PrEP for Transgender and Gender Non-Conforming Individuals

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Dr. Erin Wilson, SFDPH
Michelle Evers, Howard Brown
Cassie Warren, Broadway Youth Center

9.27.16

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Poll Question: What type of organization do you work for?
Housekeeping

Have questions during the webinar?
- Type them in the chat box!

Did you have a chance to complete the HPAT?
- If not, please do so via link in chat box!
- If yes, great! Sit back and enjoy the webinar!

Please be sure to complete the evaluation at the end of the webinar! We love all feedback.
SFDPH CBA Expertise

HIV Testing
- Community-based testing
- Home testing
- Novel testing technologies
- Linkage/Partner Services
- Internet Partner Services

Prevention for at-risk negative persons
- PrEP/PEP
- Personalized Cognitive Counseling

Policy
- Data to support HIV care continuum
- Harm reduction
- Jurisdictional Planning
- Working with cross-sector partners
Ready to find out more?

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Funded by Centers for Disease Control and Prevention
Trans people and PrEP

Data on PrEP awareness, interest, candidacy, barriers and facilitators from San Francisco

Erin C. Wilson | erin.wilson@sfdph.org
www.theshinestudy.org | www.transnationalstudy.org
HIV among transwomen

~ 40% of transwomen in San Francisco are estimated to be living with HIV

34 fold greater odds of HIV infection than the US general adult population

Rapues et al., 2013; Baral et al. The Lancet 2013.
Race/ethnicity and HIV among transwomen

- African-Americans: AOR 29.9
- Latina: AOR 10.9
- Asian: AOR 16.8

40% HIV prevalence among transwomen in SF
HIV prevalence among groups at risk for HIV in San Francisco

- Transwomen (2013)
- MSM (2011)
- PWID (2011)

San Francisco Department of Public Health Annual HIV/AIDS Epidemiology report
https://www.sfdph.org/dph/comupg/oprograms/HIVepiSec/HIVepiSecReports.asp
Overview of PrEP data

• Are transwomen aware of or interested in taking PrEP?
• Based on existing CDC criteria for PrEP, are transwomen candidates for PrEP?
• What are some of the barriers and facilitators for PrEP use in the trans community?
• What research and intervention work are we doing to make changes?
Local Data Sources

TEACH2 – Adult transwomen in San Francisco aged 18+ (2013)
  - Behavioral surveillance study, \( N=233 \)
  - *preliminary 2016 data from TEACH3, \( N=144 \)

SHINE – Longitudinal study of trans*female youth aged 16-24 years in the San Francisco Bay Area (2015)
  - Data from baseline, \( N=298 \)
  - Data from sub-sample PrEP survey, \( N=69 \)

PrEP focus groups (2014)
  - Focus group discussions with adult and young transwomen and adult transmen (4)
TEACH2 (N=233) & SHINE (N=67)

PrEP awareness and interest

- Awareness of PrEP
- Interest in Taking PrEP

TEACH (2013)
- Awareness: 13.7%
- Interest: 0.0%

SHINE (2015)
- Awareness: 13.7%
- Interest: 73.9%
TEACH2
Associations with PrEP awareness

- Self reported HIV positive vs. Self reported HIV negative (20% vs. 10.5%, p=0.05)
- Primary partner living with HIV (29.4% vs. 12.5%, p=0.05)
- History of injection drug use vs. no IDU history (45.5% vs. 8.5%, p<0.01)
Preliminary TEACH 3 data, 2016

Aware of PrEP

- Yes: 84%
- No: 16%

Not living with HIV and have taken PrEP

- Yes: 88%
- No: 13%
SHINE
PrEP Barriers

• Many concerned
  • Others seeing them with HIV medications (55.7%)
  • Difficulty with taking a daily medication (49.3%)
  • Interactions with hormone therapy (35.6%)
  • Medication side effects (34.6%)

• Not many concerned
  • Affordability (2%)
  • Effectiveness of PrEP alone and in addition to other prevention methods (2%)
  • How to determine if they are at high risk (2%)
Focus Groups with trans people in the SF Bay Area

**PrEP barriers: Stigma**

- Stigma about being on PrEP and assumed serostatus
- Worried about violence if found taking HIV medications
- Participants reported PrEP was for people who are promiscuous and worried it encouraged condomless sex
  - “PrEP your hole!”
  - Sex shaming
PrEP barriers: Attitudes & Knowledge

• Marketing aimed at gay community
  • “All the language around PRP and PrEP is targeted toward gay men. And that to me is really alienating to be put in this demographic that I’m not in.”

• Knowledge
  • No knowledge about transwomen and PrEP
  • Questions about PrEP:
    • Efficacy, toxicity and effect on body
    • Interaction with HRT, HCV and mental health treatment and substance use
    • Injectable availability
    • Concerns about PrEP and condomless neovaginal sex
    • Conflation of PrEP and PEP
No CDC guidelines exist for trans people

Analysis on how many transwomwn would be considered candidates for PrEP based on CDC indications for MSM and PWID

- TEACH2, low candidacy
  - Only 45 (30.2%) met criteria
  - Of those who had heard of PrEP, only 5 would be indicated PrEP

SHINE, low candidacy

- Only 35% (n=105) of SHINE youth were candidates
- Anomalies also popped up
  - When comparing between those with a known HIV-negative status and those with an unknown HIV-status, there were significantly more HIV-negative trans*female youth than HIV-unknown who met the PrEP criteria (n=247; 38.6% vs. 29.4%)
Research and interventions
References


Thank you SFDPH team
PrEP and Transgender and Gender Non-Conforming Individuals

Michelle Evers CNP, MSN, RN
Statistics

• Transgender women are 49 times more likely to be HIV-infected than the general population, with 19.1% of transgender women worldwide living with HIV and 21.6% of transgender women in the United States living with HIV.

• Black transgender women are approximately three times more likely to be living with HIV than their White and Latina counterparts.
<table>
<thead>
<tr>
<th>Year</th>
<th>TGNC Patients</th>
<th>TGNC Patients Receiving Hormones</th>
<th>TGNC HIV+ Patients</th>
<th>TGNC HIV+ Patients Receiving Hormones</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>467</td>
<td>135 (29%)</td>
<td>65 (14%)</td>
<td>10 (15%)</td>
</tr>
<tr>
<td>2010</td>
<td>557</td>
<td>201 (36%)</td>
<td>74 (13%)</td>
<td>16 (22%)</td>
</tr>
<tr>
<td>2011</td>
<td>695</td>
<td>292 (42%)</td>
<td>85 (12%)</td>
<td>27 (32%)</td>
</tr>
<tr>
<td>2012</td>
<td>953</td>
<td>517 (54%)</td>
<td>96 (10%)</td>
<td>47 (49%)</td>
</tr>
<tr>
<td>2013</td>
<td>1332</td>
<td>1019 (77%)</td>
<td>129 (10%)</td>
<td>79 (82%)</td>
</tr>
<tr>
<td>2014</td>
<td>1797</td>
<td>1191 (66%)</td>
<td>180 (10%)</td>
<td>163 (90%)</td>
</tr>
<tr>
<td>2015</td>
<td>2311</td>
<td>1052 (46%)</td>
<td>198 (8.6%)</td>
<td>150 (76%)</td>
</tr>
</tbody>
</table>

**Stages of change for Howard Brown’s module**

- 2010- informed consent module initiated in clinic
- 2013- opt out testing (92%)
- 2014- drop in services
- 2015 informed consent revision

Between 2009 and 2015:
- TGNC population increased almost by a factor of almost 5 (4.95)
- TGNC HIV+ population tripled (3.05)
- Positivity rate for TGNC patients decreased from 14% to 8.6%
- The % of HIV+ TGNC patients receiving hormone therapy increased from 15% to 76-90% (a 5-6 fold increase)
Role out of PrEP Program at Howard Brown

- Administration buy-in
- Involve community: development and marketing
- Identify staff interested in PrEP
- PrEP Clinical Champions/Working Group
- Be intentional about rolling out Protocols (procedures, billing codes)
- Skills-building, case-based training
- If high-volume, dedicated staff for navigating insurance/payment assistance programs
What PrEP does...

- Skills development
- Engaging sexual partners
- Enhance sex-positivity – more pleasure when less fear!
- Expanding community
BARRIERS TO PREP FOR TRANS/GNC PATIENTS
A CLINICIAN’S PROSPECTIVE
SYSTEMS OF INEQUALITY: POVERTY & HOMELESSNESS

Transgender and gender non-conforming people are much more likely to be poor or homeless than the average person. This diagram shows how various factors combine into an interlocking system that keep many trans and gender non-conforming people in situations that are vulnerable and unequal.

- Can’t apply for school or access higher education due to lack of I.D. or because their I.D. doesn’t match the name or gender they live as.
- Drop out due to harassment, violence and/or discrimination at school.
- Permanent housing inaccessible due to housing discrimination in private housing market; low-income housing options are often gender-segregated, and trans people are rejected for placement.
- Kicked out of home because of abuse from parents and foster parents; trans youth are not allowed to express their gender identity in gender-segregated group homes.
- Low income or no income
- Can’t apply for jobs or access good employment due to lack of I.D. or because their I.D. doesn’t match the name or gender they live as.
- Persistent and severe medical problems: transphobic violence leads to increased mental health and medical problems.
- No access to health care: trans people are often denied all treatment or are afraid to seek care due to past mistreatment.
- Trans-specific physical and mental health care needs are often not provided or covered even if insured; shortage of knowledgeable health care professionals who can provide trans-specific care.
- Inadequate or no health care
- Bias, discrimination and ignorance in medicine: inappropriate and harmful treatment, including institutionalization and damaging, incompetent medical procedures.
- Temporary housing inaccessible often rejected from gender-segregated shelters or experience harassment and abuse at shelters.
- Homeless or at risk for homelessness
It’s so Important for trans/GNC female patients to know....

• There is no evidence or clinical studies of potential drug interactions between different classes and combinations of antiretroviral medications (ARV) and cross-sex hormone therapy (csHT) used by transgender women for gender transition and feminization.
Estrogen and PrEP

- PrEP and estrogens
  - *In vitro* differences in tenofovir (TFV) pharmacokinetics (PK) in presence of exogenous estrogen Creatine kinase (CK) responsible for phosphorylation of TFV in colon tissue

  - 100-fold higher TFV diphosphate concentrations in colon v. vaginal tissue

- It’s feasible that **exogenous estrogen exposure could affect TFV PK in colon tissue**, a critical site for PrEP efficacy among transgender women

  - Shen 2014, Lade 2015, Hendrix 2016

  - **Clinical relevance**
    - Should there be different dosing in transgender women on estrogens?
PrEP in transgender women

- **iPrex** N=339/2499 (14%) trans women (TW)
  - Lack of efficacy: **HR 1.1** TDF detected in **zero** TW at seroconversion
  - **Zero** seroconversions in TW with TDF levels consistent with > 4 pills/week
  - TDF levels not linked to behavioral risk

Clinical Trials which looked at Transgender women’s adherence to Prep

- **iPrex** 18%
- **FEM-PrEP** 24%
- **VOICE** 29%

*Poor adherence in all trials!*
- Deutsch 2015
Pt P.E is a 19 African American transgender female here today for evaluation. She would like to discuss her hormones, as she has not been able to consistently get them due to financial constraints. She has been staying at the Crib (homeless shelter for trans*) Admits has been very depressed, and has been using more---”molly‘s,” cocaine, and THC.” She has sex for drugs, money, and housing. Pt has heard of Prep, but has not really considered it for herself. She has had positive STD screenings in the past rectal/GC/CC. Support systems lacking, grew up “in the system.”
My plan....

• START PREP!!!!
• Barriers— SO MANY! Housing, drug use, financial, mental health, priorities, lack of insight about risk
• Where can she keep her PrEP?
• This patient was prescribed PEP with goal to transition to PrEP..... She never picked up the bottle though... and seroconverted three months later was HIV +
Lessons...

• Some Transgender/GNC women do not recognize that they are at risk.
• May not have a lot of partners—but receptive anal intercourse is higher risk
• Develop rapport/trust
• Emphasis on adherence!
• Sex education needs to be trans* competent
• Don’t make assumptions—ask patient what parts they use and the names that they use to identify their parts
• Don’t presume that all trans/GNC women have dysphoria about their “front parts.”
How to target high risk patients?

- Consider use of PEP to PrEP if the provider is concerned about HIV acquisition in the past 14 days. The HIV fourth generation can be obtained, and repeated at 4 weeks to safely transition patient.

- Use supportive staff. Training MAs, Nurses, Pharmacist, Case Managers, Behavioral Health—**All Staff** about the importance of PrEP.

- For high risk patients--- develop resources for the provider so they can refer to someone during the visit. This person can ensure patient leaves with Truvada, feels empowered about using it, and has follow up appointments scheduled.
Medical Trauma: Barrier for patients

- 19% were refused care due to transgender or gender non-conforming status
- 28% experienced verbal harassment in medical setting
- 2% experienced being physically attacked while in doctor’s office
- 50% had to teach medical provider about transgender care
- 28% postponed or avoided seeking medical care when sick or injured due to discrimination or disrespect

Data from National Transgender Discrimination Survey Report (NTDS) released 10/13/2010 by National Gay and Lesbian Task Force
What about trans/GNC men?

• No existing clinical trials for PrEP have trans men in their samples
• None of the research evidence we have currently takes into account men who may be having receptive vaginal AND anal sex.
• Concern about trans men’s experience of vaginal atrophy; which can occur during testosterone therapy, and how this relates to Truvada drug levels
My experience with trans/GNC men

• Pt L.B is a 28 year old gender queer man who presented for conversation about Prep. They are an advocate in the community and have learned about Prep. They are at visit for annual evaluation, they are getting pap smear, want refills of testosterone, and want to start on Prep. At last visit they were in a monogamous relationship with Cis female partner. The patient states “I have been more sexually active with Cis men, even going to Steam works at times.” Patient does not have a history of STIs
Lessons again.....

• Don’t make assumptions!
• Sexual partners change, sexual behaviors and risks change
• Discuss sex at every visit.
• This patient was confident and aware of PrEP, however it made me consider other trans/GNC masculine patients who may not have been as proactive
• I have two HIV positive trans* men in my practice.

• TRANS* men should be aware of option of Prep!!!

• Use lube—may decrease risk by prevention of trauma (atrophy)

• When patients start on testosterone they often notice an increase in sexual libido—talk to patient’s about PrEP when starting on hormones
BARRIERS TO PREP FOR TRANSGENDER AND GENDER NON-CONFORMING FOLKS

Cassie Warren, Broadway Youth Center
Pronouns: He, She and They, please switch up and use all
KEY AREAS TO PROMOTING PREP UPTAKE

1. Provider Knowledge
2. Support and protocol for medication assistance
3. Tools for retention and measuring outcomes
4. Clinic flow and timeline to start prep
5. Social determinants of health
PROVIDER KNOWLEDGE

• Need to know about trans healthcare and how to be gender affirming as a practice across the agency not just for specific patients you read as being trans or GNC
  • EMR ability to specify preferred name and pronoun
  • Know how to provide hormones
  • Don’t make assumptions about our bodies, body parts or our partner’s body or how having sex
• Must not approach our bodies as an experiment or interesting medical specialty for your to become an expert in.
• Trust that we know our bodies very well. Our experience with the world is that other folks know it better. Do not re-affirm this!
• Be willing to put HRT first and before anything else
SUPPORT PROTOCOL FOR MEDICATION ADHERENCE

• Medication can and should be low/no cost for most patients
• Significant barriers for patients (without support) to medication access
• Real/Perceived cost
  • Insurance or assistance foundation bureaucracy
  • Retail pharmacy challenges
  • Timeline to collect documents
  • Confidentiality from parents, guardians, payors

• Clinics looking to support low income, transgender, or youth access MUST navigate medication access for their patients for both PrEP and Hormones.
TOOLS FOR RETENTION AND MEASURING ADHERENCE

- Prescribe with HRT
- Individualized medication adherence plans
- You can measure adherence by pick-ups from pharmacy, attended clinic visits, and number of missed pills by self report
- Building good relationships with pharmacy
CLINIC FLOW AND TIMELINE TO START

• Late clinic hours- after 5pm
• Walk-in and scheduled appointments
• Decrease number and length of visits required to initiate PrEP
• Sex positive, pleasure positive, gender affirming counseling
• Same day PrEP and HRT initiation
• Low barrier access to the clinic- no ID required, Individualized medication pick-up schedules if possible
SOCIAL DETERMINANTS

• Hyper surveillance
• Life expectancy
• Don’t counsel on options that won’t actually work to implement in folks life
• Be prepared for social service heavy visits over clinical
• Mental health services or referrals that aren’t just clinical
• CELEBRATE and be strengths based
Panel Q&A

Moderated by: Jenna Rapues

Featuring:
- Dr. Erin Wilson
- Michelle Evers
- Cassie Warren