Gender Identity Disparities in Cancer Screening Behaviors

Ariella R. Tabaac, MS,1 Megan E. Sutter, PhD,2 Catherine S.J. Wall, BS,1 Kellan E. Baker, MA, MPH3,4

Introduction: Transgender (trans) and gender-nonconforming adults have reported reduced access to health care because of discrimination and lack of knowledgeable care. This study aimed to contribute to the nascent cancer prevention literature among trans and gender-nonconforming individuals by ascertaining rates of breast, cervical, prostate, and colorectal cancer screening behaviors by gender identity.

Methods: Publicly available de-identified data from the 2014–2016 Behavioral Risk Factor Surveillance System surveys were utilized to evaluate rates of cancer screenings by gender identity, while controlling for healthcare access, sociodemographics, and survey year. Analyses were conducted in 2017.

Results: Weighted chi-square tests identified significant differences in the proportion of cancer screening behaviors by gender identity among lifetime colorectal cancer screenings, Pap tests, prostate-specific antigen tests, discussing prostate-specific antigen test advantages/disadvantages with their healthcare provider, and up-to-date colorectal cancer screenings and Pap tests ($p < 0.036$). Weighted logistic regressions found that although some differences based on gender identity were fully explained by covariates, trans women had reduced odds of having up-to-date colorectal cancer screenings compared to cisgender (cis) men (AOR=0.20) and cis women (AOR=0.24), whereas trans men were more likely to ever receive a sigmoidoscopy/colonoscopy as compared to cis men (AOR=2.76) and cis women (AOR=2.65). Trans women were more likely than cis men to have up-to-date prostate-specific antigen tests (AOR=3.19). Finally, trans men and gender-nonconforming individuals had reduced odds of lifetime Pap tests versus cis women (AOR=0.14 and 0.08, respectively), and gender-nonconforming individuals had lower odds of discussing prostate-specific antigen tests than cis men (AOR=0.09; all $p < 0.05$).

Conclusions: The findings indicate that gender identity disparities in cancer screenings persist beyond known sociodemographic and healthcare factors. It is critical that gender identity questions are included in cancer and other health-related surveillance systems to create knowledge to better inform healthcare practitioners and policymakers of appropriate screenings for trans and gender-nonconforming individuals.

From the 1Department of Psychology, Virginia Commonwealth University, Richmond, Virginia; 2Department of Health Outcomes and Behavior, Moffitt Cancer Center, Tampa, Florida; 3Center for American Progress, Washington, District of Columbia; and 4Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland

Address correspondence to: Ariella R. Tabaac, MS, Department of Psychology, Virginia Commonwealth University, 806 West Franklin Street, PO Box 842018, Richmond VA 23284. E-mail: tabaacar@vcu.edu.

0749-3797/$36.00
https://doi.org/10.1016/j.amepre.2017.11.009

© 2018 American Journal of Preventive Medicine. Published by Elsevier Inc. All rights reserved.
and, as a result, rates of chronic illness and care utilization among transgender and gender-nonconforming (TGNC) individuals, including cancer, have not been established. The 2014 National Summit on Cancer in the LGBT Communities called for an increase in research on the cancer risks and screening disparities of lesbian, gay, bisexual, and transgender communities, projecting the prevalence of invasive cancer within the U.S. to rise to 2.3 million cases per year by 2030, a 45% increase in diagnosis.1 This is likely to disproportionately impact TGNC individuals, given the vulnerability and stigma they face within the U.S. healthcare system.2,3 Many TGNC individuals report refusal of care (19%), harassment (28%), and lack of TGNC-knowledgeable providers (50%), and 28% cited discrimination as a primary reason for postponing care,3 although it is unknown if this included cancer screening.

Many transgender (trans) individuals seek medical care as part of gender affirmation, which can include services of mental health counseling, hormone replacement therapy, and various surgeries involving primary and secondary sex characteristics.4 Conversely, trans people may avoid care that is not gender affirming because of discomfort or distress (i.e., trans men and Pap tests).5,6 For those who do see care, clinicians may fail to provide appropriate cancer screenings on the basis of the patient’s anatomy, such as mammograms for patients of any gender with significant breast tissue or a family history of breast cancer, prostate screenings for trans women and GNC individuals assigned male at birth, and Pap tests for GNC individuals assigned female at birth and trans men who retain a cervix after gender affirmation. Thus, trans individuals may be particularly vulnerable to developing high-grade cancer cytology because of decreased clinical surveillance.7

Emerging research has found gender identity to be relevant to cancer screening. A study at Fenway Health found that trans men were less likely to be up to date (UTD) on Pap tests than cisgender (cis) women.9 Trans men and GNC individuals were also shown to have significantly lower proportions of regular Pap tests in an Internet-based convenience sample.9 Another Fenway Health study found that, of trans men who do receive Pap tests, they were ten times more likely than cis women to have inadequate tests (i.e., the cell sample taken was insufficient for laboratory testing),10 which may be associated with increased risk for developing high-grade cervical lesions at a later date.7 Rates of mammography at an urban community health center in Massachusetts similarly found that trans patients were much less likely than cis women to follow clinical screening guidelines.11 In the only study to use population-level data, Narayan and colleagues14 found that trans patients were as likely to adhere to 2014 mammography screening guidelines as cis patients.

Though these findings indicate a general trend toward decreased cancer screening among trans individuals, generalizability has been limited to the clinics from which the samples were drawn. Apart from one study on breast cancer,1,14 national data on rates of cancer screening in more representative trans populations has not yet been analyzed. The Centers for Disease Control and Prevention’s 2014–2016 iterations of the Behavioral Risk Factor Surveillance System (BRFSS) is one of the first U.S. surveys to collect information on gender identity. The aim of the present study is to establish rates of cancer screening among trans women, trans men, and GNC individuals in a national sample. Further, the present study seeks to investigate how trans individuals’ screening rates compare with cis individuals.

METHODS

Study Sample

Publicly available population-level data from the 2014, 2015, and 2016 BRFSS were utilized to compare cancer-screening behaviors among cis and TGNC adults. Analyses were limited to 28 states that collected gender identity of TGNC individuals (686 trans men, 1,085 trans women, 424 GNC individuals, 278,061 cis women, and 200,074 cis men) (Table 1). The BRFSS is a system of national telephone surveys that collected demographic and health-related data on noninstitutionalized adult U.S. residents.15

Measures

The primary variable of interest, gender identity, was computed using the question: Indicate the sex of respondent, response options: (male/female), and the Sexual Orientation and Gender Identity Module: Do you consider yourself to be transgender? If yes, respondents indicated whether they were transgender, male to female; transgender, female to male; or transgender, gender-nonconforming. Categories were computed based on whether they indicated being transgender (yes/no) and their indicated sex (male/female) as follows: cisgender women (not transgender, female sex), cisgender men (not transgender, male sex), trans woman (transgender, male to female), transgender, female to male, and gender-nonconforming (transgender, GNC; sex either male or female).

Sociodemographic and healthcare access variables were utilized as covariates. Variables included imputed age with 13 categories from 0 (18–24 years) to 13 (≥80 years), sexual orientation (straight, gay/lesbian, bisexual, other), race/ethnicity (white/non-Hispanic, black/non-Hispanic, Hispanic, and other race/non-Hispanic), education (did not graduate high school, graduated high school, attended college/technical school, or graduated from college/technical school), income included five categories from <$15,000 to ≥$50,000, relationship status (partnered versus not), health insurance (yes/no), and whether they had a personal doctor (yes/no).
دریافت فوری
متن کامل مقاله

امکان دانلود نسخه تمام متن مقالات انگلیسی
امکان دانلود نسخه ترجمه شده مقالات
پذیرش سفارش ترجمه تخصصی
امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
امکان دانلود رایگان ۲ صفحه اول هر مقاله
امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
دانلود فوری مقاله پس از پرداخت آنلاین
پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات