

# *Social Determinants of Health for Men Who Have Sex with Men and Transgender Women in San Salvador*

## **STUDY OBJECTIVES**

The objective of this research brief is to assess potential links between social and economic factors and health for men who have sex with men (MSM) and transgender women (TW), apart from the influence of sexual stigma on internal psychological processes. We use data from a cross sectional study conducted among MSM and TW in San Salvador for most analysis, but also draw on a national dataset for comparison statistics. The first part of the analysis is descriptive and presents basic social and economic indicators for MSM, TW, and the general male adult population in El Salvador. The second part of the brief focuses on homelessness and unstable housing (HUH) among MSM and TW by identifying factors that may be associated with HUH, including health outcomes. In the third section of the brief we assess factors associated with sex work and health-related behaviors and outcomes. The synthesis of this information will demonstrate the interconnection between social and economic marginalization experienced by MSM and TW, and issues in the health, education, labor, and social justice sectors.

## **STUDY METHODS**

A cross-sectional survey was conducted among 670 MSM and TW in San Salvador who were recruited through respondent driven sampling (RDS) from November 2011 to February 2012. Recruitment chains were initiated by five seeds, purposely selected based on their social standing and wide social networks. Each participant was administered up to three recruitment coupons to distribute to social acquaintances who met study eligibility criteria.

## *Introduction*

Analysis of health problems from a social determinants perspective is a useful approach to identify overlapping areas across development sectors and reach development goals in education, governance, economic prosperity, and health (1). The social determinants of health are social and economic factors that influence the life circumstances of individuals in a way that predisposes them to certain health-related behaviors and health outcomes (2). According to the World Health Organization's Commission on the Social Determinants of Health, these determinants, "...are mostly responsible for health inequities—the unfair and avoidable health status seen within and between countries" and include factors such as social position, education, occupation, income, gender and ethnicity/race (2). The distribution of these factors has been empirically demonstrated to correlate how health problems are distributed across populations and within sub-populations (2–4). Addressing inequity in these factors would have the potential multiple benefits of improved health and improved overall life experiences and opportunities.

Sexual orientation is increasingly recognized as a social determinant of health (5). Research has shown that sexual minorities<sup>1</sup> are disproportionately affected by mental health problems (6–8), substance use problems (6), and HIV (9, 10) compared to heterosexual populations globally. A main reason for disparities in health for sexual minorities is sexual stigma (11), defined as "negative regard, inferior status, and relative powerlessness that society collectively accords to any non-heterosexual behavior, identity, relationship, or community" (11). Sexual stigma influences health by causing unequal access to healthcare (12, 13), psychological stress (14), and internal feelings of shame that influences health-related behavior (14, 15).

Stigma related to sexual orientation may also influence the social conditions and life opportunities afforded to sexual minorities. In their seminal work on social conditions as causes of health, Link and Phelan (1995) note that social conditions structure access to resources that can be used to avoid risk, or minimize the consequences of health problems (18). These resources include money, power, prestige, social support, and social networks (18). Access to these resources for sexual minorities is restricted because sexual stigma devalues people who are homosexual, bisexual, or hold nonconforming gender identities. Restricted access to these resources may in turn influence "livelihood strategies," or the activities and choices people make in order to secure basic necessities

1) We use the term "sexual minority" to refer to people whose sexual orientation—homosexual, bisexual, queer, questioning—or gender identity—male, female, transgender or transvestite—is non-conforming to heterosexual norms.

## STUDY METHODS *continued*

This included being 18 years of age or older, having had anal sex with a man or TW in the past 12 months, and having lived, worked or studied in San Salvador for a minimum of three months prior to the interview. This study was approved by the Tulane University Biomedical Institutional Review Board and the National Committee for Ethics and Clinical Investigation in El Salvador. For details about the methods used in this study, including the scales referenced in this brief and item summaries, please see the full report at: <http://www.measureevaluation.org/publications/tr-13-92>

## ANALYSIS

The data from the survey was entered into the statistical analysis program, Respondent Driven Sampling Analysis Tool 6.01 (RDSAT) ([www.respondentdrivensampling.org](http://www.respondentdrivensampling.org)). This program facilitated the use of weights to account for the non-random selection of participants in the calculation of frequencies. The data was then transferred to the statistical software package STATA SE version 12.0. Bivariate and multivariate analyses were conducted by weighting the outcome variable. A cutoff of  $p < .05$  was used for statistical significance. The predicted probabilities based on multivariate logistic regression models are presented in the figures. Captions for each figure note control variables used in each model.

of life such as food and shelter (19). For example, transgender women (TW) and men who have sex with men (MSM) with limited economic opportunities may be more likely to participate in sex work (20). Similarly, TW and MSM with limited economic opportunities and who have faced rejection from their family and peers may be more likely to experience unstable housing or homelessness (21). These life circumstances—sex work and homelessness—also impact health by increasing the vulnerability of TW and MSM to health risks.

In this research brief we analyze social determinants of health for MSM and TW in San Salvador by focusing on sex work and homelessness as social conditions that may influence the health of this population. Previous analyses of data from this study identified psychological pathways through which sexual stigma affects access to healthcare, stress, and well-being (16, 22). In the current analyses, we explore the structural pathway through which sexual stigma may influence health for this population by limiting social and economic opportunities, and the resultant consequences for their health.

## Key Findings

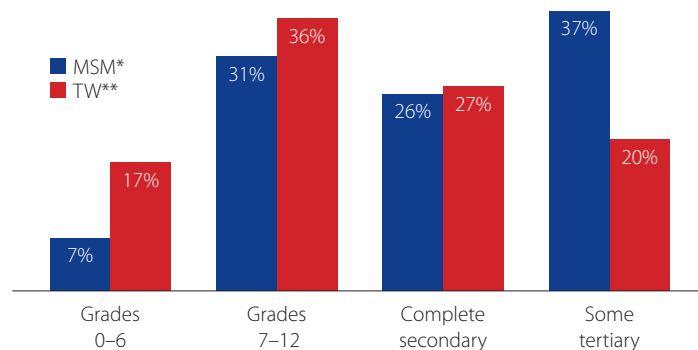
### MSM who participated in this study

MSM in the study sample were young, with 69% of participants in the 18–24 year old age group. Approximately half of the MSM in the study self-identified their sexual orientation as gay or homosexual (49%), or as bisexual or heterosexual (52%). The same percentage of MSM reported that they were either single (43%) or in a sexual relationship with another man or transgender woman (43%), while only 13% reported being in a partnership with a woman at the time of the study.

### SECTION 1—The social and economic conditions for MSM and TW in San Salvador

**Education**—Most study participants had completed high school or had some tertiary training (62%). Figure 1 shows the level of education completed by gender identity (MSM or TW). Seven percent (7%) of MSM completed primary school or less (grades 0–6), 31% completed the

Figure 1: Educational attainment reported by MSM and TW



\*Percentages for MSM add to more than 100% due to rounding.

\*\*TW were less likely to report tertiary education compared to MSM,  $p < 0.05$ .

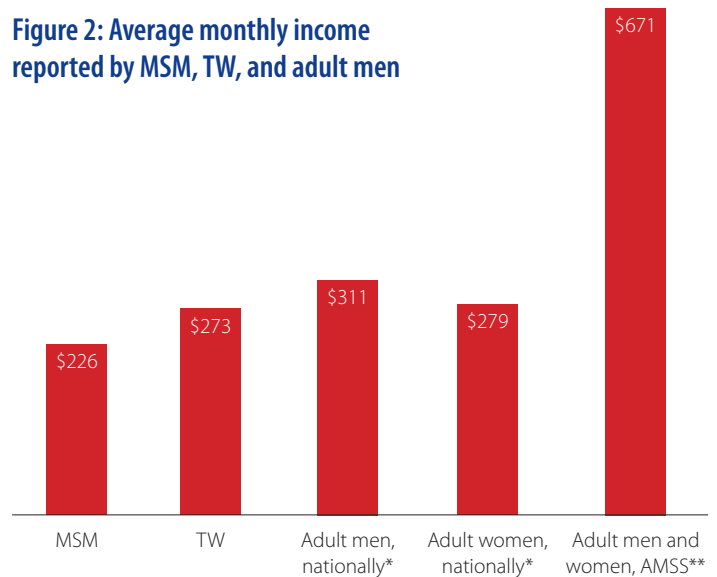
third cycle or some high school (grades 7–12), 26% completed high school, and 37% had some level of tertiary education beyond high school. TW achieved slightly lower levels of education. Seventeen percent (17%) of TW had completed primary school or less (grades 0–6), 36% completed the third cycle and some high school (grades 7–12), 27% completed high school, and 20% completed tertiary training beyond a high school diploma. The percent with advanced education through some tertiary education was statistically significantly lower for TW compared to MSM (20% vs. 37% respectively).

Data from the *Encuesta de Hogares de Propósitos Múltiples 2011 (EHPM)*, a nationally representative household survey conducted in El Salvador provides comparison statistics for men in the general population and was conducted around the same time as the MSM/TW study (23). The EHPM provides information on the average grade completed for men and women six years of age and older in urban areas, including San Salvador, in 2011. Estimates from the EHPM indicate that the average grade completed to be 7.6 grades for men and 7.1 grades for women, which translates to the completion of some high school education but not a diploma. In contrast, 63% of MSM in the current study completed high school or more education, while 47% of TW did so.

It is important to note that the EHPM estimate includes lower age categories and urban areas outside of San Salvador, whereas the MSM/TW data included persons 18 years of age or older in San Salvador. Thus the EHPM might be an underestimate of the level of grades completed for the general population due to the younger age of participants and inclusion of people outside of San Salvador.

**Income, employment, and occupation**—A substantial number of MSM and TW participants in the study were poor. Twenty-seven percent (27%) reported no monthly income. Forty-three percent (43%) of participants earned less than \$250 per month. On average, MSM and TW in this study earned \$266 and \$273 per month respectively (see Figure 2). This is less than the average reported monthly income of \$311 for adult men and \$279 for adult women in El Salvador (including rural and urban areas). It is also substantially lower than average monthly income of \$671 estimated for adults in San Salvador, based on data from the EHPM (23).

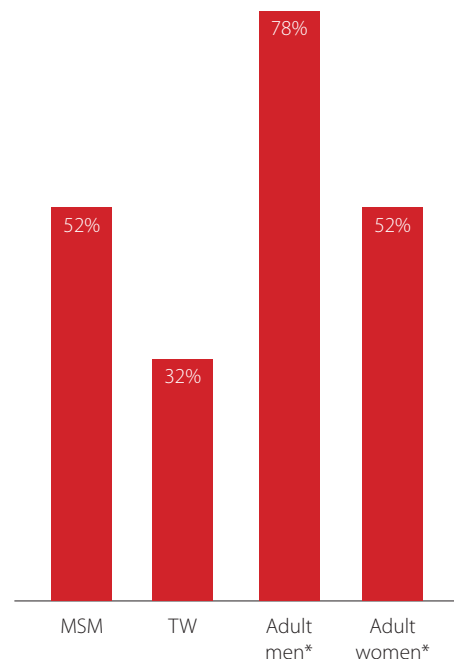
**Figure 2: Average monthly income reported by MSM, TW, and adult men**



\* Estimate derived from the EHPM.  
 \*\* MASS = Metropolitan Area of San Salvador.

MSM and TW in this study also reported lower levels of employment than men in the general working age population in El Salvador (see Figure 3). Fifty-two percent (52%) of MSM and 32% of TW reported employment by others or self-employment at the time of the study. In contrast, 78% of men and 52% of women 16 years of age or older living in urban areas of El Salvador were employed in 2011, based on estimates from the EHPM (23).

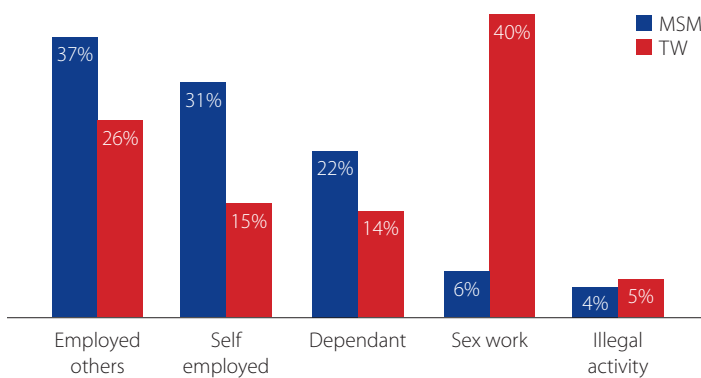
**Figure 3: Employment reported by MSM, TW, and adult men in urban setting**



\* Estimate derived from the EHPM.

Figure 4 shows the primary means of income generation reported by MSM and TW in this study. For MSM, the primary means of income generation was formal employment by others (37%), followed by self-employment (31%), receipt of finances from others including remittances or money from parents or partner (22%), sex work (6%), and illegal activities including the selling of drugs (4%). For TW, sex work was the main means of income generation, reported by 40% of TW in the study. This was followed by formal employment by others (26%), self-employment (15%), remittances or money from parents or partner (14%), and illegal activity including the selling of drugs (5%). The percentage of TW reporting sex work as their primary means of income generation is statistically significantly higher compared to MSM in the sample (40% compared to 6% respectively).

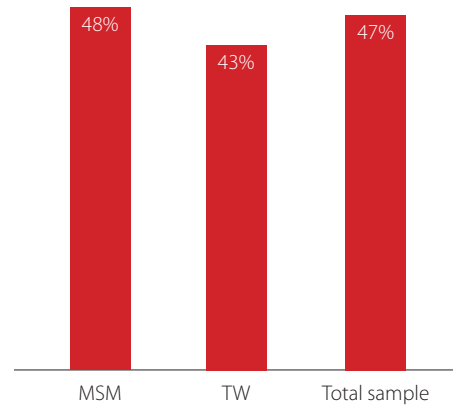
**Figure 4: Primary means of income generation among MSM and TW (n=573)**



Categories are exclusive; participants were asked to select one response option for primary means of income generation.

**Food insecurity**—Figure 5 shows the level of food insecurity among participants in this study. Almost half (47%) of the participants reported that they were worried about having enough food for themselves or their family in the six months prior to the survey. There was not a statistically significant difference in the report of food insecurity between MSM and TW participants.

**Figure 5: Percentage of MSM and TW reporting food insecurity during the last six months**

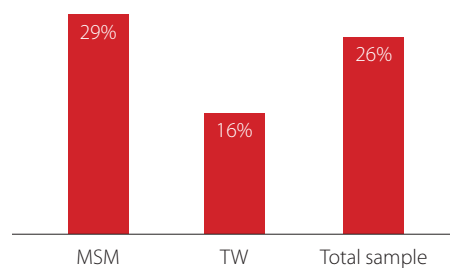


Weighted frequencies calculated in RDSAT; Statistical significance determined based on bivariate logistic regressions weighting the outcome variable of food insecurity in STATA.

**SECTION 2—Homelessness and unstable housing (HUH) among MSM and TW**

Twenty-six percent (26%) of research participants reported at least one night when they did not have a place to sleep or were homeless during the six months prior to the survey (see Figure 6). There was a statistically significant difference in the report of HUH such that MSM were more likely to report HUH compared to TW (29% versus 16% respectively).

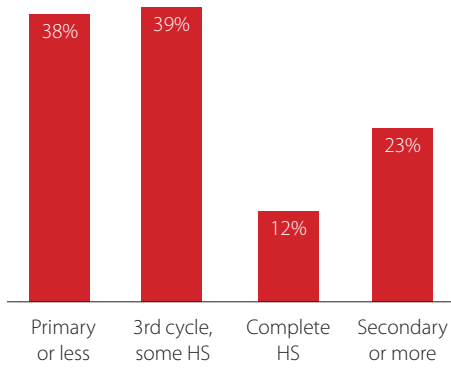
**Figure 6: Percentage of MSM and TW reporting homelessness and unstable housing during last six months**



Weighted frequencies calculated in RDSAT; Statistical significance determined based on bivariate logistic regressions with weighting applied to the outcome variable of HUH. p<.01.

The percentage of participants reporting HUH decreased as their level of educational attainment increased (see Figure 7). Thirty eight percent (38%) of participants with a primary school education or lower, and 39% with some high school education report HUH in the last year. In comparison, only 12% of participants with a high school diploma, and 23% with some tertiary education report HUH in the last year. These differences were statistically significant.

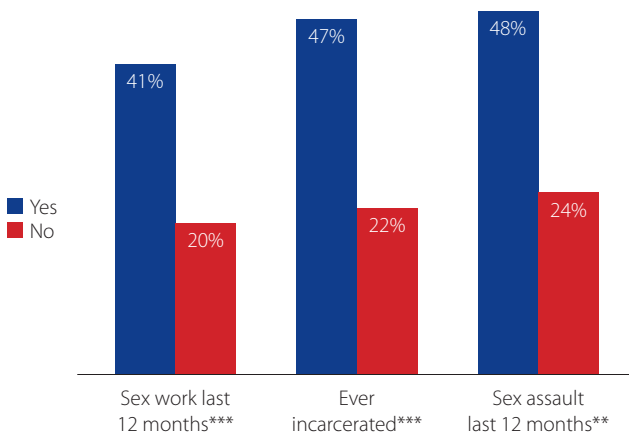
**Figure 7: Percentage reporting homelessness and unstable housing by level of education completed**



Weighted frequencies calculated in RDSAT; Statistical significance determined based on bivariate logistic regression with weighting applied to the outcome variable of HUH. For complete HS vs. primary or less  $p=.001$ ; complete HS vs. 3rd cycle-some HS  $p<.05$ . For secondary or more vs. primary or less  $p<.001$ ; secondary or more vs. 3rd cycle-some HS  $p<.01$ .

HUH was associated with other measures of vulnerability (see Figure 8). Forty-one percent (41%) of participants who reported sex work in the last six months also reported HUH, compared to 20% of participants who did not report sex work. Nearly half (47%) of participants who had ever been in jail or prison for more than 48 hours reported HUH compared to 22% of participants who had never been to jail or prison. Forty-eight percent (48%) of participants who reported past-year sexual assault also reported HUH, compared to 24% of participants who did not report past-year sexual assault. The difference in percentages of MSM and TW reporting HUH by vulnerable group was statistically significant for sex work, incarceration, and sexual assault.

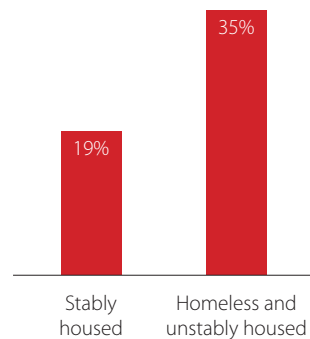
**Figure 8: Percentage reporting homelessness and unstable housing by membership in vulnerable group, MSM and TW**



Weighted frequencies calculated in RDSAT; Statistical significance determined based on bivariate logistic regressions with weighting applied to the outcome variable of HUH. \*\* $p<.01$ ; \*\*\* $p<.001$

HUH was associated with the health outcome of suicide contemplation (see Figure 9). For the total sample, 27% of participants reported that they “always” think about committing suicide, compared to “sometimes” or “never” thinking about it. Among participants who reported HUH in the last six months, 35% reported “always” thinking about committing suicide. This percentage was statistically significantly lower among participants with stable housing, 19% of whom reported “always” thinking about suicide.

**Figure 9: Percentage reporting suicide contemplation by homelessness and unstable housing, MSM and TW**

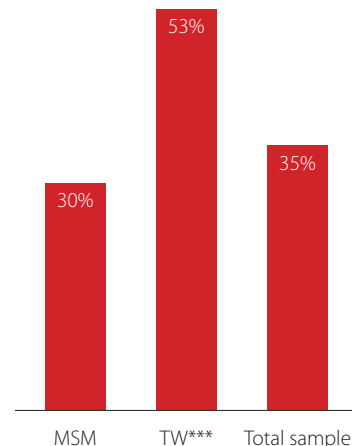


Percentages presented are converted from the predicted probabilities calculated using logistic regression models that controlled for age, education, income, relationship status, gender identity, sexual orientation, past experience of sexual assault, having been incarcerated and sex work in the past year.  $p<0.01$ ;  $n=646$

### SECTION 3—Sex work as a livelihood strategy and the health-related consequences

A substantial proportion of the study population reported sex work in the last 12 months, defined in the survey as, “having received clothing, food, money, drugs, or somewhere to sleep in exchange for sex with someone” (see Figure 10).

**Figure 10: Percentage of MSM and TW reporting sex work in the last 12 months**

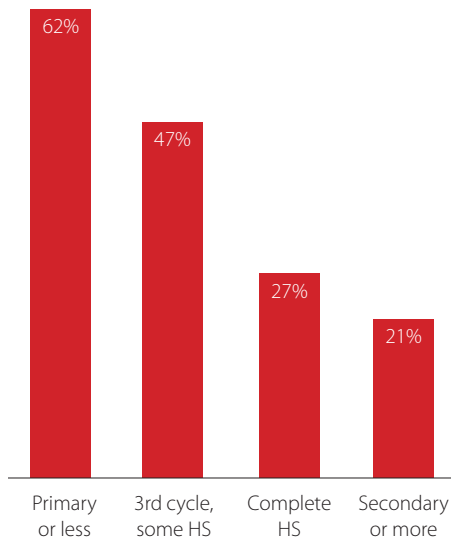


Weighted frequencies calculated in RDSAT; Statistical significance determined based on bivariate logistic regressions with weighting applied to the outcome variable of past year sex work. \*\*\* $p<.001$ .

Thirty-five percent (35%) of participants reported sex work in the last 12 months. Fifty-three percent (53%) of TW reported past-year sex work while 30% of MSM did so. This difference was statistically significant.

The percentage of participants reporting past-year sex work decreased as the level of educational attainment increased (see Figure 11). Sixty-two percent (62%) of participants completing only a primary school education or less reported past year sex work, as did 47% of participants with some high school. This percentage dropped to 27% for participants with a high school diploma, and 21% of participants with tertiary training. Differences in percentage reporting past-year sex work and educational attainment were statistically significant.

**Figure 11: Percentage of MSM and TW reporting sex work in last 12 months by level of education completed**

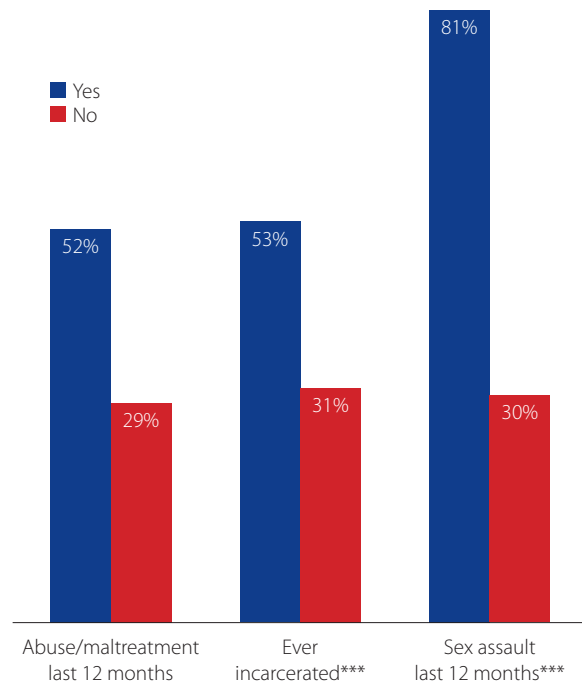


Weighted frequencies calculated in RDSAT; Statistical significance determined based on bivariate logistic regressions with weighting applied to the outcome variable of unstable housing. For complete HS vs. primary or less  $p < .001$ ; complete HS vs. 3rd cycle-some HS  $p = .001$ . For secondary or more vs. primary or less  $p < .001$ ; secondary or more vs. 3rd cycle-some HS. \*\*\* $p < .001$ .

Past-year sex work was associated with other measures of vulnerability (see Figure 12). Fifty-two percent (52%) of participants who reported abuse or maltreatment due to their sexual orientation in the last 12 months reported sex work, compared to 29% of participants who did not report abuse. Fifty-three percent (53%) of participants who had ever been in jail or prison for 48 hours or more reported past-year sex work, compared to 31% of participants who had never been incarcerated. Eighty-one percent (81%) of participants who reported sexual assault in the last year also reported past-year sex work, compared to 30% of participants with no sexual assault

in the last year. As noted above, sex work was also correlated with HUH. The difference in percentages between report of past-year sex work by inclusion in a vulnerable group was statistically significant for HUH, incarceration, and sexual assault.

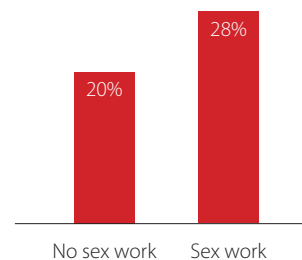
**Figure 12: Percentage reporting sex work in last 12 months by membership in vulnerable group, MSM and TW**



Weighted frequencies calculated in RDSAT; Statistical significance determined based on bivariate logistic regressions with weighting applied to the outcome variable of unstable housing. \*\*\* $p < .001$

Participants who reported past-year sex work were more likely to contemplate suicide (see Figure 13). Among participants who reported past-year sex work, 28% reported “always” thinking about committing suicide. This percentage was statistically significantly lower among participants who did not report past-year sex work, 20% of whom reported “always” thinking about suicide.

**Figure 13: Percentage of MSM and TW reporting contemplation of suicide by past year sex work**



Percentages presented are converted from the predicted probabilities calculated using logistic regression models that controlled for age, education, income, relationship status, gender identity, sexual orientation, past experience of sexual assault, having been incarcerated and sex work in the past year.  $p = .05$ ;  $n = 646$ .

## Summary

There is inequity in income generation and employment for MSM and TW compared to men in the general population in urban areas of El Salvador. Lower educational attainment among MSM and TW is related to increased exposure to HUH and sex work. Sex work primarily affects TW, while MSM are more vulnerable to HUH. Similar to research in other settings, HUH and sex work are part of a “syndemic” of vulnerability among MSM and TW, which also includes high rates of incarceration and sexual assault (24). These experiences shape the health and well-being of MSM and TW in El Salvador in a way that increases their risk for HIV/STI and poor mental health outcomes, measured in this study by contemplation of suicide. These findings are congruent with the inclusion of sexual orientation as a social determinant of health, and demonstrate the negative impact of social position, income and education on health for sexual minorities.

## Recommendations

**Increase levels of educational attainment for MSM and TW:** Ensuring that MSM and TW are able to complete high school, and if possible attain tertiary training, would decrease the likelihood of their exposure to HUH and participation in sex work. More information is needed to understand factors that influence school drop-out rates for MSM and TW in El Salvador. In other contexts, harassment, bullying and other forms of stigma from peers and teachers influences the decision for lesbian, gay, bisexual and trans students to drop-out of school (25). The visibility of TW who “express their gender,” or dress as a woman in a school environment may lead to their expulsion from schools altogether. Adolescence is a critical time in the development of individual identity and self-worth. It can be difficult period for sexual minority youth struggling to understand and accept their sexual orientation or gender identity. It is important to establish policies that would encourage a welcoming environment for sexual minorities in schools, and provide training for educators on how to support youth through the process of positive identity formation.

**Increase occupational and economic opportunities for MSM and TW:** It is important to create an environment that would support income generating

activities to prevent HUH, and serve as an alternative to sex work for MSM and TW. Workplace policies to prevent discrimination are necessary. Mentorship programs and scholarships for training are needed to promote a wide range of “possible futures” for MSM and TW in different fields. Skills in financial management would also protect against economic vulnerability. This is especially important for persons who are self-employed or earning money in the informal economy and therefore lacking benefits such as social security and health insurance.

**Provide housing services for MSM and TW:** It is important to prevent homelessness and unstable housing among MSM and TW through increased educational attainment and economic opportunities. It is possible that MSM and TW risk HUH during the coming out process, especially if they are still dependent on their parents and family for housing. In this study, no difference in HUH and age of participants was found, indicating this is an important problem across the lifespan. MSM may be at increased risk for HUH because of lower levels of financial, material, and logistical support from their social network. While TW may suffer more external forms of discrimination because of the visibility of their stigma, the tight social networks of TW in this and other Central American contexts may serve to protect against HUH (26). The relationship between concealment of sexual orientation, as a possible link to HUH among MSM should be further explored. Outreach for MSM and TW experiencing HUH through cross-over programming with established housing services for the general population should be considered. This is particularly important for MSM and TW who are also living with HIV, as levels of treatment adherence have been shown to be lower among people who are HUH in other contexts (27).

**Establish policies and programs to protect and support sex workers:** The level of sex work reported by participants in this study is remarkably high, especially among TW. Improving the context within which sex work is practiced would also lead to improvements in the well-being and quality of life of MSM and TW. This can be accomplished through trainings with police and the criminal justice system to prevent harassment and incarceration of sex workers. Within the security sector there should be specialist trained to provide support for sex workers who experience sexual assault,

and information provided to sex workers on their rights and options in the case of sexual assault. Advocacy to support the professionalization of sex work, including the establishment of workers unions and inclusion in the social security systems should also be considered. Support for sex workers through facilities like drop-in centers that provide a safe space for sex workers during working hours might also ease some of the challenges of sex work. Other structural changes to support sex work and the health and well-being of sex workers should also be explored further.

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