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STIGMA, COMMUNITY CONNECTEDNESS, AND SOCIAL SUPPORT AMONG TRANS WOMEN LIVING WITH HIV IN ONTARIO: FINDINGS FROM THE TRANS PULSE PROJECT

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STIGMA, COMMUNITY CONNECTEDNESS, AND SOCIAL SUPPORT AMONG

TRANS WOMEN LIVING WITH HIV IN ONTARIO: FINDINGS FROM THE TRANS

PULSE PROJECT

by

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THESIS

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Abstract

Trans (transgender, transsexual, transitioned) individuals face numerous challenges to their health and well-being (Bauer, Hammond, Travers, Kaay, Hohenadel & Boyce, 2009). Trans women in particular face disproportionately high rates of negative health outcomes, including HIV. Trans women face intersecting stigmas, which result in transphobia, trans erasure, isolation, and other systemic barriers to their well-being (Logie, James, Tharao, & Loutfy, 2012a). Despite their elevated risk, trans women, particularly those living with HIV, are invisible, neglected or underrepresented in research (Logie, et al., 2012a). Research suggests that community connectedness and social support are factors that impact the wellness of marginalized people (Kertzner, Meyer, Frost & Stirratt, 2009). Research has not yet, however, assessed their impact on trans women living with HIV, nor has it examined how various types of stigma may shape community connectedness and social support. The data used in this study were collected through the Trans PULSE Project, a community-based research (CBR) project that investigated the impact of social exclusion and discrimination on the health of trans people in Ontario, Canada. Trans women living with HIV were interviewed and analyses were conducted on 14 transcripts in order to understand the ways in which various types of stigma shape community connectedness, social support, and well-being for trans women. Stigma was described as a result of gender identity, HIV status, and the women's intersectional identities. Through the discussion of stigma, the women described the types of connections that they made with HIV/AIDS, LGBT/trans, and cultural communities. They also identified sources of social support that could include, family, friends, romantic relationships, sex workers and helping professionals.

Key words: stigma, trans women, HIV, community connectedness, social support, well-being, Trans PULSE

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Background and Significance

In Ontario, HIV prevalence among trans[1] women is estimated to be 3%, approximately 16 times greater than for cisgender Ontarians (Bauer, Travers, Scanlon & Coleman, 2012). This can be explained, at least in part, by the social determinants of health that affect trans women at structural levels, and render them more vulnerable to becoming HIV positive. Social exclusion and isolation, economic marginalization, and inaccessible health care services, outcomes of enacted stigma[2] and transphobia, all play significant roles in producing adverse health outcomes for trans women (Baral et al., 2013; Logie et al., 2012a; McWilliam, Leonard, Medd & members of the Ontario Women and HIV Working Group, 2007). For example, employment discrimination and poverty may force some trans women to engage in survival sex work, elevating their risk for HIV (Nemoto, Operario, Keatley & Villegas, 2004). Further, trans women may avoid HIV prevention and treatment services to avoid anticipated stigma and discrimination (Baral et al., 2013; Logie & Gadalla, 2009; Nemoto, Operario, Keatley, Nguyen & Sugano, 2005). Internalization of this stigma may result in further shame, isolation, low self-esteem and loneliness, as well as anxiety, stress and depression, known correlates of HIV risk behaviour (Bockting, Robinson & Rosser, 1998; Logie & Gadalla, 2009; Lombardi & van Servellen, 2000). At an interpersonal level, physical and social violence, sexual assault, transmisogyny, and discomfort in cisnormative settings may also increase likelihood of becoming HIV positive (Herbst et al., 2008; Logie, James, Tharao & Loutfy, 2011; Pyne, 2015). Having multiple sex partners, inconsistent condom use during receptive anal sex, sex under the influence of drugs or

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[1] Trans is used to describe a diverse group of people whose gender identity or expression differs from prevailing societal expectations. Trans includes transsexual, transitioned, transgender, genderqueer, gender fluid, as well as some two-spirit people (Bauer, Hammond, Travers, Kaay, Hohenadel & Boyce, 2009).

[2] For a list of the various types of stigma experienced by trans women living with HIV, see Table 1.

alcohol, sex with cisgender men who have sex with men, or having a partner of unknown HIV status all elevate HIV risk for trans women (Bauer et al., 2012). A search for affirmation from partners, and sexual identity conflict may also place trans women at increased risk of becoming HIV positive (Bockting et al., 1998). For example, some report having condomless sex with primary partners as a means of demonstrating love and emotional connection, as well as to achieve gender validation from these partners (Nemoto et al., 2004).

Stigma and intersectionality

Various dimensions of perceived and symbolic stigma can impact the lives of trans women living with HIV. These may include social rejection, internalized shame, or social isolation (Fife & Wright, 2000). Trans women living with HIV also face the reality of living multiple marginalized identities, best understood through an intersectional lens. These identities can be those with which the women self-identify, including gender, sexual orientation, HIV status, race, ethnicity, class, or sex work identities, but can also include identities that others attribute to them (i.e. those that are prescribed to them regardless of their self-identification, but that still shape the ways in which trans women navigate systems). Intersectionality generally refers to the interactions between gender, race, and other characteristics of identity; it can also include the interaction between these and other stigmatized identities such as illness (Bockting et al., 1998; Cole, 2009; Logie et al., 2011). Intersectionality implies that multiple marginalized identities cannot be understood in isolation, but rather that they are mutually constituted and interact to affect health and experiences of those in question (Bauer, 2014). This is of particular significance for trans women living with HIV, because it allows for the examination of their health and experiences through an intersectional lens that incorporates racism, sexism, misogyny, colonialism, and illness. Previously, the minority stress model was used to describe stressors

specific to marginalized identities that individuals could experience, and the outcomes that these stressors had on their psychological well-being (Meyer, 2003). These stressors emerge as a result of socially-based structures that dictate social processes and institutional policies that often reinforce cisnormativity, thus increasing the negative outcomes of stigma experienced by trans women (Meyer, 2003). Logie and colleagues (2011) propose a model for intersectional stigma that demonstrates how stigmatizing processes operate on multiple levels simultaneously to impact the lives of women. This can have serious psychosocial consequences, such as rejection from friend and family groups, decreased intimacy, increased social stigma, and increased isolation (Logie & Gadalla, 2009; Marino, Simoni & Silverstein, 2007). Such psychosocial stressors render individuals vulnerable to psychological distress, which can contribute to decreased well-being (Logie et al., 2011; Marino et al., 2007).

Many trans individuals fear the stigma associated with HIV/AIDS as it compounds that which already exists as a result of public reactions to their gender identity (Bockting, Robinson & Rosser, 1998). This intersectional stigma is further exacerbated for racialized trans women, as they not only experience transphobia, but also navigate racist and colonialist systems that create further inequities for them (i.e. poverty, lower rates of HIV testing and education about HIV, inequitable power dynamic in relationships, etc.) (Longman Marcellin, Bauer, & Scheim, 2013). Perceived, instrumental, symbolic, or enacted stigma from social support systems, such as family, may result in increased negative health outcomes, such as psychological distress because family is often the vessel through which belonging – a fundamental human need - is experienced (Stutterheim et al., 2009). Further, enacted stigma may significantly reduce the opportunities allotted to marginalized groups, resulting in isolation or social exclusion, and decreased emotional well-being (Fife & Wright, 2000). Conceptualizations of stigma have shifted from

social processes such as labelling and exclusion, to socio-cognitive approaches such as the psychological impacts of stigma, to examining the systems of power and oppression involved in producing inequality (Logie, Newman, Chakrapani & Shunmugam, 2012b). Parker and Aggleton (2003) offer a framework by which stigma and its effects can be understood. They suggest, "stigma feeds upon, strengthens and reproduces existing inequalities of class, race, gender and sexuality" (p.13). This may help to explain why trans women living with HIV may be at greater risk for poor mental health outcomes, given they experience multiple and overlapping (HIV, gender, class, race) forms of stigma (Logie et al., 2011; Logie et al., 2012b).

Community connectedness and social support

Sense of community, or community connectedness, has been identified as a protective factor against several negative mental health outcomes, and has been shown to increase both social and psychological well-being (Kertzner et al., 2009). Community connectedness refers to the subjective sense of closeness to one's social environment (Yoon, Lee & Goh, 2008). It is defined as an individual's desire to belong to a larger collective, or to partake in relationships that satisfy collective needs (Frost & Meyer, 2012). Trans women living with HIV may experience connectedness to numerous communities, including but not limited to, trans communities, HIV/AIDS communities, and cultural/racialized communities. It is also possible that, despite their intersecting identities, they may not identify with any of these communities. Important characteristics of community connectedness are the satisfaction of individual needs through affiliation, mutually influential relationships with the collective, and shared emotional connections (McMillan & Chavis, 1986). Furthermore, community connectedness is associated with a variety of positive outcomes, such as increased psychological and social well-being (Frost & Meyer, 2012).

Furthermore, when a marginalized group engages in social comparisons to other groups, the result may be deeper dissatisfaction with their own situation (Prilleltensky, 2012). However, feeling connected to a community of individuals who share similar experiences can provide individuals with opportunities to make positive social comparisons that increase well-being (Meyer, 2003). For example, social relationship variables such as social support and social acceptance have had positive effects on subjective well-being (Yoon et al., 2008). Building relationships with peers who share similar experiences increases social support on several levels, including emotional, informational, and spiritual, and decreases psychological distress, and can contribute to greater social acceptance and reduction in perceived stigma (Marino et al., 2007).

Varying levels of social exclusion due to transphobia have been reported among a high percentage of trans people (Bauer et al., 2015). Not surprisingly, this social exclusion has been associated with decreased well-being, more specifically, increased suicidal ideation and attempts (Bauer et al., 2015). There is currently a gap in the literature with regards to the social support and community connectedness experienced by trans women, however if we use the literature on community connectedness and social support as a starting point, we can examine whether connections to trans or HIV communities can foster a similar level of social support necessary to affect the impact of the intersectional stigma faced by trans women. Connectedness to trans communities may also lessen the impact of the experiences of intersectional stigma that arise from having multiple marginalized identities, which could increase psychological well-being (Frost & Meyer, 2012).

Methods

Research Questions

Two main questions, along with two sub-questions, guided the analysis: 1) How do trans women living with HIV experience community connectedness? What role does stigma play in community connectedness?, and 2) What kinds of social support do trans women living with HIV have access to? What effect does social support have on well-being?

The Trans PULSE Project

The Trans PULSE Project was an Ontario-wide, multi-phase study. Its methods have previously been described (Travers, Pyne, Bauer, Munro, Giambrone, Hammond & Scanlon, 2013). Data for this analysis were drawn from a qualitative phase of the study focussed solely on trans people living with HIV.

Data Collection

Semi-structured, in-depth interviews were conducted with trans people living with HIV. All participants were asked the same set of open-ended questions (Padgett, 2012). Interview questions focused on general health, service access, social support/exclusion, and intersecting identities. All interviews were conducted in English. Participants received a $25.00 stipend for their participation as well as transit fare and out-of-pocket expenses for childcare, when necessary.

Participants

Fifteen trans individuals living with HIV were interviewed, ranging in age from 30 to 58, with a median age of 40. Fourteen identified as trans women (male-to-female spectrum) and one as a trans man (female-to-male spectrum). Technical issues with audio equipment resulted in the

interview with the trans man being excluded from the data. The final sample consisted of 14 trans women living with HIV.

This project took an open approach to the definition "trans", and allowed people to self identify using their own words (see Appendix A for the self-described identities of participants). The two most common descriptors were "trans woman" and "transgender". Three participants self-identified as Aboriginal, one as First Nations, five as Caucasian, two as French Canadian-Caucasian, two as Hispanic, and one as Latina. For the purposes of this manuscript, Indigenous will be used in lieu of Aboriginal.

Data Analysis

   Structural Coding. Secondary analysis was conducted on the qualitative interview responses. NVivo 11, a qualitative data management software program, was used to code and analyze the sections of the interviews that were relevant to the two thesis questions. Structural or question-based coding (Saldaña, 2013), was used as it allowed for similarly coded segments to be separated from the larger data set in order to explore them in greater depth and to address particular questions. Segments of data that were coded included community connectedness, social support, stigma (HIV-related, gender related, or due to any other identity), and well-being. After the initial structural coding phase, similarly coded data were organized in a manner that allowed for secondary coding and analysis, as suggested by Saldaña (2013).

   Thematic analysis. The next step in the analysis was the development of themes. This was done in order to determine patterns, regularities, contrasts, paradoxes and relationships that arose from these codes (Braun & Clarke, 2006). This step consisted of reading through the initial coded sections in order to determine a narrative that was present in the transcripts, and then expanding and collapsing the previously coded sections as required (i.e. grouping or separating

previously coded segments of data). What emerged was a set of broad themes with specific sub-codes that demonstrated the major experiences and important reflections on the experiences that the women shared. These themes then served as a starting point for reflection and theory creation (Coffey & Atkinson, 1996). An audit trail (See appendix B) was also kept during the analysis in order to demonstrate methodological transparency, as well as to document how codes were expanded or collapsed into themes. The codes that emerged from the structural coding phase of the analysis were then grouped into the following parent codes during thematic analysis: community connectedness, social support, stigma, well-being. Within these parent codes, a clear picture began to emerge about the lived experiences of the trans women in the study.

Theory creation. Stigma theory as described by Goffman (1963) suggests that stigma is the result of "tainted" or "flawed" attributes or identities that people or groups possess that set them apart from others. For the purposes of this article, I have chosen to analyze stigma theory not only as the result of a tainted or flawed attribute or characteristic, but as a process that operates on multiple levels simultaneously (i.e. at the interpersonal (micro), community (meso), and structural/institutional (macro) levels) to influence the experiences faced by marginalized groups (Logie et al., 2011). Intersectional stigma theory was thus used as a lens through which key findings were contextualized, and understood during the final and interpretive stages of analysis.

Results

Stigma

Trans related stigma. For many of the women, being trans often meant experiencing discrimination:

"I was coming out of the women's washroom one day and one of the owners was going into the washroom and she said, "oh, you used the women's washroom." ... To me that's stigmatizing." – Caucasian, 58 years old.

Trans women also described being negatively stereotyped in ways that furthered symbolic stigma:

"If you were tranny living 24 hours [as a woman], even if you're not working the stroll, if you're just living as a woman, they assume you are working the stroll, they assume you're a drug addict. See you got these stereotypes that are attached to you even if you aren't." – Caucasian, 34 years old.

Trans women employed strategies for avoiding anticipated stigma. For some of them this included the necessity of living in their assigned gender:

"Well during the day ... I dress up as a man and try to behave as normally as a man as possible, and then when it's over I change my clothes, and I just like, I feel more comfortable finally in women's clothes and ... it's like I'm a two spirit person because of that. It's because of the society. Cause if it wasn't for the society, I would just be like one spirit, which is female." – Caucasian, 48 years old.

It became clear through the women's experiences that trans-related stigma existed both at the interpersonal and systemic levels. Several of the women felt that their trans identity led people to discriminate against them, particularly when accessing various community services. One explained how she had to endure staff discrimination at a women's homeless shelter, because they did not want to serve trans women:

"I never did last long in the shelters, and they put me right back out on the streets, false allegations of me raising my voice and getting in quarrels with the staff and stuff or you

know other confrontations that didn't happen, other trans women that you know were accused of doing things or not doing things… to make a long story short, what these staff did, and I'm thinking of a number of staff basically they accept everyone and their mandate is to serve [cisgender] women, you know, a lot of these staff don't approve of serving trans women." – Caucasian, age n/a (1).

However, even when the trans-related stigma did not result in overt discrimination, the women still felt the judgement of staff in the services that they accessed:

"Your view of the trans [community] is burn in hell, or you know [that] you're not a real woman… Maybe you're mental or maybe you think you're a woman but you're not. You don't menstruate, you don't bear children … you haven't done any of that stuff. You're sick, who knows what the case is, you're somebody I really don't support."- Caucasian, age n/a (1)

HIV related Stigma. One of the most salient themes that arose was HIV-related stigma. Many of the women recounted stories stemming from the instrumental stigma related to misinformation or fear of HIV.

"And now everyone knows [about her HIV status] they were scared. Don't touch that, don't touch the sink, drink from the glass."- Hispanic, newcomer, 44 years old.

Many women felt shame (internalized stigma) and feared disclosing their HIV status; one described the complexity and magnitude of these fears:

"It's tough, it's tough because you're scared of telling people, you're scared of rejection, you're scared of getting sick, you're scared of your looks going, you're scared of work, money, lots of things." – Caucasian, 31 years old.

Stigma due to intersecting identities. At times, the women in the study spoke of stigma resulting from two or more intersecting identities. While trans and HIV positive identities may lead to experiences of stigma, some of the women also identified with two-spirit, Indigenous, Hispanic, Latinx, or sex worker identities that further compounded the stigma that they experienced. Many drew a distinction between the types of enacted stigma they experienced as a result of the intersection between their HIV status and their gender identity versus the stigma that other trans people who were HIV negative faced:

"[After discussing being turned down for laser hair removal at a clinic after having

disclosed HIV status to employee at front desk] But yeah that's something that I'm sure

that the trans community that doesn't have HIV, they won't go through… So, that's the

difference". – Hispanic, newcomer, 36 years old.

Numerous participants said that living with multiple marginalized identities contributed to greater experiences of stress:

"Since not a lot of people are accepting towards trans people … and for someone to

identify with being HIV positive and trans well that's just another way to single them out

or whatever, to label them, to marginalize them. It makes it harder for them to survive or

whatever. So yea, I do [think] there's a lot more stigma … because it's that extra little bit

that they have to overcome. – Indigenous, 30 years old.

Trans women living with addictions or hepatitis C also felt that drug-related stigma compounded their trans-related sigma.

"Those of us who have health [conditions], whether it's hep, whether it's meth addiction,

crack addiction, whether it's whatever. If you have an addiction, you're homeless, you're

HIV positive, they put you in this box. You're over here, they don't want you."- Caucasian,

34 years old.

The women also said that engaging in sex work, either for financial or survival reasons, resulted in them being stigmatized. One woman explained that she chose sex work to support herself as employment options were limited, but then experienced instrumental stigma as a result of her work:

"When [immigration services] say, because I'm a transgender person, working on the

street living with HIV, I'm a danger to the public so I tell them that I use protection, I

always make sure to use protection, so that was discrimination… I feel I've been

discriminated." – Latina, newcomer, age n/a.

Ironically, even when not engaging in sex work, the women who disclosed their HIV status sometimes felt that they were perceived as having brought it on themselves because of their "risky lifestyles":

"Her attitude was, you know, you have [HIV] because you either asked for it, you were a

working girl or you engage in risky behaviours." – Caucasian, age n/a (1)

Many of the women were also racialized, or newcomers to Canada, and they experienced stigma as a result of these intersecting marginalized identities. While they may have been able to conceal their HIV status, and in some cases their gender identity, they often felt that they were still discriminated against as a result of their race, religion/spirituality, or culture:

"I feel discriminated [against], I think most of the time I feel discriminated because I'm

Hispanic. But then when they find out that I'm trans then yeah of course the discrimination

is double."- Hispanic, newcomer, 36 years old.

One of the women explained her multiple marginalized identities as a series of "negatives" that she must face; she used race and HIV status as a simplified example of living with multiple marginalized identities:

"Well for example, if you're black and gay oh my god it's like a double negative or whatever you want to call it so I guess that can be the same for trans, if you're trans and you're positive, double negative." – Caucasian, 31 years old.

Intersectional stigma also played out at the institutional level; one two-spirit Indigenous person spoke about the discrimination that other Indigenous people faced in health care settings:

"A lot of my native friends have experienced a lot in the health care community. Especially with addiction and stuff. I guess with other natives they get, I don't know, they just don't get helped as much as I do. I don't know what I do differently that they don't. But I hear lots of horror stories in hospitals and doctors that won't help them. Or if they find out that they have HIV or if they're homeless or if they're, I don't know, lots of things." – Indigenous, 34 years old.

Despite the complex forms of stigma that trans women living with HIV face, they were also able to speak to the importance of sense of community or community connectedness as a buffer.

Community Connectedness

Despite the limitless communities to which trans women living with HIV may have connection, three of the groups that were discussed at length in the interviews included: HIV/AIDS communities, trans communities and cultural/racialized communities. These communities, the social support derived from these communities as well as from other sources (i.e. from families, romantic relationships, and identity specific social support), and the effects

that community connectedness and social support had on the well-being of the trans women living with HIV were explored.

Connections to HIV/AIDS communities. While some participants had accessed various AIDS service organizations, others found it difficult to do so for various reasons. One Indigenous trans woman spoke about the difficulties of accessing HIV/AIDS services in Ontario reserve communities:

> *"Here on reserve ... there isn't a lot of support ... They have an HIV educator that will come once a year or whatever just to educate people on STDs but that's the only thing they have. Other than that there is ... nothing really, there is no support, no network or whatever for us people that are HIV positive." – Indigenous, 40 years old.*

The lack of relevant programming and supports for people living with HIV/AIDS was not specific to reserves however. Many of the women living in cities smaller than Toronto also reported similar experiences with HIV/AIDS services:

> *"[My small town] should have like ... support groups or whatever, and services to offer to people who are HIV positive. They don't have any HIV programs. They have a lot of like drug programs or whatever but there's nothing, for people that have [HIV] or whatever."*
> *- Indigenous, 40 years old.*

When trans people were able to access HIV/AIDS services, they often had mixed feelings about them, feeling unwelcome in the space:

> *" I don't like [name of ASO]... I think they're very transphobic. I uh just find that they're cold when people go in there; they're not receptive to what you're telling [them] ... it's just that feeling, you know, the look. You're not welcomed" – Caucasian, 58 years old.*

Other trans women felt HIV/AIDS services to be more welcoming of gay men than they were of trans women living with HIV:

"I just find it's too male-oriented to be honest with you. They don't have a lot for the trans community and stuff…I think for years [name of ASO] was known as a male, gay, HIV agency, so that could be a lot of it." – Caucasian, 58 years old.

Trans women with HIV felt invisible and underrepresented in ASOs:

"I thought that I was the only one when I was doing volunteering [at name of ASO] because I never seen anyone who is trans that comes here." – Hispanic, newcomer, 36 years old.

Others felt that the HIV/AIDS services were immensely helpful, and they felt a strong sense of community connectedness to them; one described an ASO to be like a family of choice:

"These people [at ASO], they become my family, I don't speak to my family right now… because of HIV issues, they refused me from [their] house … so its the services that I access in the city, they're my family, they're my support… they're the ones I go to when I need to feel loved which is absolutely wonderful." – Indigenous, 30 years old.

One of the women explained that it was easy to feel connected to communities in Ontario because of the various options for accessing services and groups, and the conferences that she could attend as a person living with HIV:

"When I go out I always make sure I [integrate] myself into the community. The community is so interconnected; cause there's conferences … everybody winds up knowing everybody in some way or another."- Caucasian, 34 years old.

Those who accessed services and had positive experiences stated that it was because they felt comfortable or safe in the space. This was extremely important as a factor in determining whether people felt connected to the HIV/AIDS communities that were available to them:

"[The different services that you go to, do you find a lot of support there as well?] Yeah. It's not only the support, but it's a safe place, we can feel safe. Nobody bothers us." – Latina, newcomer, age n/a.

Connectedness with trans communities. The interviews also demonstrated that the women felt connected to various trans communities. Some formed bonds and connections with other trans women, allowing them to form their own communities:

"In the trans community I have a lot of trans girls that look up to me or if they see me on the street they'll be like oh [name] can you look out for me 'cause if I go into a car can you watch the license plate or this or that… I always watch out for my girls" – Indigenous, 38 years old.

Many of the women created community by seeking out services that provided resources to trans people. One agency provided meals to trans women, offering a space that was gender-affirming:

"Like when you go to [ASO name] it's just a meal with the girls. It's a good bonding experience … you do feel like a woman with other women." – Indigenous, 34 years old.

Other women were more connected to other trans people regardless of their access to trans-specific spaces. In some cases, they had met other trans people in shelters or as sex-workers:

"I have a lot of girlfriends. I talk to everybody, they call me. [I'm] pretty mellow with everybody. Yeah, if I need to talk to people, I call them up. I actually have a lot of friends across the country, so its like, Facebook helps. Having the phone helps." Indigenous, 34 years old.

However, not all the women who participated in the study felt connected to trans communities. Some women felt that the trans communities around them were toxic environments and could actually be detrimental to their health:

"It can be a very bitchy community. I don't do a lot with the trans community. I never go to the [name of agency], the male trans acceptance centre… There can be some groups that are really good in the trans community and there could be others who just want to sabotage what you're doing basically."- Caucasian, 58 years old.

The issue of erasure also emerged, as many of the women felt that they could not easily find other trans women with whom they could build a community. One Indigenous woman explained that often trans women did not attend certain trans events because the events did not cater to their needs:

"There's no role models I guess you can say. There's no one public speaking in that realm. Especially in the native community. When we do conferences, I keep putting every year, trans and HIV, hormones and HIV medication, like workshop ideas or stuff like that. It hasn't developed anything like that, or found anything. I think they just categorize us with the women… and that's it." - Indigenous, 34 years old.

It is important to note that many of the women who completed the interviews spoke specifically about "trans" communities rather than "LGBT" communities. To them there was often a distinction because "LGBT" communities were not always seen as inclusive or safe for trans people:

"Because you know what, is not everyone [who] have acceptance, even in [the LGBT community], some gay people… they don't like us … So we feel discriminated not only

from the heterosexual community, yeah. We can have that in our community too." –

Latina, newcomer, age n/a.

Connections with cultural/racialized communities. The trans women who participated in the study also felt a sense of community connectedness to the cultural or racialized communities that they were a part of. For example, some spoke about the intersection of having a positive HIV status and being Indigenous, and finding communities that represented these two identities:

"Every year I go to two‑spirit gatherings, so it's good to go get revived at those, and the

Canadian Aboriginal AIDS network, they have yearly skills building conferences, so its

good to just go be with other people who are HIV positive." - Indigenous, 34 years old.

It can be at these types of culturally-specific events that trans women meet others from similar geographic, cultural, religious, or racialized communities, and where they are able to form relationships:

"[I met] my closest friends now that I am enter in the group of Latinos Positivos you

know? I go to the seminar I go to the conference. I learn more everyday too…[Latinos]

Positivos I love the group with Latinos." – Hispanic, newcomer, 44 years old.

It was also noted however, that being part of a certain cultural group does not necessarily mean that you will find support there. Some participants spoke of moving away in order to find their true selves, while still identifying as part of a cultural group:

"I'd never seen gay people before, I'd never seen trans people before. When I grew up on

rez, you know, everyone who is of the homosexual nature, they all move away and you

never see them again or, you know. It's always just straight people and colonized people

and religious people… so when they scare you away and you come [to Toronto], you

discover yourself." - Indigenous, 34 years old.

For some of the women, the way in which trans people were perceived in their culture shaped the relationships that they had with those communities. If the culture was more accepting about gender fluidity or sexual orientation, then the women tended to report closer ties to these communities:

> *"I love [Peruvian parties]… I feel more comfortable [with a] group of family, people that I know is like [me]."- Hispanic, newcomer, 44 years old.*
>
> *"All the Latino trans, transgender, they have a good relationship with their parents and siblings." – Latina, newcomer, age n/a.*

For the women who participated in the interviews, community connectedness often played an important role in their lives because it was through these various communities that they received social support. While social support could come from HIV, trans, cultural/racialized communities to which the women belonged, it could also come from family, friends, or romantic relationships.

Social Support

Families. For some women in this study, relationships with their families were an added source of stress, as their families were not accepting of their trans identity, HIV status, or both:

> *"Yeah there's… you know my family stigmatized me and you know…" – Indigenous, 30 years old.*

Some women chose to come to Ontario because of their families' disapproval of their identities. For example, one Latina woman explained how she left her country because her mother feared the shame that having a trans child would bring to the family:

> *"That's why I am here because… my mom when I was 14, it's when I got my first boyfriend. Um, she's like 'you know I have this money, so, I'm gonna give it to you please*

go away, stay away from us, because I don't want the rest of the family to find out you're

trans' so I had to go." – Hispanic, newcomer, 36 years old.

One of the trans women in the study said that she was not shunned by her family, but that her

relationship with them was strained because they chose to cover up the fact that she was trans

and living with HIV, in order to satisfy other family members:

"They know [that I am HIV positive]. I also had the uncle [who died of AIDS]…They

don't like to mention it in the family…[they say] 'oh he's working and his health is good,

he's got a girlfriend', they don't mention that I'm gay or the bi, [on] social assistance.

They're always lying for me."- French-Canadian Caucasian, 41 years old.

Having an unsupportive family was upsetting for some of the women as they wished that they

could receive social support from their families about being trans and HIV positive, but also

support for other issues that they may be facing:

"My family has shattered. Which is really bad because I really would have enjoyed some

support for my transgender issue, for my HIV issue, but also just for normal stuff." -

French-Canadian Caucasian, 48 years old.

On the other hand, some women reported feeling a sense of closeness with their family members,

and indicated that their families wanted what was best for them:

"My family is pretty accepting, my mother has passed away so I just have my father who

lives [on the east coast], he knows all about me and is very accepting of it and so as far as

he's concerned he just looks at me as his child. He doesn't care what I do with my life… as

long as I'm happy." – Indigenous, 38 years old.

Some of the women also received social support from their families despite their families not

being completely familiar with trans or HIV issues:

"[Does your family know you identify as trans?] Yes they do… they don't know what to think about that. It's kind of over their head or whatever. I've tried to explain it to them but… they still don't get it I don't think. Because before, you know, they considered me just to be gay ... so now that I was identifying as trans ...they didn't know how to react, how to accept that. It was just all a bit too much for them I think. [Did they react badly?] No they didn't. For the most part they were very, very supportive." – Indigenous, 40 years old.

Not all families were unaware of trans or HIV issues however. Some families still chose to act as a source of social support to the trans women by normalizing their experiences. For example, one woman described the calm way her mother reacted to her coming out as trans:

"I come out of the washroom and I said to my mother, when I go back to Toronto, I'm going to legally change my name, I'm gonna live as a woman and be happy. My mother patted me on the back and said, "that's nice dear.""- Caucasian, 58 years old.

Many of the women, irrespective of whether their families were supportive of them, reported that their families rarely mentioned their HIV positive status:

"[Do they know that you're HIV positive?] Yes. [How did they react] Nothing, they didn't say anything. No. They didn't say anything."- Hispanic, newcomer, 36 years old.

This dismissal of one's identity, or lack of support led some of the trans women living with HIV to turn to friendships rather than family for social support:

"It gets lonely. I think that's why I just fill my world up with friends."- Indigenous, 34 years old.

The interview questions did not focus specifically on friendships, however some of the women spoke about the ways in which they experience friendships, and how they provided them with

social support. Most however, did not go into great detail about the types of friendships that they made outside of HIV, trans or cultural communities.

Romantic relationships. Many of the women chose to disclose their feelings about the social support, or lack thereof, which they received from romantic partners. Some reported relationships that they regarded as healthy and supportive:

> *"My husband right now he's in [unspecified country]. He was deported – He's HIV [positive] too… Plus my husband accepts me the way I am."- Hispanic, newcomer, 36 years old.*

One of the participants said that despite not currently being in a relationship, she found that it was easier to find casual partners as a trans woman that it was as a gay man:

> *"I find it much easier to get laid as a trans than as a gay male, I don't know, and the sex is much hotter."- Caucasian, 31 years old.*

Many relationship experiences, however, were not positive. Many of the women endured physical or emotional abuse. One Indigenous woman described a possessive and jealous partner, who became violent to the point of the relationship ending:

> *"I met him as [name]. We came here; we lived [on reserve] for 3 months. I introduced him to my family. And they seemed accepting, accepting of him I guess. During those 3 months, whenever we'd go out or whatever, go to the bar, go to the beach, if there were guys there he was just extremely possessive and jealous … He'd say 'well okay you shouldn't talk to him'… So that relationship lasted for 2 years, near the end he was going to kill me… he threatened to kill me. He actually got like a hatchet."- Indigenous, 40 years old.*

Some of the women who reported being in abusive relationships said they feared being alone, or that they did not feel that they deserved better:

"I was in a relationship, I allowed myself to be the victim, because I didn't believe I deserved any better than that." – Caucasian, 34 years old.

Moreover, some of the women spoke about how difficult it was to be in a relationship if you are trans and HIV positive. For example, one woman described the interactions of HIV stigma and trans-related stigma when dating:

"Primarily with meeting new people and relationships, that's where being trans and HIV positive is kind of very hard. Because for a regular person … it is so easy, no problem. But as soon as you're HIV... okay [so they are more] open minded here in Toronto about HIV and AIDS. But when you get that combo of HIV and transition, it's harder, it's even harder." – French-Canadian Caucasian, 41 years old.

Unfortunately, many of the trans women saw these same relationship patterns playing out in other trans communities that they frequented. One shared her concerns about aging, living with HIV, being trans, and going through a break up:

"Things happen … and I see that there are a lot of people like me, by myself, because a couple years [ago] I broke up with my other boyfriend. I won't find boyfriend anymore, I won't have anyone, nobody would love me, I'm HIV positive I'm getting old you know? I'm getting fat, so I get depressed a lot." – Hispanic, newcomer, 44 years old.

While being single was not a choice for some of the women, others chose it sometimes cultural/religious reasons (i.e. same-sex attraction was forbidden or seen as a sin), but at other times it had to do with being seen as a threat or as undesirable if living with HIV:

"I'm working on the streets so I'm danger to the public so [the police] made me understand that a HIV person can't have sex, can't have relationship."- Latina, newcomer, age n/a.

Some of the women discussed seeking a partner for companionship because they currently felt very isolated. They spoke of the types of social interactions that they were seeking; often these were less about sex and more about social interaction, affection, and support:

> *"I would just like a companion, somebody to go out with, do things with, you know, go*
>
> *have drink on the patio or go to the theatre, go to the casino or something."- Caucasian,*
>
> *58 years old.*

Shared identity as a form of social support. Finally, social support emerged as a result of shared identities. The women described their identification as HIV positive, trans, or as part of a cultural group in the interviews. For example, one woman described how she met a lot of other trans women when she stayed in homeless shelters. While she described the shelter as a negative experience, she speaks of the relationships that she made there in a very positive way:

> *"It was a bed, whatever. It was a place to sleep… but in there that's where I met a lot of*
>
> *other transgender people, and we became sort of like our own little support network or*
>
> *whatever. We became family, we all supported each other … protected each other." –*
>
> *Indigenous, 40 years old.*

It was through these interactions with people who had similar lived experiences that the women were able to gain knowledge, advice, or resources. For example, one of the women explained how she had met a trans woman who became her friend and provided her with social support, but also brought her to meet people within the trans community and paid for her to have surgeries:

> *"She's actually the one who brought me to get my face done, she actually paid for it as*
>
> *well… I held her hand while she got her ass and all her hips pumped … all the trannies*
>
> *know about it so it was like we all went together and there was a line up of girls getting*

pumped… My friend held my hand because I couldn't do it alone, I was scared right."-

Caucasian, 31 years old.

Sometimes these relationships were based in reciprocity, and the women described that they too had been in positions where they had given advice to others. One described explaining to another trans woman how to access resources and groups in which she could gain information that she needed:

"I'll listen to [trans women who had recently transitioned], I'll point them to where I've been and how to accesses services they may not know how to. I'll tell them this is what I did, if you want it, this is what I did and I got [the resources I needed]." – Caucasian, 34 years old.

This was not specific to being trans however. Similar stories emerged of women providing advice about sex work, employment, community resources, etc. For example, one woman described how a friend who was concerned that she may have contracted HIV approached her because she only felt comfortable discussing this with someone who had also gone through that experience:

"She kind of was afraid because she had a boyfriend who recently was found [to be] HIV positive. She called me very afraid and she was crying and I say you know, it's not the end of the world, everything's going to be okay."- Hispanic, newcomer, 36 years old.

Well-Being

Two salient themes emerged regarding well-being. The first theme was the sense of isolation linked to either one or more of the intersecting identities that the women lived every day. The second had to do with the women's ability to resist or reframe the negative experiences and narratives of the various types of stigma that they experienced.

Isolation. Because of the multiple stigmatized identities that trans women living with HIV face, many reported feeling very isolated. Some reported feeling like there was nowhere that they could go, and that they didn't know anyone experiencing similar circumstances:

> *"There are no other trans people here. [Do you know like any trans people at all in the area at all?] Like beyond the reserve? Mmm No. None close by that I know." – Indigenous, 40 years old.*

For those women who could connect with people who had similar lived experiences, they described this as life changing:

> *"Yeah. I'm glad they kinda reeled me into [Indigenous organization] cause I think I would have been just another lost soul out there and wouldn't want to care to take the medication." – Indigenous, 34 years old.*

Unfortunately, not all of the women who participated in the interviews had ties to communities that represented them, resulting in a lack of support:

> *"[If you ever need to talk to somebody about either stuff related to trans things or stuff related to HIV things, who do you usually go to?] No one. I talk to myself. You know, what can I say… I don't have no one to talk to."- Hispanic, newcomer, 36 years old.*

This was further compounded by a lack of support from family that so many trans women experience as a result of their gender identity or sexual orientation:

> *"I was kicked out as a kid because of my sexuality and gender… you know like these major health issues have really been put on the back burner and its you know so unfortunate."- Indigenous, 30 years old.*

For those who felt isolated, negative health outcomes such as depression often emerged in the interviews:

"Mental health… yeah [it] was not too bad, maybe I was a little too [solitary], too much

alone, so sometimes I feel a little depressed, but I managed to uh focused on being…

healthy."- French-Canadian Caucasian, 48 years old.

Isolation, feelings of rejection and depression were common among the women. One woman

attributed suicidal thoughts to the lack of support she received from her family:

"I got to a point of suicide. And there's one time I said, if I can't be who I am, and dress

the way I am, I'm not coming to your houses. I've already told them… I said I'm not

pushing them away, well they're pushing me away… I can't keep going through this. I

mean it's gone on so long."- Caucasian, age n/a (2).

Resisting and reframing. Not all of the women who participated in the interviews reported

feeling isolated. Many reported being connected to multiple community groups, with social

support coming from a variety of sources. For these women, the discussion of their experiences

was reframed in a more positive light. Despite the multiple forms of stigma they experienced,

they were more likely to draw strength from their various identities.

One participant reported being very close to her family and receiving considerable

support from them, as well as from Indigenous community groups. She stated that she no longer

let the stigma associated with her HIV status affect her:

"In the beginning… I guess I was kind of ashamed, I didn't want anybody to know that I

was HIV positive… but that's changed now. Now I no longer worry about being

stigmatized or whatever. It really doesn't make any difference to me what people think." –

Indigenous, 40 years old.

She went on to say that having lived with HIV, she felt that she had become a stronger person.

She was able to reframe a stigmatized identity into one that was empowering:

"I guess this disease has made me more of a stronger person I guess… I don't take a lot of shit from people. If they try to give me shit I don't take it. If they say or do something I'm going to put them in their place and let them know I don't like how they're treating me." – Indigenous, 40 years old.

Another woman with multiple marginalized identities shared a similar story of finally standing up for herself after having lived through some difficult experiences:

"I've become more aggressive, and I'm like back off! Enough is enough. I've had enough of being this abused by people, and I get to a point in life that I stopped doing that. I've had to explain to people. You know why I'm like that? It's because I stopped taking that crap. I really stopped taking it. There's no reason for it." – Caucasian, age n/a (2).

Her reasoning for not putting up with abusive relationships anymore was that she was finally able to be comfortable with who she was:

"I figure people are going to accept it or not…I'm not going back anyway so, I'm not going to do it for them. I'm not compromising that part of my life for them. There's no way… I'm not going to allow them to take it away from me." - Caucasian, age n/a (2).

Some of the women even took this resistance further and were able to give back to the communities to which they belonged. One spoke of her experiences of being both a trans and HIV activist. She explained the importance of being open about her identities so that people living with HIV and trans people could be visible in communities:

"[How often do you disclose your status] All the time. I talk to people on the subway, I talk to people on buses. [So you tell them that you're trans?] yes [and you tell them that you're positive?] yes, I get really good reactions… and maybe I do it as a high for myself, I don't

know. See what the reaction's going to be in different buildings." – Caucasian, 58 years

old.

This was also the experience of one of the woman who identified as Latina, and who stressed the importance of talking about the discrimination and HIV stigma that she experienced as a learning opportunity for others in her communities:

"I don't mind actually because before I [had] stigma, with my HIV status, but not anymore so I think I don't care [what] people know… So, yeah. I feel I've been discriminated, when I have the opportunity to talk about it, I do it." –Latina, newcomer, age n/a.

Being able to resist and reframe narratives of the intersecting stigmas that they encountered allowed the women to experience fewer negative health outcomes. They were better able to cope with the multiple forms of stigma tied to their trans, HIV, cultural, and intersecting identities.

Discussion

Stigma

As discussed, the isolation described by trans women living with HIV is perpetuated by the various forms of stigma (see Table 1) they experience as a result of their multiple marginalized identities. While isolation is not the only negative outcome of these stigmas, I have chosen to discuss it as a structural factor that can be addressed through connection to communities with which the women identify, or through the social support to which they have access (Baral et al., 2013; Logie et al., 2012a; McWilliam, et al., 2007). While internalized stigma can increase experiences of shame, low self-esteem, loneliness and negative mental health outcomes, its effects can also be reduced if connections to communities with which women identify are made available to them (Bockting, Robinson & Rosser, 1998; Lombardi & van Servellen, 2000). At the very least, the effects of intersectional stigma can be reduced if the

women have social supports available to them through family, friendships, romantic relationships, or identity specific forms of social support.

However, finding communities that are representative of marginalized individuals' identities can be difficult, and often, social support is not an option because family, friends and romantic relationships can be greatly impacted by symbolic, instrumental, or enacted stigma associated with either HIV status, trans identity or both. Social support systems thus can be created through connection to communities of individuals with which one has shared experiences or identities. These relationships can provide the social support that is lacking if an individual does not have connections to family, friends, or romantic partners. These relationships can be fostered through gathering places such as organizations, events or social groups, and can be maintained through continued engagement and participation in the community. It is also important to note that barriers to participation and engagement should be regularly addressed by having those within the groups bring these issues to light and actively work with administration to find acceptable/effective solutions.

Intersectional Identities and Stigma

The results reported on suggest that most of the women experience at least one type of stigma as a result of one or more of their identities, and they recognize stigmatization when it is happening. These findings are consistent with those of Logie and colleagues (2011) who found that women living with HIV were able to identify relationships between their social identities and systemic inequalities that they faced at interpersonal, community and structural levels (i.e. due to HIV, gender, racism, sexism, etc.). Stigma related to trans identity was also found to contribute negatively to well-being. For example, the women reported being exposed to transphobia as consequence of trans-related stigma. Transphobia was discussed as affecting the

women's lives in the forms of, violence, transmisogyny, erasure, stereotyping, as well as both overt and subtle discrimination. Transphobia has been documented as a risk factor for several negative health outcomes including those listed above, as well as suicidal ideation and attempts (Bauer et al., 2015; Pyne, 2015, p.132).

HIV status was another major source of stigma for the women. They spoke of the instrumental stigma that emerged from misinformation about HIV. Furthermore, HIV-related instrumental and enacted stigma resulted in the women being denied access to certain health and community services, and denied access to jobs, which led to financial strain; results reflected in other literature (Logie, et al., 2012a). Due to the unclear laws regarding the criminalization of HIV, trans women living with HIV, particularly those engaging in sex work, may be more likely to experience discrimination and symbolic stigma (Canadian HIV/AIDS Legal Network, 2014). Because the current laws around HIV criminalization place the onus on the person living with HIV to disclose, the women may feel that they must take on the entire burden of responsibility for using condoms and disclosing their HIV status (Canadian HIV/AIDS Legal Network, 2014). This added to the constant fear that those around them would reject them because of their HIV status. This is consistent with Marino, Simoni and Silverstein, (2007) who also found that psychosocial stressors such as rejection and social stigma result in fear and other negative health outcomes. This is important because policy that currently exists at a macro systems level is negatively affecting individual well-being of an already marginalized group, further contributing to their marginalization and criminalization, thus increasing negative health outcomes experienced at a community level. This is in line with Parker and Aggleton's (2003) discussion on the power that research informed policy could have on reducing macro level stigma through the development of legal protections, reporting and enforcement mechanisms.

Furthermore, various forms of stigma were compounded given that the women lived with more than one marginalized identity (Longman Marcellin, et al., 2013). Some of the women viewed their identities as a series of "negatives" that all acted against them in various aspects of their lives. This was in line with Meyer's (2003) theory of multiple minority stressors, in which stressors related to a marginalized identity would compound stressors that resulted from other marginalized identities to create worse health outcomes for those in question. They also stated that besides their identification as HIV positive, and their trans identity, they also experienced stigma as a result of having addictions or other mental health issues, being homeless, or engaging in sex work. Substance use, mental health issues, homelessness and sex work however are often outcomes of systemic inequalities (i.e. transphobia, transmisogyny, sexism, racism, colonialism) that trans women face (Bauer et al., 2009; Bauer et al., 2015, Nemoto et al., 2004). Bauer et al. (2015) explain some of the systemic inequalities that exist for trans people including social exclusion and erasure. If we consider an intersectional model of stigma when examining the experiences of trans women, it becomes clear that identities cannot exist in isolation, but rather that are a product of the systems to which they belong, and that these can only be shifted if current systems of inequality, hierarchy, and oppression are called into question (Bauer, 2014; Parker & Aggleton, 2003). This demonstrates the need to address the systemic level, rather than only the individual level, if we wish to change the negative outcomes experienced by trans women.

Racialized trans women face disproportionately greater inequalities (Longman Marcellin, et al. 2013), and this held true in this study. The women who identified as Indigenous, First Nations, Hispanic, or Latina spoke about the ways in which their cultural and ethnic identities interplayed with their HIV and trans statuses. Some of them recounted experiences of

discrimination at an interpersonal level, while others experienced discrimination at institutional levels that often stemmed from systemic racism and colonialism. Examples included discrimination in shelters, hospital settings, the immigration system, as well as HIV or trans services. Logie and colleagues (2011) found that stigmatizing processes operate on micro (interpersonal), meso (community), and macro (structural, systems) levels, often simultaneously, to affect marginalized groups. This provided support for the findings of this study.

Community connectedness and social support as resisting stigma

Trans women who felt connections to HIV, trans, or cultural communities said that these were a source of support, families of choice/friendships, safe spaces in which they could be themselves and feel comfortable, as well as a source of information and resources. The positive aspects of community that the women described were in line with the characteristics of community connectedness originally outlined by and Mcmillan and Chavis (1986). These spaces not only provided trans women living with HIV satisfaction of their needs through affiliation, mutually influential relationships with the collective, and shared emotional connections, but also gave them the group level coping resources necessary to protect them from the multiple minority stressors that they experienced (Frost & Meyer, 2012). Furthermore, the women often said that these connections to community increased their social and psychological well-being by reducing their sense of isolation. This supports the idea that sense of community, or community connectedness, could serve as a protective factor against negative health outcomes for trans women much as it has for other marginalized groups (Kertzner et al., 2009).

It is important to note that while some women did not have connections to HIV or trans communities, they were strongly connected to their cultural communities. Generally, they reported the same positive protective factors as the women connected to HIV or trans

communities, however they often desired to also build connections to these communities. This was particularly true of cases in which racialized women had been rejected from their cultural communities as a result of one or more of their identities. This was difficult for them, as they then had limited sources through which to obtain support, information, and resources. The fact that some women had been rejected from cultural communities with which they identified spoke again to the enacted stigma associated with HIV or trans identity. At times, the symbolic, and enacted stigma within Hispanic/Latina and Indigenous communities resulted in extreme situations (i.e. threat of violence/death, physical and emotional violence, etc.) in which women felt unsafe and had to leave their town, reserve, or country in search of a safer space. For racialized women who wanted to stay in their cultural communities, this may not have been an option either due to lack of resources or information within certain communities about HIV or trans-related issues. This was particularly true of small towns and reservations. This speaks to the need for culturally sensitive supports or programs about HIV and trans issues across Ontario. With geographic access to culturally relevant services, benefits would be twofold, first, women would be able to build stronger communities with people who share lived experiences, and second, trans women with HIV would become more visible in places where they were previously underrepresented (Bauer et al., 2009). Visibility and education about HIV and trans issues would also serve to reduce the instrumental and symbolic stigma associated with these two identities. However, these types of interventions should not only be targeted at trans individuals, as the onus for reducing stigma should not fall on their shoulders.

One of the biggest advantages of community connectedness was the ability of the women to draw social support from these. Communities were however not the only ways in which

women could experience social support. Support could also come from family, romantic relationships, or from connections to people who had shared identities with the women.

The data show that the women who reported close relationships with their families found these to be a source of social support, and they were more likely to resist and reframe the negative effects of stigma. These findings seemed to be reversed for the women who reported having little to no support from their families. This can be explained as a consequence of losing a sense of belonging to one's family, often the first vessel through which people feel social support (Stutterheim et al., 2009). This loss of support from family can often result in increased psychological distress, which decreases one's well-being (Stutterheim et al., 2009).

Romantic relationships seemed to play a similar role in the lives of the trans women living with HIV. Those who reported having strong relationships to partner(s), found that these provided them with social support, increasing their sense of well-being. It was however evident in the data that many of the women lacked romantic relationships and were often distraught about this. Many reported avoiding relationships because they had experienced trauma in the past. It is not uncommon for trans women to experience violence and transmisogyny in romantic relationships because their identity challenges cisnormative assumptions about what sex and relationships should look like (Pyne, 2015, p.132).

Finally, some of the social support that the women described came directly from individuals with which they shared common experiences (e.g. gender identity, HIV status, cultural identity, or sex work). Through these relationships they gained guidance, resources, friendships, and validation of their identities. This is important because interacting with individuals with whom you can make positive social comparisons can increase self-esteem and as a result can increase well-being (Meyer, 2003). These positive social comparisons also combat

erasure of marginalized identities and allow trans women to resist the narratives of enacted stigma that perpetuate erasure. The women found this to be extremely helpful, and some even used their own stories to provide this type of social support to others who were living similar experiences. The women found that using their experiences as strengths rather than weaknesses was an act of resistance, and could be used to speak out about the various intersecting stigmas that trans women living with HIV experience.

Recommendations

Countering the multiple forms of stigma experienced by trans women living with HIV will increase their well-being. Based on the data from the qualitative interviews, a series of recommendations for countering stigma at multiple ecological levels of analysis, through community connectedness, are provided (Table 2). These recommendations are based on the feedback from the women's interviews, as well as from the recommendations listed by Stangl and colleagues (2013) that examined a multi-level approach to stigma reduction. This approach was used because it became clear that the multiple forms of stigma that the women reported experiencing could not be teased apart and analysed in isolation, but rather they seemed to overlap and interact to create the negative health outcomes previously listed. Finally, some of the recommendations also came from the theoretical work of Parker and Aggleton (2013) who discussed community mobilization as a tool for social change.

The data suggest that community connectedness and social support are factors that can greatly impact the lives of trans women. When community connectedness and social support are present, well-being will be increased, however when these are absent, negative health outcomes such as isolation will decrease well-being. This particular research study suggests that for trans women living with HIV in Ontario, identification with particular identities can foster a sense of

community connectedness to those with shared identities. For example, identification as trans, as a person living with HIV, as a sex worker, as Hispanic/Latina, or as Indigenous, may allow for connections to communities that foster social supports. These social supports may exist in addition to supports from families, friends, and romantic relationships, or may exist independently. For trans women living with HIV, resistance and reframing of stigma and negative experiences was dependent on the types of community connectedness and social supports that were available to the women.

Implications for Stigma reduction

Addressing stigma reduction through the increase of community connectedness and social support for trans women living with HIV means addressing the barriers to community connectedness and social support that exist. As indicated in Table 2, much of the work to be done within trans, HIV, LGBT and cultural communities requires funding. For programs to be developed, trainings to be hosted, and resources to be produced, funding has to be made available to the organizations that will take on these tasks.

To further demonstrate the need for funding, and in order to bring greater attention to the needs, lives and experiences of trans women, researchers should strive to conduct research with trans women, for trans women. This has been a problem in the past, as we know that trans women, particularly racialized trans women and trans women living with HIV, have been invisible or underrepresented in research (Logie, et al., 2012a; Longman Marcellin, et al., 2013).

Because societal norms and structures influence attitudes and behaviours, stigma reduction efforts need to be made at micro, meso, and macro levels. For example, targeting interventions at the individual, interpersonal, organizational, community, and policy levels works to address the various types of stigma previously described (Stangl, Lloyd, Brady, Holland &

Baral (2013). This is particularly important as the data from this project indicate that the various types of stigma experienced by trans women living with HIV do not exist in isolation, but rather interact and overlap, resulting in negative outcomes for the women. While previous recommendations and interventions have addressed mainly the micro and meso levels, structural factors create a system in which stigmatization strengthens and reproduces existing inequalities, and thus targeting these is key in reducing stigma and creating social change (Logie et al., 2011; Parker & Aggleton, 2013; Stangl, et al., 2013).

For example, at a systemic level, laws need to address the flaws that currently exist regarding criminalization of HIV. At a minimum, laws should be made more clear so that people living with HIV understand what their rights and obligations are (Canadian HIV/AIDS Legal Network, 2014). Laws and policy that focus on deterrence and rehabilitation, and that have been proven to be ineffective, should be revisited and revised in order to address shortcomings (i.e. a move towards education and harm-reduction rather than coercive interventions, and the taking into account of an individual's safety in the disclosure process) (Canadian HIV/AIDS Legal Network, 2014). Laws should also serve as a tool that protects trans women living with HIV by ensuring that there are systems in place that allow reporting, inquiry, and enforcement against discrimination that may be experienced. Policy can also be used to implement mandatory intersectional, anti-oppression trainings (that include discussion on HIV, gender, race, class, sexual orientation, sex work, etc.) for ASOs, community organizations, and research teams.

Another important implication of this study is the ability of the women to resist and reframe narratives of stigma, and the potential this has to be a tool for social justice. The women who were able to resist or reframe narratives of intersectional stigma demonstrated the benefits that this had on their psychological well-being. Resisting social narratives that produce stigma

can be useful on an individual level (producing positive health outcomes), but it can also simultaneously challenge stigmatizing community/social norms and structural inequities (Parker & Aggleton, 2013). HIV or trans activism in the form of community mobilization can lead to social change through the empowerment and collective resistance of marginalized groups. This form of community organizing/mobilization has been empirically proven to be effective in shifting societal norms, and thus it is essential that it be integrated into any interventions aimed at reducing structural stigma (Parker & Aggleton, 2013).
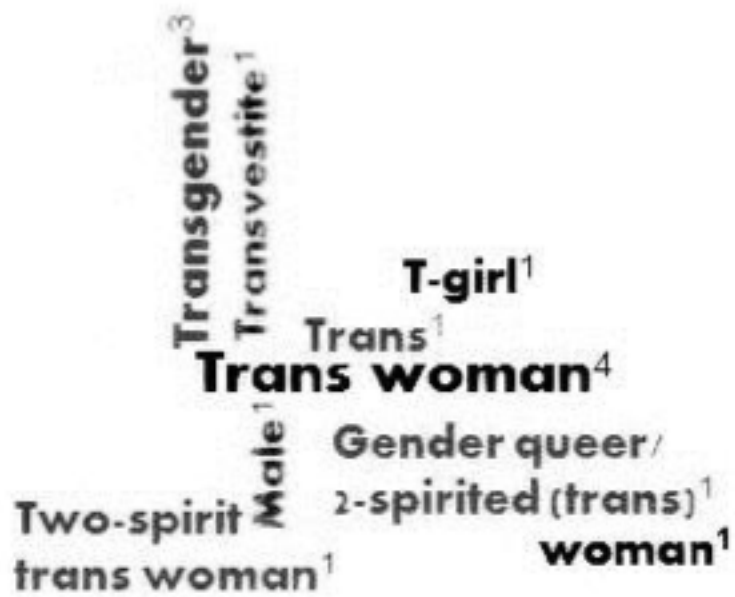
Finally, this research will have implications for AIDS service organizations and LGBT/trans organizations as they are in the best position to develop interventions that reduce the types of stigma that are faced by trans women (i.e. trans-related stigma, HIV related-stigma or stigma due to other intersecting identities). They are also in the position to combat the erasure that further perpetuates enacted stigma by making trans people visible within their organizations (i.e. as staff or peer-workers). Having people with lived experiences in these roles increases community control and community capacity (Travers et al., 2013). These community organizations are also in the best position to work with trans women in order to determine what is successful and what should be modified within their organizations.

Limitations and Conclusions

Analysis of the data did not appear to show a distinction between racialized and non-racialized trans women in terms of community connectedness to HIV/AIDS or trans communities. There was also no distinction between the social support experienced by the racialized and non-racialized trans women who participated in the interviews. This lack of distinction between racialized and non-racialized trans women is perhaps due to the particular group of trans women who were able to be reached for this phase of the Trans PULSE Project.

While 7 of the 14 women identified as Hispanic, Latina, or Indigenous, none identified as part of other communities of colour. This is a limitation of the study, as we know that certain communities of colour, African, Carribean and Black trans women for example, experience more severe outcomes of transphobia and other forms of stigma (Longman Marcellin, Bauer, & Scheim, 2013). Travers et al. (2013), spoke to the difficulty of maintaining representation of racialized trans people on the Trans PULSE Project. Presumably, if representation was not maintained on the project, this would have had an effect on the people choosing to participate. Individuals who had certain forms of privilege as a result of their race and class may have been more likely to be reached by a project like Trans PULSE (Travers et al., 2013). To address this, members of the Trans PULSE team attempted to address systemic problems that may be due to racism by engaging in anti-racism training, and having a standing item of anti-racism on each meeting agenda, as well as a anti-oppression/anti-racism statement for the project (Travers et al., 2013). Future research should address these issues by having trans women of colour conduct research within trans and HIV communities in order to increase representation of racialized trans women on the research team. Hopefully having a more diverse research team, one that can address systemic issues in the research process (i.e. potential racism, colonialism, power inequalities, etc.), will also lead to recruitment strategies that can reach racialized trans women whose voices were not previously represented.

Appendix A. Participant self-description of gender identity (Phase III participants)

Transgender[3]
Transvestite[1]
T-girl[1]
Trans[1]
Trans woman[4]
Male[1]
Gender queer/
2-spirited (trans)[1]
Two-spirit
trans woman[1]
woman[1]

Appendix B. Audit Trail

Selective coding:
- Upon gaining access to the transcripts, I initially read through them once to familiarize myself with the data.
- I read through the transcripts a second time in order to identify sections that would later be coded.
- I read through the transcripts a third time to ensure that all sections that were to be coded had been identified and that none had been missed.

    Criteria for coding:
- Any portion of the interviews that discussed community, sense of community, ties to community, community groups, group membership
- Any portion of the interviews that discussed social support, family, friendships, romantic partners/relationships, advice, comfort, guidance, lack of support or isolation
- Any portion of the interview that discussed stigma (HIV-related, trans-related, intersectional stigma, racism, transphobia, sexism, as well as anything that was a result of stigma (violence, transmisogyny, erasure, isolation, negative health outcomes, addictions, exploitation, microaggressions)

Secondary coding:
- Identified sections were then coded to produce a series of nodes in Nvivo11. At first these were all separate nodes that were very detailed and sometimes used the women's words to describe codes.
- Eventually, multiple codes started to emerge that discussed similar topics. As this happened, I started to create parent nodes (by collapsing similar codes into one group). E.g. Codes came up for friendship and family, and once there were enough of these, they were made into sub-codes of a larger code called "social support".
- Once all the transcripts were coded in this way, my supervisor and I went through the list of codes and the quotes contained within these in order to determine if they made sense, and if anything should be moved or recoded. My supervisor also ensured that all coded sections were relevant to my thesis questions.

Thematic analysis:
- At this phase of analysis, the codes were expanded and collapsed as necessary in order to create themes.

    Collapsing and expanding codes:
- Code "violence" along with its subcodes were moved under the parent code "stigma". Reasoning: All of the violent acts that were coded were the result of either gender identity, HIV status, or intersecting identities. We established that the violence that the women experienced was a result of stigma.
- Code "work experiences" was originally a parent code, but we went through the quotes that it contained and re-coded these to more suitable codes. E.g. some sex work quotes actually spoke to social support being received from sex workers, so these were re-coded as "sex-work related" under the parent code "social support". Working at an Indigenous HIV center was re-coded "connection to cultural communities" under "community connectedness".
- Anything that was coded under "sex-work related" (originally under "work experiences") was recoded under "due to intersecting identities" under "stigma". Anything still under this code that wasn't about stigma or its effects was uncoded (e.g. time engaging in sex-work, money made). Reasoning: Systemic transphobia resulted in many of the women having to engage in sex work for survival or financial reasons, but once they were engaged in sex-work, they experiences more stigma as a result of this identity.
- Some of the codes were renamed in order to make them more representative of the data contained within. E.g. "internalized homophobia/transphobia" was renamed "shame" and included as a sub-code to "stigma".
- The code "family of origin issues" was moved under the code "family" within "social support". Reasoning: This fit within social support because it could be used to explain why a family was or

wasn't supportive, e.g. some of the coded data were about religiosity or abuse, and may indicate why there is a lack of support.
- A code called "systemic effects of stigma" was created because many of the women described issues that arose as a result of the stigma that they experienced (erasure, violence due to transphobia, issues finding employment). In order for this code to have meaning, I went through all of the stigma data in order to re-code the quotes that were listed under it. Those that were actually related to systemic effects of stigma were moved to the new code (as a result, "erasure", "violence" and "shame" were moved).
- A coded labeled "resiliency" was renamed "resisting and reframing". Reasoning: the data contained within this code did not necessarily align itself to resiliency literature, but instead was used to describe how the women thought about or behaved as a result of their identities. Anything in this code related to resistance of societal expectations or norms.
- The code "advice from communities" was broken down into the relevant "social support" sections. E.g. "HIV-specific" and "trans-specific" were moved under "social support"
- The code "reliance on community knowledge" was moved under "community connectedness" and all the data within was re-coded into "HIV/AIDS communities", "LGBT communities", "trans communities", or "cultural communities".
- "Resisting and reframing" was moved under the parent code "well-being". Reasoning: resisting and reframing can be seen as a coping strategy to stigma, and also an outcome of community connectedness and social support.
- A code titled "what would you change" was moved under "well-being". Reasoning: this is what the women identified as necessary to their well-being.

Theory creation:
- Stigma emerged as an overarching theme that was then used to make sense of the other findings. By centralizing stigma in the analysis, I was able to organize and bring together all other sub-themes. Stigma theory was thus used as a lens through which key findings were contextualized, and understood during the final and interpretive stages of analysis.
- The codes community connectedness and social support, along with their sub-codes, were analyzed further. I found that they seemed to act as buffers to stigma, and that most of the women reported having some ties to communities, wanting some ties to communities, or having/wanting social support, which indicated that my findings were supported by the existing literature on community and social support.
- This stage of analysis also allowed me to see that there was a connection between community connectedness/social support and resisting and reframing. Similarly, a lack of community connectedness/social support led to feelings of isolation (which also led to negative health outcomes). This was also supported by previous literature.
- In the end, the theory that arose was that community connectedness and social support were buffers to the intersectional stigma experienced by trans women living with HIV. If community connectedness and social support were present, then women were more likely to resist and reframe their experiences, however if it was not present then they were more likely to experience isolation leading to negative health outcomes.

Other notes:
- "What would you change" under "well-being" was used to guide the recommendations listed in this paper.
- While I had intended on writing about friendships as a form of social support available to the women, further analysis of this code demonstrated that there was not enough depth in the quotes to incorporate these into the final analysis. This may be a limitation of using secondary data, as the women were not asked directly about the friendships that they maintained, although some brought up brief details about these.

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Table 1.

Types of stigma that may affect the lives of trans women living with HIV

Anticipated:	The fear of experiencing stigma if a given identity, characteristic, or status is revealed.
Perceived:	When those living with a stigmatized identity/status are aware of the negative societal attitudes, reduced opportunity, and negative social identity associated with a given identity or social position
Internalized:	When an individual holds negative views or beliefs about a stigmatized identity, characteristic or status that they hold.
Symbolic:	When those not experiencing stigma shame, blame, or other people as a result of a stigmatised identity, characteristic, or status.
Instrumental:	Actions taken that perpetuate stigma, but that are taken in order to protect oneself or one's health (e.g. avoiding behaviours out of fear of becoming HIV positive).
Enacted:	Overt acts of discrimination against people as a result of a stigmatized identity, characteristic, or status (e.g. violence, transphobia, exclusion).

Note. The definitions listed above were summarized from:
Kamya, H., (2012). HIV/AIDS: The global pandemic. In Healy, L. M., & Link, R. J. (Eds.), Handbook of international social work: Human rights, development, and the global profession (196-202). New York, NY: Oxford University Press.

Table 2.

Recommendations for Countering Stigma through Community Connectedness

Micro level (interpersonal)
•Consult trans women about the services, community groups and resources that they need, have their input guide decision-making processes.

•Provide counselling and ongoing support for trans women living with HIV.

•Engage families, friends, romantic partners in skills building workshops to reduce negative attitudes (e.g. judgement, shame, blame).

•Create materials and resources for trans women and their support systems.

Meso level (community)
•Engage with leadership in Indigenous and Latinx communities to develop culturally specific programs focused on trans issues and HIV/AIDS.

• Have existing HIV and trans services work with translators to provide language specific services.

• Engage with leadership in small towns and rural areas in order to create trans specific programs, services and groups.

•Encourage LGBT spaces to work towards greater inclusion of trans women.

•Provide education/workshops and training about trans issues and HIV in existing cultural community spaces.

•In order to increase visibility of trans people, hire trans staff to work in trans, LGBT, and HIV/AIDS spaces.

Macro level (systems, institutions)
•Engage with policy makers to develop mandatory trainings in LGBT community spaces so that staff can address needs of trans women living with HIV.

•Revise HIV criminalization laws that target trans women engaging in sex work.

• Ensuring that laws and policies are in place that protect trans women living with HIV by allowing them to report discrimination (i.e. in the workplace, in healthcare settings, in communities, etc.).

•Implement policy that requires intersectional, anti-oppression training for ASOs, community services, and research teams.

•Increase funding for activism and community mobilization programs so that trans women living with HIV can engage in collective resistance of stigma at systemic levels.

Note. The recommendations were created in part from the suggestions of the 14 trans women who completed the interviews. Additional recommendations based on findings from:
Stangl Lloyd, Brady, Holland, & Baral, (2013). A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: How far have we come?. Journal of the International AIDS Society, 16(3).