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Need For Transgender-Specific Data From Africa And Elsewhere

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Transfeminine people, or transgender women, have been shown to have a large HIV burden worldwide.¹ Until 5–10 years ago, an apparent conflation of gender and sex had led several countries to inappropriately categorise transfeminine people as men who have sex with men (MSM), a behavioural term coined by WHO. A WHO report from 2018 highlighted that only ten (22%) of 45 national HIV strategic plans from African countries mentioned transgender people, and only four (9%) offered interventions.² UNAIDS notes that countries with generalised HIV epidemics, like some countries in Africa, might also have concentrated subepidemics among transgender people, and recommends reporting on several indicators (eg, HIV prevalence, use of antiretroviral therapy).³ The UNAIDS 2020 fast-track commitment focuses on ensuring access to combination HIV prevention options, including pre-exposure prophylaxis (PrEP), in at least 90% of people, including transgender people.³ Similarly, to achieve the UNAIDS 95-95-95 targets by 2030 (for 95% of people living with HIV to know their HIV status, 95% of those diagnosed to be on antiretroviral therapy, and 95% of those on treatment to be virologically suppressed), it is crucial to have data that are specific to key populations. Nevertheless, several national HIV programmes do not include such data.

In The Lancet HIV, Adrian Smith and colleagues' study⁴ from Nairobi, Kenya, shows a high HIV prevalence among transfeminine people who have sex with men (41%), approximately 80% higher than that among cisgender MSM, who also had high HIV prevalence (25%). Furthermore, when compared with cisgender MSM, transfeminine people who have sex with men were found to have higher prevalence of current symptoms suggestive of rectal sexually transmitted infections (STIs), condomless anal sex with men in the past 3 months, and transactional sex with men in the past 12 months; were less likely to have ever had an HIV test; and had suboptimal HIV care cascades that were substantially short of the UNAIDS 90-90-90 targets for 2020 (transfeminine people 72-85-71; cisgender MSM 78-86-80).

A key contribution of Smith and colleagues' study is that it shows that transfeminine people who have sex with men have higher risk of HIV than cisgender MSM in Kenya, and face barriers in accessing HIV prevention and treatment services. To capture the gender identity of the participants, the authors used a two-step approach,⁵ comprised of assessment of sex assignment at birth (male, female, or prefer not to say) and current self-reported gender identity (male, female, transgender, or none of these terms). However, the authors reported that the two-step approach "might be too simplistic and might not allow individuals to affirm

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other specific gender identities (eg, gender non-binary, gender fluid, gender queer)". Future studies could thus modify this approach to suit the local contexts—eg, by adding indigenous transgender identities to the response options as well as having an open-ended option to specify other gender identities. The small sample size in this study prevented Smith and colleagues from comparing transmasculine people who have sex with men (<1% of the sample) with cisgender MSM. Capturing the gender identity of transgender people should not be limited to research, and needs to be routinely collected in HIV programmes to understand the specific needs of and inequalities faced by transgender people. For example, India's National AIDS Control Organization has initiated transgender-specific HIV interventions during the fourth phase of the National AIDS Control Programme (2012–20), as well as transgender-specific HIV and behavioural surveillance studies.⁶

The study by Smith and colleagues primarily shows the presence of health inequalities among transfeminine people who have sex with men compared with cisgender MSM, which is an essential step before attempting to explain and address these health inequalities. Except for their data on non-consensual sex in the previous year, their study does not provide the empirical data to explain the health inequalities between the gender identities. Nevertheless, in an article by Fearon and colleagues⁷ that used qualitative and quantitative data, the authors stated that "participants in Kenya...reported that police raids or general hostility towards gay bars or hotspots were commonplace", highlighting the presence of discrimination and violence, which are structural drivers of HIV among sexual and gender minorities.¹ Another limitation of the study by Smith and colleagues is that they did not explicitly use theoretical frameworks to explain the observed health inequalities, although they acknowledged the role of discrimination in increasing HIV vulnerability. Some useful theories to show how stigma and discrimination faced by sexual and gender minorities contribute to psychosocial problems include Meyer's minority stress theory,⁸ and syndemic theory that posits that synergistic co-occurring epidemics of certain psychosocial health problems, due to sociostructural conditions such as societal discrimination, increase HIV risk.^{1,9} These theories could be used to explain the health inequalities faced by gender and sexual minorities in Kenya and other African countries. However, one should not wait too long by following the seemingly linear path of first documenting and then explaining health inequalities before starting to address health inequalities. Citing evidence from multiple studies, Crowell and colleagues¹⁰ argue that African MSM and transgender women face several barriers "due to discriminatory policies, criminalizing legislation, stigmatizing healthcare systems and under-allocation of limited healthcare resources". These structural, legal, and policy barriers could explain why the progress toward achievement of the UNAIDS 90-90-90 targets for 2020 is suboptimal, as reported by Smith and colleagues, and justify taking steps to address these barriers.

Hopefully the study by Smith and colleagues will be the beginning of the reporting of transgender-specific research and HIV programme data from African nations and other low-income countries. Their results provide further evidence of the need for inclusion of specific responses for transgender people in national HIV strategic plans from Africa and elsewhere; support not subsuming transfeminine people who have sex with men as MSM; and indicate the need for using relevant theoretical frameworks to explain health inequalities. Data that are specific to key populations, including transgender-specific data, are needed to identify

the gaps in HIV responses, and to achieve the third Sustainable Development Goal (SDG-3) of ending the HIV epidemic by 2030.

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