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A Tale of Two Cities: Access to Care and Services Among African-American Transgender Women in Oakland and San Francisco

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Abstract

Purpose: The San Francisco Bay Area attracts people from all over the country due to the perception of lesbian, gay, bisexual, and transgender (LGBT) acceptance and affirmation. African-American transgender women are severely marginalized across society and as such have many unmet health and social service needs. This study sought to quantitatively assess unmet needs among African-American transgender women with a history of sex work by comparing residents of Oakland versus San Francisco.
Methods: A total of 235 African-American transgender women were recruited from San Francisco ($n = 112$) and Oakland ($n = 123$) through community outreach and in collaboration with AIDS service organizations. Participants were surveyed regarding basic, health, and social needs and HIV risk behaviors. Pearson Chi-squared tests and a linear regression model examined associations between city of residence and unmet needs.
Results: While participants from both cities reported unmet needs, Oakland participants had a greater number of unmet needs in receiving basic assistance, mental health treatment, and health care services. Oakland participants also reported less transgender community identification but higher social support from the family.
Conclusion: These findings demonstrate the enormity of African-American transgender women's needs within the Bay Area. Greater resources are needed for social service provision targeting this marginalized group of people, particularly in Oakland.

Key words: access to care, mental health needs, transgender.

Introduction

Transgender women are people who were designated male at birth but identify themselves as transgender, women, or something other than male.[1] Because gender variance is heavily stigmatized, transgender women face institutional and individual discrimination (transphobia) across a wide variety of contexts.[1–4] Transgender women have heightened rates of mental health problems, including depression and anxiety, and may turn to substance use as a means to cope with these problems and the underlying source of stigma.[1,5–9] Transgender women are also at higher risk for human immunodeficiency virus/sexually transmitted infections (HIV/STIs) and have an increased rate of suicidal thoughts and attempts, especially among those who report experiencing transphobia.[2,4,10] This marginalized group of people experiences rampant stigma and discrimination, which thus impacts their health and well-being.

When stigma and discrimination originate within the context of healthcare provision, transgender women experience decreased access to care.[11] Given the mental health needs exhibited by this marginalized group of people, this is particularly disturbing as it leaves transgender women with little to no support from healthcare providers. One study conducted in San Francisco found that transgender women have high basic survival needs yet have a severe lack of access to health and social services.[12] Health and social services have the potential to provide culturally sensitive and specifically tailored programs and clinics for transgender women. Decreased access to care represents a missed opportunity for improving the health and well-being of transgender women. Transgender people have reported delaying seeking medical care because of medical professionals' insensitivity and lack of knowledge about healthcare provision and issues pertinent to their experience.[13] Healthcare providers have also reported being poorly equipped to provide services for transgender

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patients, citing not having the proper training, knowledge, or resources to serve this group of people.[14] Both healthcare providers and transgender women would benefit from centralized resources and infrastructure support for transgender health, including both general primary care and transition-related care.

Oakland as Shadow City

Geography has also been found to play a crucial role in transgender women's access to care. Some transgender people must travel long distances to receive care due to the lack of sensitive and knowledgeable service providers in their local area.[15,16] Certain areas, particularly urban cities with a high number of financial resources, may be more likely to be able to provide services specific to transgender people. This paper examines the two cities of San Francisco and Oakland, in which one city possesses considerably fewer resources, support, and infrastructure for the health needs of all of its inhabitants than the other. Some health advocates have developed the term ''shadow city'' to describe the relationship Oakland has to its more prominent neighbor.[17]

San Francisco is internationally recognized as a city with greater acceptance toward gay and lesbian people, and is also one of the cities most impacted by the HIV epidemic among gay and transgender people in the United States. Many transgender people travel to the San Francisco Bay Area with the hope of receiving greater social acceptance of their gender identity and expression. There are several transgender specific clinics in San Francisco that provide hormonal therapy services for free or on a sliding scale basis.[18] Additionally, San Francisco recently became the first city to cover sexual reassignment surgical services as part of its public health care plan for uninsured and low-income residents.[19] As a neighboring city, the city of Oakland does not offer health and social services for transgender people on the same magnitude as San Francisco. There are no transgender-specific health clinics available, and transgender people do not experience the same degree of visibility that they have in San Francisco.

Health needs

Both San Francisco and Oakland have high rates of HIV sero-prevalence, especially for African Americans. Twenty-eight percent of the population of Oakland (390,724) and 6% of the population and San Francisco (805,235) are African American;[20–21] thus, it is expected that there are large African-American transgender communities in both cities. However, the resources for HIV/AIDS care and prevention, substance abuse and mental health treatment services, and other health and social services significantly differ between two cities. For example, San Francisco has a budget of $35,567,587 while Alameda County that includes Oakland has a budget of $2,740,713 for HIV/AIDS prevention and care services.[22–23] Recent meta-analyses have estimated high HIV prevalence among transgender women (e.g., 27.7% based on studies with HIV testing, not self-report).[1,24–26] San Francisco Department of Public Health has reported the highest levels of HIV incidence among transgender women among risk populations.[27] The HIV sero-prevalence among transgender women in San Francisco ranged from 15.5% to 35%.[4,24,28] Higher HIV sero-prevalence was found among transgender women who were African American or Latina ethnicity.[1,29–32] Thus, communities across both sides of the bay experience severe need and are disproportionately affected by multiple social and health problems.

Transgender women also exhibit a relatively higher proportion of mental health needs compared to the general population due to heightened stigma, discrimination, and a lack of employment and education opportunities. One review notes a high prevalence of major depression among transgender women at 62%, also noting the importance of the lack of social support, exposure to violence, and limited occupational opportunities outside of sex work due to discrimination.[33] A recent study found a prevalence of 51.4% for depressive symptoms and 40% for anxiety among transgender women.[34] Depression and anxiety are often compounded by experiences of gender dysphoria; some research suggests that the provision of transitioning treatment may ameliorate feelings of dysphoria and address other corresponding mental health concerns.[35] However, stigma and discrimination may continue to impact the mental health of this group of people regardless of access to and use of hormones or other transitioning treatment, particularly as it relates to finding social support and employment opportunities, accessing social services, and interacting with other people.

This study sought to describe unmet needs for health services and public assistance programs among African-American transgender women with a history of sex work in relation to geography (Oakland vs. San Francisco), other demographic variables, transphobia, social support, and transgender community identity. Previous research has documented increased vulnerability to negative health outcomes, particularly HIV infection, as associated with engagement with sex work among this group of people.[29] This paper thus focuses on the most marginalized segment of this population, as this group likely has the highest amount of needs and warrants greatest attention and consideration. We hypothesized that transgender women residing in Oakland would demonstrate higher levels of unmet needs, as well as higher levels of transphobia, decreased levels of social support, or lesser degrees of identification with the transgender community than those residing in San Francisco.

Methods

For the current study, we used a sub-sample of African Americans from a larger parent study which recruited participants who self-identified as transgender or transsexual women, regardless of surgical status, lived in San Francisco or Oakland, and were 18 years or older. The inclusion criteria also included a history of sex work; that is, having ever engaged in exchanging sex for money or drugs. The study had two cohorts with different recruitment periods. First, 112 African Americans were recruited in San Francisco from November 2000 to July 2001, followed by 123 African Americans in Oakland from August 2004 to July 2006. The time difference of these cohorts of transgender women was mainly due to the funding of the study. About half of the participants (54%) were recruited through direct community outreach and the rest were though referrals from collaborating AIDS service organizations. Participant recruitment procedures have been described elsewhere.[36] After obtaining informed consent, participants were personally interviewed by trained transgender project staff using a structured

questionnaire. After completing the interview, participants were compensated with a cash reimbursement, and were provided with a safer sex kit and a resource guide for transgender people.

Measures

Based on the data collected for the parent study, the measures of participants' demographics, perceived needs for services, transphobia, transgender community identification, and social support were used for this study. The transphobia measure was modified from a homophobia measure and asked participants the frequency of exposure to discrimination, harassment, or verbal, physical, and sexual abuse due to their gender identity or expression as adult ($\alpha = .75$).[37] Modified measures of transgender community identity and social support from family, transgender friends, and non-transgender friends were also used.[38–40] Participants were asked whether they needed 19 different types of services; if they expressed need, they were asked whether they received services to fulfill the need. Types of services were categorized into services for basic assistance (nine items), mental health care (four items), substance abuse treatment (one item), and general health care (five items). Basic assistance services included general government services, such as ''permanent housing,'' ''food,'' and ''job training.'' Mental health care services included psychological and social services, such as ''counseling'' and ''spiritual support.'' General health care services included ''sexually transmitted diseases (STD) screening,'' ''emergency room,'' ''alternative healthcare,'' and other health services. If a participant expressed a need for specific types of services, but did not receive the service, the response was coded as an ''unmet'' need. Participants who expressed no need for services, or needed and received services were counted as no unmet need.

Analysis

Pearson Chi-squared tests were first conducted to compare the background demographics of participants from San Francisco to those from Oakland. T-tests were also performed for scales and non-categorical variables. Pearson Chi-squared tests were then performed comparing the number of participants in San Francisco with any unmet need in a need category to those in Oakland. T-tests were performed to compare the standardized number of needs within each need category. This additional test captures the amount of need, whereas the Chi-squared test identifies participants with any need regardless of amount. Finally, a linear regression model was developed to predict the number of unmet needs among African-American transgender women in relation to demographics, social support, community identification, and geography.

Results

Demographics

The two cohorts of African-American transgender women recruited in San Francisco and Oakland were very similar: no significant differences were found in levels of education, monthly income, full- or part-time job status, housing, sex work in the past 6 months, and sexual reassignment surgical status (see Table 1). However, participants residing in Oakland were significantly younger than those in San Francisco. Significant differences were also found in gender identity and sexual orientation. Compared with transgender participants in San Francisco, more participants in Oakland identified their gender as a term other than woman or transgender/transsexual and their sexuality as homosexual, bisexual, or other.

Health Status

The prevalence of self-reported STIs in the past 12 months among San Francisco participants (35.7%) was significantly higher than that from Oakland (19.5%); however, participants from Oakland (50%) were more likely to report untreated STIs compared to the participants from San Francisco (17.5%). There was no significant difference in the prevalence of HIV at 46.5%. A significantly higher proportion of the participants from Oakland (55.4%) were depressed than participants from San Francisco (39.3%) with a score of 16 or greater on the Center for Epidemiologic Studies Depression (CES-D) scale.

Psychosocial factors

There was no significant difference on the transphobia scale between those recruited from Oakland and San Francisco (see Table 1). San Francisco participants reported significantly higher levels of transgender community identification than Oakland participants. Oakland participants had significantly greater social support need than San Francisco participants, but they had received social support more frequently.

Unmet needs

Overall, 54.0% of the participants reported unmet need for at least one out of 19 types of services (see Table 2). The proportion of participants who expressed unmet need in each category (at least one unmet need in each category) were: 48.1% for basic needs assistance, 25.1% for mental health services, 9.4% for substance abuse services, and 16.6% for healthcare services). A significantly higher proportion of Oakland participants than San Francisco participants had at least one unmet need for basic need assistance, mental health services, and health care services.

For each category of needs, a standardized mean number of needs was calculated. This percent of unmet need represents the number of unmet needs per the number of items used in each category. Oakland participants had a higher percent of unmet need in each need category compared to San Francisco participants, with the exception of substance abuse treatment.

Linear regression analysis on number of unmet needs

A multiple linear regression analysis was conducted on the total number of unmet needs in relation to geography, transphobia, need for social support, social support received, transgender community identification, and background demographics (see Table 3) . After controlling for demographic variables and HIV and STI history, geography (Oakland vs. San Francisco), social support need, community identification, and social support received were found to be independently associated with the number of unmet needs: Oakland participants had a higher number of unmet needs than those in San Francisco. Those who expressed need for social support were more likely to show higher levels of unmet needs and those who had received social support

Table 1. Demographic Characteristics of Participants

	African American from San Francisco (n = 112) %	*African American from Oakland* (n = 123) %	*Total* (n = 235) %	χ^2
Age	(*n* = 111)	(*n* = 123)	(*n* = 234)	8.97*
18–30	24.3	42.3	33.8	
31–40	45.0	30.9	37.6	
41–65	30.6	26.8	28.6	
Mean (years)	36.5	33.8	35.1	$t = -2.35$*
Foreign Born	(*n* = 112)	(*n* = 123)	(*n* = 235)	1.36
	5.4	2.4	3.8	
Highest Level of Education	(*n* = 112)	(*n* = 123)	(*n* = 235)	3.23
Less than high school	31.2	31.7	31.5	
High school/GED/ Technical/Vocational school	38.4	41.5	40.0	
Some college	24.1	16.3	20.0	
College and above	6.2	10.6	8.5	
Monthly Income (past 30 days)	(*n* = 112)	(*n* = 118)	(*n* = 230)	4.86
Less than $500 (ref)	13.4	14.4	13.9	
$500–999	45.5	51.7	48.7	
$1,000–1,999	27.7	28.8	28.3	
$2,000 and above	13.4	5.1	9.1	
Full-Time Job (past 6 months)	(*n* = 112)	(*n* = 123)	(*n* = 235)	2.754
	16.1	8.9	12.3	
Part-Time Job (past 6 months)	(*n* = 112)	(*n* = 123)	(*n* = 235)	.112
	18.8	17.1	17.9	
Housing Situation (past 6 months)	(*n* = 111)	(*n* = 122)	(*n* = 233)	7.45
Permanent housing	38.7	54.1	46.8	
Temporary housing	42.3	36.1	39.1	
Halfway house/Treatment center	7.2	3.3	5.2	
Homeless (shelter, street)	9.0	4.1	6.4	
Other	2.7	2.5	2.6	
Gender Identity	(*n* = 112)	(*n* = 121)	(*n* = 233)	11.57**
Female	39.3	33.1	36.1	
Preoperative transgender/Transsexual	58.0	51.2	54.5	
Other	2.7	15.7	9.4	
Recent Engagement in Sex Work (past 6 months)	(*n* = 112)	(*n* = 123)	(*n* = 235)	.035
	50.0	51.2	50.6	
Sexual Orientation	(*n* = 108)	(*n* = 119)	(*n* = 227)	13.76**
Heterosexual	88.0	68.1	77.5	
Homosexual	7.4	16.8	12.3	
Bisexual	4.6	12.6	8.8	
Other	0	2.5	1.3	
Post Sex Reassignment Surgery Status	(*n* = 112)	(*n* = 122)	(*n* = 234)	.56
	6.2	4.1	5.1	
HIV-Positive Status	(*n* = 101)	(*n* = 116)	(*n* = 217)	.0
	46.5	46.6	46.5	
History of STI (past 12 months)	(*n* = 112)	(*n* = 123)	(*n* = 235)	7.77**
	35.7	19.5	27.2	
Treated for STI	(*n* = 40)	(*n* = 22)	(*n* = 62)	7.28**
	82.5	50.0	71.0	
Transphobia[1]	(*n* = 112)	(*n* = 121)	(*n* = 233)	$t = -.52$
	1.99	2.05	2.02	
Depression (CES-D)	(*n* = 112)	(*n* = 121)	(*n* = 233)	6.03*
< 16 (No)	60.7	44.6	52.4	
≥ 16 (Yes)	39.3	55.4	47.6	
TG Community Identification[2]	(*n* = 109)	(*n* = 120)	(*n* = 229)	$t = 3.49$**
	3.98	3.66	3.81	
Social Support Needed[3]	(*n* = 112)	(*n* = 119)	(*n* = 231)	$t = -2.12$*
	1.75	1.88	1.82	
Social Support Received[4]	(*n* = 112)	(*n* = 116)	(*n* = 228)	$t = -4.48$***
	1.28	1.66	1.47	

*$P < .05$, **$P < .01$, ***$P < .001$.
[1]1–5 (1 = "never" to 5 = "almost daily").
[2]1–5 (1 = "strongly disagree" and 5 = "strongly agree").
[3]1–3 (1 = "not at all" and 3 = "need quite a bit" on a three-point scale).
[4]1–5 (1 = "never" and 5 = "almost every day" on a five-point scale).
STI, sexually transmitted infections; CES-D, Center for Epidemiologic Studies Depression scale; TG, transgender.

Table 2. Unmet Social Service Needs

	San Francisco (n = *112*)	*Oakland* (n = *123*)	*Total* (n = *235*)	χ^2	*t*
Basic Assistance					
Participants with Unmet Needs	44.6%	51.2%	48.1%	1.02	
Percent of Unmet Needs (mean, 9 items)	8.5%	19.7%	14.4%		−4.60***
Mental Health Services					
Participants with Unmet Needs	17.0%	32.5%	25.1%	7.54**	
Percent of Unmet Needs (mean, 4 items)	5.4%	11.4%	8.5%		−2.87**
Substance Abuse					
Participants with Unmet Needs	8.0%	10.6%	9.4%	0.44	
Number of Unmet Needs (mean, 1 item)	8.0%	10.6%	9.4%		−0.67
Healthcare Services					
Participants with Unmet Needs	8.9%	23.6%	16.6%	9.08**	
Number of Unmet Needs (mean, 5 items)	1.8%	7.0%	4.5%		−3.79***
Any Service Need					
Participants with Unmet Needs	54.5%	53.7%	54.0%	0.02	
Number of Unmet Needs (mean, 19 items)	6.1%	14.1%	10.3%		−4.61***

**$P < .01$, ***$P < .001$.

Participants with Unmet Needs, the percentage of participants with any unmet need in a need category; Number of Unmet Needs, the standardized mean need per participant in a need category out of the number of items in each category.

more often or identified with transgender communities were less likely to have reported unmet needs.

Discussion

The general population of the County and City of San Francisco is about twice as large as that of Oakland. Similarly, the budget for public health and social services of San Francisco City and County is much larger than that of Oakland. The City of Oakland also extends over considerably more area than San Francisco. The current study quantified the differences between two cities in terms of unmet needs for services among African-American transgender women with a history of sex work. Study results showed that need for social support, transgender community identification, and receiving social support were strongly correlated with unmet needs. The unique considerations of each city, including geographical area, budget, historical and social significance, and existing social service provision likely play a role in the fulfillment of needs among transgender women in the San Francisco Bay Area.

Table 3. Linear Regression, Total Number of Unmet Needs

City	
San Francisco (ref)	
Oakland	1.191**
Transphobia Scale	0.351
Social Support Need	1.358**
TG Community Identification	− 0.756**
Social Support Received, Family	− 0.910**
Age	− 0.027
Education	
Less than high school (ref)	
High school/GED/ Technical/Vocational school	− 0.672
Some college	− 0.804
College and above	− 0.998
Monthly Income	
Less than $500 (ref)	
$500–999	− 0.422
$1,000–1,999	0.154
$2,000 and above	− 0.072
HIV Status	
Negative (ref)	
Positive	− 0.151
STI History Past 12 Months	
None (ref)	
At least one	− 0.214
Constant	4.027*
R^2	0.301

*$P < .05$, **$P < .01$.

There is no estimated number of African-American transgender women who live in San Francisco and Oakland. San Francisco attracts many transgender people to live because of its history for accepting LGBT populations and available LGBT specific health services. For example, several public health clinics provide transgender health care services, including cross-gender hormone therapy.[18] A few community-based AIDS service organizations provide HIV prevention and care services specific to transgender women who are at the highest risk for HIV/STIs. The existence of these services does more than provide an avenue through which health and social service needs can be met; it also shows the formal recognition of a group of people who are often ignored within health provision, addressing the sense of uncertainty transgender people may have when seeking medical care. Thus, providing these services may play a role in fostering a transgender community, allowing networks to expand by providing an informal form of social support.

While participants from both Oakland and San Francisco expressed some form of unmet need in each need category, more participants in Oakland expressed at least one unmet, basic assistance, mental health, or health care need. Additionally, Oakland participants expressed a significantly greater number of needs within each category except for

substance abuse treatment. This suggests that while transgender women across the board have considerable unmet needs, transgender women residing in Oakland have a greater number of unmet needs than those residing in San Francisco. This was also confirmed through the linear regression analysis. African-American transgender women residing in Oakland are particularly vulnerable as they have a greater number of unmet needs and fewer established city resources to fulfill those needs. An example of this was observed with participants' history of STIs: Despite San Francisco residents being more likely to report having had an STI in the past twelve months, they were also more likely to receive treatment. Oakland residents demonstrate greater unmet need yet have fewer opportunities to address this deficiency.

Given that Oakland participants have a greater number of unmet social service and health needs, they may particularly need forms of social support to counteract these unmet needs and maintain a reasonable standard of health and wellbeing. However, transgender women in Oakland had significantly lower rates of transgender community identification, higher rates of identifying as ''other'' rather than ''female'' or ''pre-operative transgender/transsexual,'' and higher rates of identifying as ''homosexual,'' ''bisexual,'' or ''other'' rather than ''heterosexual'' compared to transgender women in San Francisco. These findings likely speak to differences in identity between Oakland and San Francisco residents. Community identification, personal identification as something other than ''female'' or a status in relation to surgical transition, and sexual orientation all represent social factors that highlight the situated nature of the experience of transgender women. For example, it is possible that transgender women in Oakland are more likely to identify as gay through involvement with a gay community. LGBT communities in Oakland may be smaller or less visible than in San Francisco such that the lack of a visible transgender community in Oakland may make transgender women seek community through gay networks. Additionally, it is possible that engagement with transgender-specific social services, such as those provided in San Francisco, plays a role in identity formation in exploring differences between being gay versus transgender. As others have noted, researchers and care providers play a role in shaping the people they study or provide care for.[11,41] Geography, social networks, and access to certain kinds of care all inform people's transgender experience, and the types of social support available to them. These complexities and differences should be taken into consideration in providing care to transgender people, especially given their relationship to a community and geography.

At the same time, Oakland participants reported receiving higher levels of social support compared to San Francisco participants. This suggests that participants may also seek social support from a variety of sources rather than specifically from transgender community, or at least seek support from community to a lesser degree than those residing in San Francisco. In the linear regression model, both receiving social support and transgender community identification were found to be significantly associated with a decreased number of unmet needs. Social support may serve as a resource to address the multiple complex needs for this group of people. Community identification may also suggest greater sharing of resources and information, especially in San Francisco where community is stronger and sensitive and transgender-specific services exist. Future research should consider how different forms of social support relate to one another and access to certain kinds of services. Oakland residents may exhibit stronger ties with different types of support network members including biological families either due to a lack of incorporation into a larger transgender community that may not be visible or available in Oakland. At the same time, San Francisco residents may have experienced greater family rejection and thus seek to find support where community can more easily be accessed.

Limitations in this study include the timing gap in recruitment, limited measures in capturing kinds of social support, and original birthplace for U.S.-born participants. This latter point warrants considerable investigation, as there might be significant differences between Oakland and San Francisco residents in terms of Bay Area birth, which would suggest more ready availability and physical access to family networks and support. Additionally, geographical place of growing up, age of identification as a transgender woman, and years of living in the Bay Area all represent additional social factors that may impact a person's experience, including personal identification, engagement with types of community, and relating to family. Future qualitative work may provide fruitful insight into social relations with other transgender women, LGBT community members, service providers, family members, neighbors, and other people. Future work should also examine the relationship between birthplace, reason for migration, access to services, and the role of social networks in addressing unmet needs. Lastly, the generalizability of this study may be compromised due to the sampling method and to the restricted inclusion criteria. Researchers and providers should take caution before extrapolating the findings to transgender women more broadly. Instead, this paper should inform future research that should address some of the limitations presented here.

Conclusion

Transgender women exhibit higher levels and variety of needs that have been routinely unmet by current health and social service providers. As the results show, these needs are often co-occurring and compounded by multiple factors across different realms. Increasing access to care for this marginalized group of people requires a greater allocation of resources and research targeted toward the unique needs across multiple municipalities and jurisdictions. At the same time, however, expanding and providing services will only yield its full potential when provided in a socially specific and culturally sensitive manner. Geography, social networks, involvement with available community, and personal and social identification all inform the number and type of unmet needs, as well as the best avenues for meeting these needs. The expansion of transgender-specific services to all cities with relatively large populations will increase access to care for transgender people with severe health and social service needs. The allocation of greater financial resources to provide sensitive, open, and affirming sites of care will begin to address the extreme vulnerability and marginalization faced by this group of people.

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