricant anal sex.

Conclusion: Generally, the behaviors and sexual characteristics of the young transgender women do not only render them vulnerable but also promote other factors that may predispose them to HIV and other STIs. Programs aimed at key population should focus more on behavioral patterns and motivational skills aimed at reforming the attitudes and knowledge on HIV and other STIs.

I. Introduction

Transgender is an evolving terminology that comprises all forms of non-gender conforming characteristics. Originally this term referred to those who sought medical intervention to change their gender; lately this refers to a range of possibilities such as transvestitism and trans-sexualism. Transgender women are biological male individuals who self-identify as women and prefer to be referred as such. This sub-population was termed as a key population as a result of their high prevalence to HIV. Globally, the HIV prevalence among transgender persons is 27%. Transgender women have 49 times the risk of HIV infections compared to the general population[1]. Sex work is more prevalent among transgender women due to social and economic marginalization. Transgender people face social and legal exclusion and have high risks of gender-based violence in addition, stigma and Trans phobia also create barriers to access to HIV testing and treatment. This reveals an overwhelming need to bridge the gap of unmet needs for effective HIV prevention strategies. Contextual differences arising from trans phobia-related stigma can limit opportunities and access to resources in a number of critical life domains e.g. employment and health care. This leaves the transgender women vulnerable and with limited life choices therefore resulting to sex work as a means of survival thus heightening their risks for HIV. In order to understand the specific needs of the transgender women, there is need to understand their behaviors, and lifestyle.

Up to recently Kenya has been defining key population to only include female sex workers, men who have sex with men and people who inject drugs (PWID). The global health research has since asserted the high prevalence of HIV among transgender women at 13 times more than the general population therefore including the transgender women as key population[2]. The behavior and lifestyle of the transgender women renders them prone to HIV acquisition. This is promoted by the personal and community constraints that have rendered them even more vulnerable. Towards affirmation of their gender, the transgender women prefer receptive anal sex, mostly of which if done for commercial purposes will be done among multiple partners, without condom and without lubrication. Dependence on sex work promotes drug and substance abuse besides predisposing them to violence, all these behavioral factors lead to increased HIV susceptibility among the transgender women.

An analysis of the literature available globally, regionally and in Kenya illustrate that transgender is a new concept that lacks comprehensive research, in fact it is until recently that the transgender women were recognized by global health as part of key population[2]. It is on this backdrop that the Kenya National Aids and STI Control Programme (NASCOP) is currently developing transgender specific guidelines for HIV and STI programming of the transgender population. Previously, programs

recognized key population to be female sex workers, male sex workers, men who have sex with men and People who inject drugs. Transgender women were shelled into men who have sex with men, gay and bisexuals and their health care needs assumed to be similar, this is however not satisfactory since being a transgender woman encompasses more than the sexual orientation and the preferred sexual partner. This assumption has further been challenged, a study done in Kenya shows a higher risk of HIV acquisition among transgender women compared to men who have sex with men at 20% and 5% respectively[3].

Historically in Africa, cultures across the continent have recognized the presence of transgender population and many societies have accepted them[4]. However this has been modernized with all kinds of non-conforming individuals introducing same-sex societally non-acceptable behavior thereby leading to criminalization and victimization of transgender persons in most African countries. The non-conforming tendencies of the individuals to their gender has aroused violence and victimization, therefore epidemiological research aimed at identifying their needs has failed because this is perceived as potentiation of exposure to greater levels of risk[5]. Transgender women in Africa have been categorized in most studies as men who have sex with men, and in extension transgender men to be women who have sex with women. This may be biased and focused on the behavioral characteristics and may not describe the insight of the transgender people as they may not be linked to these social or sexual networks, or are "stealth", as many do not express their gender identity in their daily lives[3]. Lack of medical health care and considerations has been cited as the most common barrier to SRH among the transgender women population. This has been attributed to general factors just like other minority key population; however lack of more specific transgender expertise is a single most vulnerable inhibiting factor. Even though transgender is an evolving subgroup of the population with no precise medical curricula, there is no requisite knowledge on their health needs. Real and/or perceived stigma has led to social discrimination with the transgender women bearing the burden of disproportionate HIV prevalence of 20% globally. The most relevant explanation to the high prevalence of HIV among the transgender women is their preference for receptive anal sex; this can be understood as an affirmation of their female gender. This in turn places them at a greater risk of HIV contraction.

While there has been tremendous progress in access to HIV/STI services to key populations (KP) in Kenya, which has resulted in a significant decline in the number of new infections among KP, this progress is limited to female sex workers, men who have sex with men (MSM) and people who inject drugs (PWID). Transgender populations remain marginalized by most KP programs. In some programs, Transgender persons are categorized as MSM which drives the stigma even further. A major reason for this is the lack of understanding of SRH needs and the best service delivery models for Transgender persons. Consequentially in Kenya, lack of data has led to lack of funding aimed towards transgender specific HIV programs; although other (Lesbian Gay Bisexual Transgender and Queer) LGBTQ funded programs somewhat provide insight to their plight, they do not specifically provide custom made preferences for the transgender women. Most studies focusing on transgender women have behaviorally defined them as men who have sex with men (MSM). Lack of attention to the transgender women has broadened the bridge and included diversity of other identities that HIV prevalence and risk could significantly differ between. A recent respondent driven sampling study in Nairobi Kenya revealed the prevalence of HIV among Transgender women is at 39.3%, a higher burden compared to the general population or MSM and bisexual which is at 24.6%[6]. Up to recently Kenya has been defining key population to only include female sex workers, men who have sex with men and people who inject drugs (PWID). The global health research has since asserted the high prevalence of HIV among transgender women at 13 times more than the general population therefore including the transgender women as key population[2].

II. Methods:

Study Design

This was a cross-sectional study. We performed interviews using open ended questionnaires this process was necessitated by the paucity to avoid re-engaging participants after the first contact. The questionnaire was translated into Swahili for those participants who preferred Swahili.

Setting

The research assistants who doubled up as peer educators phone-called the young transgender women and enquired where they were comfortable to meet up, 5-10 peers agreed to meet in one place at a particular time then the RA would meet them there. This could be in the drop in center (safe space) or in the hotspots where they hang out. The RA informed them about the study in a group and respond to their queries, before holding the interviews privately. Usually a peer educator has only up to 30 peers, so in order to attain the sample size, snowballing method of referral was done until the desired sample size of 200 young transgender women were reached. Screening of the participants preceded the consenting process and enrollment of participants into the study. The screening process entailed the participants voluntarily confirming their gender conformity as transgender women, and explaining what the term meant to them as having a different sexual orientation to that assigned at birth, and also confirming their age as below 24 years old before being enrolled into the study.

Data Collection and Tools

A structured open ended questionnaire was developed, key areas that were captured included: a) sociodemographic characteristics which included age, residence, level of education, occupation, and marital status. b)Behavioral and sexual characteristics included preferred hotspot, age of transgender identification, owning a cell phone, and preferred online hotspots, drug use and abuse , health services access and delivery, identification as a sex worker, age begun sex work, position during sex, and frequency of use of condoms and lubricants, HIV status and frequency of HIV testing. Data was cleaned in analyzed using STATA.

Ethical considerations

The study received ethical clearance from KEMRI SERU.

III. Results

Sociodemographic Factors

The TGW women enrolled into the study were aged between 18-24 years of age; 18 to 21 years were 21% and the older TGW of 22 to 24 years were 80%. In this cohort, 8% had not completed primary schools, 30% of them had not completed secondary schools only 8% confirmed being in tertiary colleges, 54% of the TGW had finished secondary school but not enrolled to any tertiary institutions. Transition into TGW for most of the participants was between 15 and 20 years of age (80%). The marital statuses were; 73% single, 17% married and 11% neither single nor married. The recreational points for the young transgender women population in this study varied from online platforms to physical joints, with most of them preferring to hang out in physical hotspots 73% as opposed to online dating sites at 27%. This is presented in table1.

Table 1: Sociodemographic characteristics of young transgender women.

Sociodemographic characteristics	n	%
Age		
18-20	24	12%
21-24	176	88%
Level of education		
none	1	1%
primary	41	21%
secondary	99	50%
Post-secondary	59	30%
Marital status		
single	146	73%
not single	54	27%
Transition age to transgender		
below 16 years	52	26%
above 16 years	148	74%
Preferred Recreation point		
online dating sites	54	27%
physical hotspot	146	73%

Behavioral and Sexual Characteristics

Over half of the young transgender women were sex workers (54%), and others spread across doing business, employment, and being students. Most were introduced to sex work after 16 years (59%) at the age when they are able to individually discern good from bad. And most of the TG participants confirmed to be recipients of anal sex (bottom) 54% and had sex under the influence of drugs (42%). 60% of the participants had 2-5sexual partners, and up to 50% accepted to always using condoms during sex. While most of the transgender women were always using lubricants during sex, the most widely used lubricants were oils including coconut oil, Vaseline, cooking oils and body lotions to lubricate during anal sex. Half of the participants in the study accepted to be using only water to douche (wash their anus) however 29% used other harmful products including bleach, herbs, lemon and soap to wash their anus while a whole 22% do not douche at all or did not prefer to disclose how they do it. The healthcare providers were the source of condoms and lubricants of most of the young transgender women enrolled in this study, 28% received their supplies from the CHV and peer educators. A majority of the participants had HIV tests within the last 3months.

Behavioral and sexual characteristics	**n**	**%**
Occupation		
sex workes	105	52.5%
Non sex workers	95	47.5%
Age begun sex work		

below 16 years	44	41%
above 16 years	63	59%
Daily average sex acts		
less than 3	109	55%
more than 3	92	46%
Sex Position		
bottom	107	54%
Equal times bottom as top	47	24%
top	46	23%
Use of drugs during sex		
always	84	42%
sometimes	76	38%
never	38	19%
Sexual Partner Count		
less than 2 partners	51	26%
2-5 partners	117	59%
more than 5 partners	32	16%
Frequency of condom use		
always	97	49%
sometimes	92	46%
never	11	6%
Frequency of lubricant use		
always	106	53%
sometimes	80	40%
never	14	7%
Type of lubricant		
Oils(coconut oils, Vaseline, cooking oils, body lotions)	116	41%
water	88	31%
water based gels	78	27%
saliva	3	1%
Anal washing-Douching		
Water only	99	50%
others(soap, bleach, herbs, lemon)	57	29%
Do not wash	44	22%
Source of Condoms and lubricants		
CHV/PE	55	28%
Health provider	105	53%
Chemists	38	19%
HIV tests in the last 3months		
yes	170	85%
no	30	15%
HIV status		
Negative	181	91%
positive	17	9%

don't know	2	1%

IV. Discussion

The young transgender women described in this study are those aged between 16 and 24 years. The young transgender women population was of essence in this study in order to understand the background of the transgender women before they become fully camouflaged; we intended to understand their sexual patterns and behavior before they can fully mature into adulthood. Ages between 18 and 20 years were only 20% while the majority,80%, were 21 years and above; however much this outcome is entirely reliant on the sampling process(snowballing), the TGW below 20 years are still young adults who are on the verge of understanding themselves. They have not fully come to terms with the idea of being a transgender or they have mixed feelings about the whole idea, mioght have just been initiated into the system or they do not completely understand the meaning of being a transgender. Most of the indecisiveness arise from the fact that most transgender women acquire the gender conforming traits in their puberty and this is emphasized as they proceed into adulthood. As confirmed in other studies, education, and knowledge geared towards behavior change could be more practical if exercised during puberty as the TGW transition into adulthood. The first contact for health care is the pediatricians who ought to be aware of the gender affirming questions or concerns from these individuals who may be seeking for hormones or gender blocking recommendations, even though most of these health care personnel's are not aware of the guidelines related gender affirming medical care(GAMC). The Endocrine Society do not recommend use of puberty blocking prior to initiation of puberty, instead the health care providers are advised to affirm and recommend acceptance of the patients gender prior to any procedures or introduction to any hormonal therapies. The African child however is constrained by financial capabilities leaving them vulnerable and eager to experiment any possible way to counter the effects they are experiencing in their bodies. They therefore left with cheap accessible hormonal therapies containing progestin and GnRH agonists to achieve pubertal suppression.

While most of the young transgender women had attained or dropped off secondary school level of education, this might not be a significant contribution but it determines the literacy levels, and level of understanding of simple health recommendations. Kenya's learning system does not discriminate based on the gender conforming patterns neither does it recognize transgender nor others genders other than cisgender. This therefore might have contributed to the rise of sexual assaults and same sex behaviors in the secondary schools, which might imitate transgender behavior although it is different. Transition into being a fully aware self-proclaimed transgender requires understanding of oneself, the risks and the mitigations these individuals have to have in place in order to service in a community that is not ready to accept them. While most of the young transgender women accepted that they transitioned into being transgender after 16 years, to mean they were fully aware of their decisions, it is until they are 18 years, when they are considered independent adults capable of making mature decisions. This however does not affect their decisions to engage in sexual behaviors that could predispose them HIV risk and also be victims of psychological distress and suicide arising from seclusion, discriminations, and depressions . This contributes primarily as to why these young populations is ideal for studies targeting behavior change among transgender women.

The definitions of sex work differ depending on the localities. Sex work in this study was defined as exchange of sex for money directly or sex in exchange of other favors, goods and services; most commonly is drugs, friendship, and employment. Several studies have cited that the TGW enter into sex work mainly because of stigma and discrimination [7–10].Sex work is the only credible money generating source of income among the transgender women in Coastal Kenya, with most of the participants in this study accepting to be sex workers for lack of anything better to do. Like other studies across Sub-Saharan Africa[10–12], the transgender women like other key population are more predisposed to sex work as the only source of livelihood as a result of sociocultural and economic factors. For the young TGW source of livelihood is a big challenge, even though non-employment among the youth is a concern in Kenya, the condition gets worse for the transgender youths who have socio-cultural non-gender conforming issues affecting their acceptance into the community leaving them with sex work and dealing drugs as the only option. In coastal Kenya, sex work is rampant, as young as 12 year olds sell sex work for survival[13], in this study, most of the TGW sex workers were introduced to sex work after 16 years of age, which responds to other studies done in the region which confirms that most of the sex workers are introduced into the trade around the age of 14,15,16 and 17 years[7,13,14].

Other studies have cited that younger sex workers earn more from sex work, have more clients, and are treated better compared to older sex workers; in this study, the daily average sex acts reported by the young transgender sex workers (TGSW) was 3 acts per day, with most of them reporting 2-5 sex partners. Other studies done in Harare and among Ugandan sex workers shows an average of 10-15 clients per week[15,16], this depicts that the transgender women with an average of 3 clients per day have a higher client count per day compared to other sex workers. According to Nairobi prostitutes study, the average number of clients per week still remains at 9-16 clients per week depending on the locality of the sex work whether rural or town center based[14].

The most used and abused drug by sex workers is alcohol, with most studies associating use of drugs to violence and poor negotiation during sex[17–19]; among the young transgender women in this study, up to 50% reported to be under the influence of drugs during sex; however these drugs were not only limited to alcohol, they included weed, miraa, muguka, cocaine and tobacco. According to a recent study among transgender women in Guatemala, TGSW are three times more likely to abuse drugs compared to non sex workers[20]. While under the influence of

drugs, there is a higher risk of being forced into sex, non-use of condoms and/or lubricants and physical violence, all these factors are associated with risk of HIV and other STIs. Other studies have associated inconsistent condom use with use of hard drugs, forced sex and physical violence among the transgender; other studies related lack use of condoms to knowledge deficit and stigma, while others associated it with discrimination of the transgender women[8,9,21,22]. However in a controlled environment where the transgender women have safe spaces, peer educators who are easily accessible and drop in centers to which they can access any health service they need, only 46% of young transgender women consistently used condoms during anal sex. Condom and lubricant use among the transgender women is very essential, not only for the prevention of STIs but also to avoid cracking and tearing of the thin anal membrane. Knowledge levels have been cited to adversely affect the use of condoms and lubricants, according to a Chinese study, not knowledge but lack of motivation and unstrengthen behavioral skills mostly led to low use of condoms among the transgender women[23]. Even though this theory does not satisfactorily provide an explanation why the young TG do not consistently use condoms and lubricants, other studies analyzing low use of condoms among this group tend to gravitate on the attitudes of the TG and the general health perception they have on HIV preventive measures[21,24,25]. Most of the YTGW in this study were more comfortable receiving their health supplies including condoms and lubricants from health care providers as opposed to the peer educators, in contrast of what is expected of key population including the female sex workers, male sex workers, and men who have sex with men. The young transgender women have not come to terms with themselves and definitely not with the peers in their circle, therefore have not developed rapports with each other, which explains why they prefer the key health care providers i.e. the doctors and nurses they interact with at the clinic, drop in center and safe spaces. Other studies on the preferences of health service access , depicted transgender showing closer relations and more preference to the peer educators and community mobilisers as opposed to the key health care providers. The HIV prevalence among transgender women is four times other key population and even higher among transgender women sex workers[10,26]. The HIV prevalence among the young TGW in this study was however lower(9%) compared to other studies[8,27,28], this finding however is not conclusive as it is self-reported, this means it could be higher upon testing. The behaviors and sexual tendencies of the transgender women expose them to vulnerabilities therefore heightening the HIV prevalence. More studies have suggested activities geared towards promotion of use of PREP and PEP to control the contraction and spread of HIV among this population. Additionally most recent recommendations have suggested a quarterly testing for the TGSW and 6 monthly testing for TGW[29], this has been embraced by the young TGW in this study,85% had done a HIV test within the last 3 months. This trend is however unique to young transgender women, the naivety and cowardly nature that comes with sexual contact may be creating fear that drives them to HIV self-awareness.

V. Conclusion

There are other studies that have determined the general predisposing factors of transgender women to high HIV prevalence, this study focused on the young transgender women of ages between 16-24 years. Generally, the behaviors and sexual characteristics of the young transgender women do not only render them vulnerable but also promote factors that may predispose them to HIV and other STIs. Programs aimed at key population should focus more on behavioral patterns and motivational skills aimed at reforming the attitudes and knowledge on HIV and other STIs.

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