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TRANS MEN IN THE HIV RESPONSE


DON'T EXCLUDE TRANSMEN OR NON-BINARY PEOPLE
TRANSMEN WILL NOT BE SILENT
don't forget trans men
TRANS GUYS FUCK TOO!

Trans men, trans masculine persons, and gender diverse persons assigned female at birth, hereafter referred to as **trans men and other AFAB trans persons,** have historically been excluded from the HIV response.

To counter this, GATE has developed this document, in collaboration with the International Trans Men and HIV Working Group, for trans and gender diverse communities to use in their advocacy efforts. It summarises key information on trans men and other AFAB trans persons to ensure they are not left behind. For further information and detailed research, please refer to GATE's ***Policy Brief on Effective Inclusion of Trans Men in the Global HIV Response.***

Why this population?

As we move towards the Global AIDS Targets 2025 deadline, HIV continues to have a disproportionate impact on trans persons. The **omission of trans men and other AFAB trans persons in the global HIV response threatens to undermine progress and entrench inequities**. Community-led responses can deliver a more holistic wellness approach, especially where criminalization or crises result in general services under-serving marginalized populations. In line with the Prevention 2025 Road Map, community empowerment requires resourcing for capacity building, advocacy, and community mobilization to ensure trans-led responses can continue sustainably.

It is important to note that, in presenting this case for the inclusion of trans men and other AFAB trans persons in the HIV response, we are not suggesting a redistribution of resources already dedicated to trans women as a key population. Rather, **we argue that not only are the resources currently dedicated to trans women are inadequate and thus should be increased, but that donors should allocate additional resources for the inclusion of trans men and other AFAB trans persons in the global HIV response**.

MYTH

Trans men and other AFAB trans persons have low rates of HIV / don't exist / are too small a population to prioritize.

FACT

Lack of data creates false assumptions of low HIV burden and leads to exclusion from key population definitions.

Trans men have HIV prevalence rates of 3-38%, within UNAIDS' 'high' to 'very high' risk category, and are almost seven times more likely to have HIV than the general population.

RECOMMENDATION

Reliable, disaggregated data on trans men and other AFAB trans persons is urgently needed to build a stronger case for inclusion (further evidencing unmet need, HIV prevalence, and population sizes).

Train researchers, healthcare professionals, and policymakers on effective methods of collecting and disaggregating data on trans men and other AFAB trans persons, using the two-question approach or requesting sex assigned at birth, followed by gender identity, to adequately identify this population.

MYTH

Trans men and other AFAB trans persons are already included in key population definitions.

FACT

Key population definitions are taken to mean trans women and cis men who have sex with men. Because of this, **trans men and other AFAB trans persons are excluded from IBBS research, Pepfar definitions, National Strategic Plans, and national HIV responses.**

RECOMMENDATION

Based on emerging HIV prevalence and risk data, we recommend that PEPFAR, UNAIDS, the Global Fund, and the WHO institutionalize and explicitly identify **trans men and other AFAB trans persons within transgender persons as a key population and support this group within National HIV responses**

MYTH

The needs of trans men and other AFAB trans persons are already being met through other key populations and/or general services.

FACT

With trans men and other AFAB trans persons **not being regarded as a key population in practice**, even when eligible, this **translates into poor access to condoms, lubricants, PrEP, and other HIV services** that target (cis) MSM and trans women. This further undermines global HIV prevention, HIV/STI testing, treatment, and care targets.

Stigma and discrimination are significant societal barriers driven by homo- and transphobia. Within healthcare settings, this leads healthcare providers to exclude trans men and other AFAB trans persons from HIV services.

RECOMMENDATION

Resource community- and peer-led approaches, which are best placed to provide care tailored to community needs, to ensure sustainable HIV responses, and to strengthen resilience and preparedness solutions.

Build towards a model of trans-competent care that can offer a route towards acceptable, affordable, accessible, quality services and universal health coverage.

MYTH

Services for men who have sex with men don't need to meet the needs of trans men and other AFAB trans persons as there are "no trans men who have sex with men'/ they are 'still female"

FACT

Trans men and other AFAB trans persons are less likely to be heterosexual than cis men. **There are significant numbers who engage in behaviors common to the MSM community (e.g., condomless sex with multiple partners living with possibly transmissible HIV),** which makes them eligible for PrEP and priority HIV interventions.

RECOMMENDATION

Recognizing the diversity of identities, bodies, and sexual behaviors can mean HIV interventions are better tailored to meet different needs.

Ensuring the uptake of trans-cultural and -clinical competencies into models of care, supported by healthcare provider medical education and training, will help to address stigma and discrimination within health settings and support the implementation of trans-competent care.

MYTH

Taking PrEP or anti-retroviral medications (ARVs) will reduce the effectiveness of masculinizing hormone replacement therapy.

FACT

There are **no documented interactions between masculinizing hormones and ARV drug combinations**. Additionally, research increasingly shows **no interactions between masculinizing hormones and PrEP.**

RECOMMENDATION

Evidence-based information and education materials targeting trans men and other AFAB trans communities and healthcare providers are needed to **dispel myths on adverse interactions between masculinizing hormones and ARVs and masculinizing hormones and PrEP.**

MYTH

There is no benefit in funding gender-affirming care, as it does not impact the uptake of HIV prevention and care or awareness of the same.

FACT

Access to gender-affirming healthcare services is associated with higher uptake of HIV and STI testing and greater awareness of PrEP. The WHO 2022 Consolidated Guidelines recognize gender-affirming care as the top healthcare priority for trans persons.

Access to gender-affirming care can be based on a diagnosis of 'gender incongruence,' as per the WHO ICD-11, but **it needs to be translated into practice.**

RECOMMENDATION

Gender-affirming care (hormones, trans-specific surgeries) must be **prioritized as a key HIV intervention. Integration of HIV services and gender-affirming care** is critical to improve the uptake of HIV/STI testing, treatment, and care.

States must translate the WHO ICD-11 **into national health coverage schemes and monitoring.**

TRANS MEN IN THE HIV RESPONSE

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