HIV prevention research - a new forum for advocacy on the latest

Transcript

Transgender Research 2026 – Findings from CROI and Beyond

June 11, 2026

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00:00:05.830 --> 00:00:24.209

Jim Pickett: And then, we have a really fantastic lineup today. We have a wonderful moderator, Brian Manalga from Hank, who will introduce themselves shortly, who has partnered on a number of TCA webinars, and is just a great partner in crime in general.

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00:00:24.210 --> 00:00:38.049

Jim Pickett: And then we have 3 really excellent presentations from some really interesting researchers, Bakani, Seri, and Wan Chi. And, I am going to now stop sharing my slides.

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00:00:38.210 --> 00:00:40.440

Jim Pickett: And turn it over to Brian.

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00:00:41.410 --> 00:00:46.380

Jim Pickett: who, will take us from there, take us from here. So, thank you so much.

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00:00:46.530 --> 00:00:49.740

Jim Pickett: And, over to you, Brian.

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00:00:50.830 --> 00:01:00.999

Brian Minalga: Thanks, Jim, and thanks, everyone, for being here, seeing lots of familiar names and faces, so that's always just really nice to see all your friends looking back at you in the audience.

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00:01:01.180 --> 00:01:13.140

Brian Minalga: I saw the... the latest, He-Man movie last night, so I had to, you know, wear my ultra-gendered Mattel influence, to balance things out today.

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00:01:13.370 --> 00:01:27.949

Brian Minalga: And, you know, I just want to wish everybody happy Pride. It is June, which is Pride Month, and, you know, if you're here, you know what's going on in the world, so I won't belabor the point, but just, you know, want to make sure everyone is welcome and

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00:01:27.950 --> 00:01:49.960

Brian Minalga: And celebrating happy Pride, and we are really proud to have, three incredible, brilliant researchers and just human beings here with us today to tell us about their trans-focused and trans-centered research. We wouldn't have Pride if it wasn't for trans people. We wouldn't have HIV research if it wasn't for trans people.

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00:01:50.070 --> 00:02:06.749

Brian Minalga: We wouldn't have, you know, talent and truth and just so many amazing things that we have in the world if it weren't for our beautiful trans community. So, really, I'm looking forward to spending the next, about hour and a half with you all in celebration of Pride Month and our trans community.

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00:02:07.640 --> 00:02:21.659

Brian Minalga: So let's talk a little bit about CROI. You may be wondering, like, why we, you know, we're here in June, we're talking about CROI, which was back in... was that February or March, in Denver this year. So, just to give you a little background of how we ended up here.

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Brian Minalga: With a little bit of encouragement from my friends at AVAC, when I was at CROI, earlier this year, I gave myself an assignment to track down all of the trans

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Brian Minalga: related research that was being presented at CROI, whether it was a presentation, a workshop, a poster, I wanted to find all of the trans-focused or trans-related research at CROI. And for those who may not know, CROI is the conference on Retroviruses and opportunistic infections. It's an annual conference that takes place in the United States.

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00:02:58.760 --> 00:03:15.470

Brian Minalga: And is widely regarded as one of the premier scientific conferences, on this topic of infectious diseases. And so, you know, it's important to me that we are representing the community, and that populations who,

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00:03:15.470 --> 00:03:20.470

Brian Minalga: really have the greatest need when it comes to HIV are centered in this work.

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00:03:20.790 --> 00:03:35.510

Brian Minalga: So I gave myself this assignment, I looked for all the trans-related research, and as you may expect, there wasn't a lot. Maybe a little more than we would expect. I think, if I recall correctly, there were about 17 abstracts total.

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00:03:35.510 --> 00:03:50.349

Brian Minalga: that included, any information about trans people whatsoever. So there may have been, you know, some studies that didn't focus exclusively on trans populations, but included, like, you know, one line in the demographics that at least named

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00:03:50.490 --> 00:03:52.460

Brian Minalga: trans population.

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00:03:52.650 --> 00:04:01.059

Brian Minalga: And Jim's posting some of the CROI materials in there, so you can, you know, do a Ctrl-F word find and take a look at some of those abstracts.

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00:04:01.160 --> 00:04:10.149

Brian Minalga: But, while I'm about to take a little sip of my coffee here, I'm gonna ask you a question and, test this chat function and see how chatty you are this morning.

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00:04:10.190 --> 00:04:28.589

Brian Minalga: So, of all of those abstracts, I said, you know, there were about 15, 17, something like that at CROI that were related to trans people at all. I want to ask you how many of those abstracts were focused specifically and exclusively on transgender men.

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00:04:29.320 --> 00:04:32.720

Brian Minalga: So, go ahead and put your comments in the chat.

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00:04:32.940 --> 00:04:37.780

Brian Minalga: how many of those abstracts at CROI, and presentations, posters,

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00:04:38.680 --> 00:04:43.969

Brian Minalga: topics were about transgender men, and I'm gonna take my sip of coffee here.

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00:04:49.780 --> 00:04:52.350

Brian Minalga: Okay, I'm seeing some good answers, yay!

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00:04:52.600 --> 00:04:55.400

Brian Minalga: Okay, this is a chatty group, that's what I wanted to see.

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00:04:56.550 --> 00:05:02.989

Brian Minalga: Perfect, so we have some guesses here, some people are saying no abstracts on trans men.

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00:05:03.230 --> 00:05:10.939

Brian Minalga: One or two... Betting 0... 0... yeah, a lot of people are guessing 0.

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00:05:11.240 --> 00:05:16.420

Brian Minalga: Which, frankly, is a really good guess. However, luckily, in this case.

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00:05:16.660 --> 00:05:21.280

Brian Minalga: it's not true. We had one abstract, one, one topic.

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00:05:21.340 --> 00:05:35.349

Brian Minalga: at CROI that was really focused on transgender men. It's a good guess because that is typical, that zero is usually the number we see. When we talk about trans people, typically the focus is on trans women.

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00:05:35.350 --> 00:05:52.630

Brian Minalga: But, I was walking around the poster hall, and I found a poster that was focused on trans men. It was a really exciting poster, and it got me thinking about how we really need to amplify trans-focused research, especially on such underrepresented populations.

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00:05:52.670 --> 00:06:05.620

Brian Minalga: So I'll note that last time I did a webinar for the Choice Agenda, I was wearing a t-shirt that says, I Heart Tea Girls, but it's also no secret that, I Heart T-Boys as well.

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00:06:05.640 --> 00:06:22.349

Brian Minalga: And so, in that regard, I am so, proud and happy to introduce Bokanyin Leia, who is the scientist in question, who featured this incredible poster at CROI. We happen to miss each other, I saw her poster, she wasn't there at the time.

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00:06:22.350 --> 00:06:33.440

Brian Minalga: But since then, we've had a chance to catch up and get to know each other. I met with her a little bit last week to go over her research. Really incredible path that Bocani has taken.

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00:06:33.450 --> 00:06:47.650

Brian Minalga: Focused on trans men and cervical tissue and susceptibility to HIV. So with that, I'm going to turn it over to Bokani so we can hear from her and this incredible research focused on trans men. Over to you, Bokani.

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00:06:48.910 --> 00:07:01.609

Bokani Nleya: Hi, everyone. I'm truly honored, greatly honoured to be here this morning, sharing part of this work, which is part of my post-doctoral work here at UAB.

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00:07:01.610 --> 00:07:13.769

Bokani Nleya: So thank you, Brian, for that lovely introduction, and to Jim for organizing this. So, with that, I think I'll just go straight up and share my slides.

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Bokani Nleya: So, we've been... doing this work here at UAB, where we sought to assess the susceptibility of cervical.

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00:07:47.850 --> 00:07:52.269

Brian Minalga: Thanks for Connie Sorry to interrupt, I don't see your slides quite yet.

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00:07:52.680 --> 00:07:53.590

Bokani Nleya: O.

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00:07:56.350 --> 00:07:57.770

Bokani Nleya: Sorry.

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00:07:57.770 --> 00:07:58.980

Brian Minalga: That's okay, yeah, that's okay.

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00:08:01.120 --> 00:08:10.770

Brian Minalga: While Bocani's bringing those up, too, I just want to remind folks, we'll probably save the full Q&A portion for the end, but please feel free to put your questions in the chat.

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Brian Minalga: While Bokani's going through her presentation and the, all three presenters. And now I see your slides. Perfect.

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00:08:17.640 --> 00:08:19.230

Jim Pickett: King's great, thank you.

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00:08:36.780 --> 00:08:38.929

Bokani Nleya: Just trying to get my pointy tongue.

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00:08:40.679 --> 00:08:45.820

Bokani Nleya: Yeah. So, just by looking at the literature on HIV,

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00:08:45.960 --> 00:09:03.910

Bokani Nleya: And, the published studies conducted on trans women and trans men, there's very little that has been done in trans men, and then when, like, this is globally. And then when you look in the few studies that have been done in trans men.

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00:09:04.160 --> 00:09:19.500

Bokani Nleya: Only two have actually focused on the clinical or brain science side, and most are usually focused on epidemiological, studies, as well as a bit on interventions. Not enough, but just a little bit.

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00:09:19.500 --> 00:09:36.450

Bokani Nleya: And so these two that have, done some bench science showed that, there seems to be some level of chronic inflammation that happens in an androgen receptor-dependent manner in trans men that are on gender-affirming hormone therapy.

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00:09:36.730 --> 00:09:53.420

Bokani Nleya: And I think we all know that chronic inflammation leads to a number of, immunological changes that may increase susceptibility to infections, including STIs as well as HIV.

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00:09:54.350 --> 00:10:11.079

Bokani Nleya: But none of this has been actually assessed in cervical tissue, which, comprises a lot of immune cells that also express androgen receptors, so the receptors through which hormones, testosterone in particular, signals.

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Bokani Nleya: Which would suggest that the HIV target cells, or just immune cells that are present in cervical tissue, are potentially amenable to modulation by testosterone.

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Bokani Nleya: And so, we sought to investigate in the lab to see whether or not cervical tissue in trans men may or may not

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Bokani Nleya: be modulated in a way that may increase susceptibility to infection, or if the chronic inflammation that has been described in blood is also present, or also manifests in the cervix.

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00:10:46.660 --> 00:10:51.249

Bokani Nleya: And so to do this, we're able, through, help.

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00:10:51.320 --> 00:10:59.469

Bokani Nleya: by a very kind OB guy in UAB Clinics, who actually conducts hysterectomies on trans men.

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00:10:59.490 --> 00:11:10.629

Bokani Nleya: And so she was able to get us cervical explant tissue following his hysterectomies that we then, processed in the lab to these small tissue blocks.

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00:11:10.630 --> 00:11:34.030

Bokani Nleya: that we then use to isolate immune cells from, and then we stain with some antibodies that then help us to identify the different immune cells that are present. And so, not only was she able to get a cervical explant tissue from trans men on gender-affirming hormone therapy, she was also able to give us some of the hysterectomy samples from cis women.

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00:11:34.030 --> 00:11:37.500

Bokani Nleya: So that we could just have that as a separate group,

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Bokani Nleya: And then, in the second part of this experimental approach, we'll take the tissue blocks and then expose them to HIV in the lab, and then just culture them for up to 14 days.

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00:11:51.250 --> 00:12:14.280

Bokani Nleya: During which we then sample, we take the tissue blocks, we digest again to get the cells so that we can identify the type of HIV-infected cells, as well as the frequency. And then, from the supernatins, or the tissue microenvironment, we also sample for the release of cytokines, so that we're able to measure that

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00:12:14.280 --> 00:12:33.630

Bokani Nleya: those inflammatory markers, and then also, at the same time, measure HIV replication kinetics, so that we don't just, identify the infected cells, but we're also able to monitor over time how the replication kinetics compare between, trans men on

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00:12:33.630 --> 00:12:35.490

Bokani Nleya: Hormone therapy.

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00:12:35.750 --> 00:12:38.730

Bokani Nleya: And then cis... against, cis women.

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00:12:40.120 --> 00:12:42.539

Bokani Nleya: And so we're able to identify

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00:12:42.540 --> 00:13:07.539

Bokani Nleya: different kinds of cells, including T cells as well as macrophages. And at first glance, there was really no significant differences between the two groups, although you could see that among the transmen groups, so all the reds here, you can see that there's that heterogeneity among the samples, and that was really contributed to, by the fact that we could not get, like, the individuals from which we got the

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00:13:07.540 --> 00:13:21.090

Bokani Nleya: samples on had been on hormone therapy for different periods of time. So we had individuals that had been on therapy for, like, 2 months, then we had some that had been on therapy for 7 years.

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00:13:21.090 --> 00:13:43.570

Bokani Nleya: And there was also... there were also differences in age. I think the youngest individual that we had may have been 22, and then the oldest was 33. So that could have contributed to the heterogeneity. But, we did our analysis by just treating the trans men on gender-feming hormone therapy as a separate group.

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00:13:43.570 --> 00:13:56.600

Bokani Nleya: Compared to the C-Suite men. Among... and the cis women also, I must point out that, we also did not know anything about any hormone intake in the form of contraceptives or anything, like that.

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00:13:56.600 --> 00:14:01.249

Bokani Nleya: So that was, I think, one of the major limitations of the study as well.

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00:14:01.840 --> 00:14:26.810

Bokani Nleya: But then we wanted to... then we saw some... some trends, even though those were not significantly different, where there seemed to be fewer, comparatively fewer CD8-positive T cells, which are the cells that are important or involved in antiviral immunity. And then when we looked at inflammatory macrophages, we also saw them to be reduced in the cells that we got from transmission.

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00:14:26.810 --> 00:14:35.899

Bokani Nleya: So, kind of opposite to what, they had shown in the blood, where they saw, markers of chronic inflammation, where you'd expect

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00:14:35.900 --> 00:14:43.180

Bokani Nleya: The macrophages that are responsible for inflammation to also be higher, but in tissue, they seem to be lower.

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00:14:44.940 --> 00:15:06.160

Bokani Nleya: And then next, we wanted to see... so among these T cells that we identified, we wanted to see what, the expression of the HIV entry receptors looked like. So these are the receptors, CD4 and CCR5 that are needed for the virus to interact with before it can gain access to HIV target cells and establish infection.

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00:15:07.420 --> 00:15:25.779

Bokani Nleya: So we looked among the CD4 T cells, and when we looked at, CCR5, so CXR4 is also another HIV core receptor that functions almost similarly to CCR5. So among the CD4 T cells, we looked to see if these two core receptors could be

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00:15:25.780 --> 00:15:38.680

Bokani Nleya: more highly expressed or upregulated in the cells from the trans men, and they see... that seemed to be the case. There seemed to be, and this was a significantly different between the two groups.

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00:15:38.680 --> 00:15:49.470

Bokani Nleya: And then we also saw another HIV attachment factor, alpha-4-beta-7, to also be seemingly upregulated in cells that we got from trans men.

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00:15:49.470 --> 00:15:59.340

Bokani Nleya: samples, and, this was also seen among the different macrophage, which... macrophages, which are also identified as HIV target cells.

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00:15:59.340 --> 00:16:08.459

Bokani Nleya: So that seems to be a trend among the different macrophage subsets as well. And so together, this, suggests that there may be

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00:16:08.590 --> 00:16:19.289

Bokani Nleya: increase susceptibility to HIV infection if these receptors are being upregulated within the cervical mucosa of trans men on gut.

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00:16:20.530 --> 00:16:43.179

Bokani Nleya: And then we also did automated clustering, which is an unbiased manner of, analyzing flow cytometry data, because with manual gating, the previous two slides I showed, there may be some... you have to place... the analysis involves having to place the gate manually, so we tried to also do it in a way that the computer just,

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00:16:43.180 --> 00:16:48.810

Bokani Nleya: does it for you. And what we saw was that there seemed to be some clusters of cells

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00:16:48.810 --> 00:17:01.089

Bokani Nleya: that, still bright... more brightly express the HIV receptors and attachment factors in the samples from, trans men, yeah, from the trans men samples.

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00:17:02.260 --> 00:17:23.600

Bokani Nleya: And then, then we saw these to actually translate to distinct cell types that were only present in the cells that we obtained from the transplant samples, that were

completely absent in the C samples. And then when we looked closely, we saw that these, indeed, were the cells that expressed the HIV core receptors.

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00:17:23.599 --> 00:17:26.989

Bokani Nleya: Although, we did see this one big cluster.

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00:17:27.260 --> 00:17:30.710

Bokani Nleya: And these green... the two greens, actually.

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00:17:30.710 --> 00:17:53.989

Bokani Nleya: to be less frequent in the cells from the trans donors, and these were identified as the M1 macrophages, which are the macrophages responsible for inflammation. So, kind of confirming what we had seen with our manual getting, that there seems to be loss of the macrophages that would promote inflammation, and then these ones that we saw to actually

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00:17:53.990 --> 00:18:18.580

Bokani Nleya: pop up with the ones that are anti-inflammatory. So this could mean one of two things, that there seems to be... there may be inflammation in the microenvironment, and then you get these anti-inflammatory macrophages coming up as sort of a compensation mechanism, or to resolve the inflammation, and then the M1 macrophage, or the inflammatory macrophages would then go down, so kind of

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00:18:18.770 --> 00:18:30.410

Bokani Nleya: polarization from an inflammatory state to an anti-inflammatory state to kind of resolve that inflammation. But up to this point, we didn't know until we could actually assess

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00:18:30.410 --> 00:18:53.960

Bokani Nleya: the cytokines in the microenvironment, and we really did see that there seemed to be higher pro-inflammatory cytokine secretion in the trans samples compared to cis, and these are the same pro-inflammatory cytokines that were reported in those two studies that I shared earlier that were done in blood. So then this would suggest that the

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00:18:53.960 --> 00:19:02.370

Bokani Nleya: Is chronic inflammation in that cervical tissue microenvironment, but the cell types are changing.

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00:19:02.380 --> 00:19:21.369

Bokani Nleya: sort of being more dealt by the environment to become more anti-inflammatory. But then these anti-inflammatory macrophages express HIV attachment receptors, so they kind of also contribute to the presence or to the frequency of HIV-infected target cells.

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00:19:22.680 --> 00:19:34.179

Bokani Nleya: And so we wanted to see if these observations do actually translate to increased replication kinetics. So we exposed the explant tissue that I was showing in the approach.

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00:19:34.180 --> 00:19:43.420

Bokani Nleya: to different subtypes of HIV strains. These were originally isolated from Ugandan cis men.

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00:19:43.420 --> 00:20:07.410

Bokani Nleya: And this subtype D was one of the more virulent strains of the two. So we wanted to see if we, exposed tissue to the two. Do we still see that difference in the virulence and just general infectivity? And we saw that, and again, you see that heterogeneity, that there may be some individuals that seemed to be more susceptible.

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00:20:07.410 --> 00:20:14.969

Bokani Nleya: Or, display increased replication kinetics, but you still had some individuals that, were

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00:20:14.970 --> 00:20:30.399

Bokani Nleya: more at baseline, just a similarity to the CIS women samples. But overall, when you look at the GME, there seemed to be increased replication kinetics in the blocks that we got from trans men compared to CS women.

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00:20:31.380 --> 00:20:43.889

Bokani Nleya: And then lastly, we wanted to see if these, changes are... can also be detectable at gene expression level, because all the data that I was showing was, on protein level, so just

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00:20:44.000 --> 00:20:49.779

Bokani Nleya: proteins that are expressed on the soil surface. Now, we took samples from,

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00:20:49.850 --> 00:21:14.640

Bokani Nleya: HMACH samples, and the transmit sample had been... the individual had been on affirming hormone therapy for a year, and then we also treated in the lab with

testosterone, and the hypothesis here was that we would not see any added difference with, exogenous testosterone treatment on the individual that had already been on

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00:21:14.640 --> 00:21:31.829

Bokani Nleya: Hormone therapy. And then that, if the changes that we're seeing at protein level were indeed an effect of, testosterone or androgen receptor modulation, then we'd be able to see that when we treat C-serment tissue with testosterone in the lab.

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00:21:31.830 --> 00:21:44.420

Bokani Nleya: So after doing that treatment, we then did our HIV challenge, and then we... I sorted for immune cells that we then analyzed for... with single-cell RNA sequencing.

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00:21:45.520 --> 00:21:50.380

Bokani Nleya: And so, we're just looking at, infections, so we use this, mouse

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00:21:50.490 --> 00:22:14.989

Bokani Nleya: CD24, which is a reporter or proxy for HIV infection, we saw that in the C samples, so this top row here, that you see increased frequency of HIV-infected cells when you expose or pre-treat the tissue with dihydrotestesterone, suggesting this to be a direct effect of testosterone on cervical tissue cells.

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00:22:15.250 --> 00:22:25.389

Bokani Nleya: And then with the single-cell RNA-seq data, we also saw that there were different frequencies among the different cell types that we identified, in the two groups.

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00:22:25.430 --> 00:22:48.980

Bokani Nleya: But what was mostly striking was the loss of this plasma cell population. So, plasma cells are B cells that secrete antibody, and antibodies are required for resolving infection, or just maybe even vaccine response. These are the cells that will be responsible for antibody production, and they seem to be lesser

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00:22:48.980 --> 00:22:52.079

Bokani Nleya: In the samples that we got from, trans men.

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00:22:52.940 --> 00:22:55.060

Bokani Nleya: And then we wanted to see in...

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00:22:55.060 --> 00:23:17.879

Bokani Nleya: specific cell types, if you also pick up any of these differences. And so when we looked among the myeloid cells, we found that there were a lot of myeloid cell states that were pro-inflammatory among the trans compared to cis, so kind of tying together with our cytokine data, where there seems to be a pro-inflammation state that is being resolved

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00:23:17.880 --> 00:23:41.060

Bokani Nleya: or compensated for at the protein level. And then among the B cells, we could also... we identified all these different B-cell clusters that seemed to differ. So these were all our... the C samples, and these were the trans samples, and they seemed to really differ between the two. And then, again, what was striking was the loss of these IgA-positive B cells.

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00:23:41.060 --> 00:23:58.169

Bokani Nleya: That would also be important in resolution of infection in the cervical tissue. And then, in contrast, there seemed to be enrichment of these B-cell states that are also identified as a pro-inflammatory state.

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00:23:58.750 --> 00:24:17.190

Bokani Nleya: And then lastly, among the T cells, we also identified different clusters of T cells that also seemed to differ by gender, and not so much by exogenous hormone treatment at this point. And then what also, was striking was that the cells that seemed to

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00:24:17.270 --> 00:24:29.770

Bokani Nleya: be lost, in the trans samples, where the cytotoxic CD8 T cells and these naive CD4-positive T cells, that would be important, again, in antiviral immunity.

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00:24:29.970 --> 00:24:39.599

Bokani Nleya: And then, in place, we saw an enrichment of, these HIV targets over the pro-inflammatory CD8 states.

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00:24:41.170 --> 00:25:05.600

Bokani Nleya: And then lastly, we wanted to then see if any of these really translated to exogenous treatment with dihydrotestesterone. The difference was quite subtle, but you could see that cluster 0 seemed to be less frequent when you treat the cells from CIS with DHT. And then when we looked at gene expression, we saw that this cluster that seems to

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00:25:05.600 --> 00:25:11.159

Bokani Nleya: Be less represented It's the one that actually ex...

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00:25:12.480 --> 00:25:34.039

Bokani Nleya: is the one that, expresses granulosine, which is an effective antimicro... which is an effective antimicrobial in antiviral infection, and, was down-regulated for this Cranzanne K, which is what you wouldn't want, and that seemed to be the cluster that actually gets reduced, and in turn, you get the cluster that upregulates these,

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00:25:34.040 --> 00:25:38.370

Bokani Nleya: These less desirable genes is the one that leaves untouched.

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00:25:38.370 --> 00:25:43.219

Bokani Nleya: So... It's amazing.

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00:25:47.920 --> 00:25:56.519

Bokani Nleya: Seems like sharing my video is not allowing me to move to the next slide, which is my conclusion slide.

123

00:25:57.950 --> 00:26:03.309

Brian Minalga: You wanna try, stop share and then reshare just on your last slide?

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00:26:05.920 --> 00:26:06.600

Bokani Nleya: Just stop here.

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00:26:11.760 --> 00:26:29.070

Bokani Nleya: Well, well, I can just say what the last slide is, because it's just, conclusions. So basically what we saw, in this study, also keeping in mind that it was a very small sample size, we only had 10 individuals from both groups.

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00:26:29.070 --> 00:26:52.100

Bokani Nleya: What we saw was that there seems to be upregulation of the HIV core receptors on the HIV target cells, and there seems to be a pro-inflammatory state, that would also potentially exacerbate the presence of these HIV target cells, and also, HIV... promote HIV entry and other

127

00:26:54.380 --> 00:27:14.170

Bokani Nleya: bacterial infections, like STIs. And, and so, yeah, that's... that's... that's what I had to share today, and we hope, to continue this and just, with more participants, obviously, and, investigate further to see if these findings

128

00:27:14.170 --> 00:27:15.540

Bokani Nleya: really hold.

129

00:27:16.370 --> 00:27:19.489

Bokani Nleya: And with that, I will conclude. Thank you so much.

130

00:27:20.010 --> 00:27:29.990

Brian Minalga: Thank you, Bakani. Yeah, this research is so fascinating to me, and especially when we think about just trans men overall, and, you know, greater research that we need.

131

00:27:30.020 --> 00:27:41.370

Brian Minalga: to protect trans men in the context of HIV. So, really appreciate that. There is one question in the chat for you, Bokhani, that I'll just maybe ask you in the interest of time to, respond in the chat.

132

00:27:41.370 --> 00:27:51.929

Brian Minalga: to Cindra's question about whether you, whether some of the men in your sample were not on hormone therapy at all. So you can take a look in the chat at that.

133

00:27:52.040 --> 00:27:57.510

Brian Minalga: And if you wouldn't mind, stopping share so our next, presenter can bring up.

134

00:27:58.150 --> 00:27:59.740

Brian Minalga: His slides, too.

135

00:28:02.160 --> 00:28:05.309

Brian Minalga: Awesome. Oh yeah, looks like you're getting out of it there.

136

00:28:05.610 --> 00:28:21.459

Brian Minalga: Okay, great, thank you. So, Sari is our next presenter, and, I attended Sari's in-person topic, the oral presentation, on, trans women, so we're gonna move now to trans women and to Sari's presentation.

137

00:28:21.680 --> 00:28:26.069

Brian Minalga: From University of Michigan and Harvard, so take it away, Sari.

138

00:28:26.070 --> 00:28:49.110

Sari Reisner (he | him): Thank you so much. I'm really delighted to be here with you all, and to have the opportunity to, to talk about trans health research, HIV research, and also to celebrate... to celebrate Pride. So today I'll be talking a bit about, the so-called situated HIV vulnerabilities and resiliencies, that, that shape and situate... that are situated, for transgender women specifically, and people

139

00:28:49.110 --> 00:29:12.330

Sari Reisner (he | him): who are identifying as transfeminine. I don't think I need to tell this group about the HIV burden for this population. Overall, in a meta-analysis, about 20% seropositivity, a 66-fold increased risk compared to cisgender people. Notably, they're also experiencing inequities in prevention, for example, pre-exposure prophylaxis uptake, as well as in HIV care.

140

00:29:12.600 --> 00:29:27.049

Sari Reisner (he | him): And so one of the things that, you know, when I think about this is, you know, why do we see these persistent inequities? You know, we've seen them for years. We haven't seen a whole lot of change in terms of making epidemic impact in this population.

141

00:29:27.050 --> 00:29:49.880

Sari Reisner (he | him): And I think here it's very important for us to look at the fact that these are situated in a set of multi-level, i.e. occurring at multiple levels of influence, biopsychosocial contexts, right? So, biological, social, and psychosocial. And these include things like biobehavioral, like, for example, STI co-infections, some of the amazing work that Bukani presented, like thinking about the biological pathways.

142

00:29:49.880 --> 00:30:00.540

Sari Reisner (he | him): Individual factors like mental health and substance use, interpersonal factors like violence, gender non-affirmation. We could look at provider mistreatment, discrimination on an interpersonal level.

143

00:30:00.540 --> 00:30:15.489

Sari Reisner (he | him): Network characteristics, so there's an idea of the HIV epidemiologic burden, right, in the population, so especially, for example, in partnership pools, if that burden is high in partnership pools, there would be an increased likelihood of probability of infection.

144

00:30:15.530 --> 00:30:33.690

Sari Reisner (he | him): At the community level, we can think about societal stigma, social exclusion, and lack of gender-affirming care systems that support communities. And then at the structural level, we can think of things like economic vulnerability, lack of legal protections, and intersectional oppression, all of which are shaping vulnerability to HIV.

145

00:30:34.200 --> 00:30:59.130

Sari Reisner (he | him): And I think where we are right now, and Brian, you alluded to it, is, you know, we are sort of in a moment of crisis. I'm showing you some of the actions here from the United States, but certainly there have been actions elsewhere. Thinking about, for example, the executive orders about a year ago that recognized only two sexes, male and female, thinking about the rise of anti-trans legislation. But really, what does this mean for HIV science?

146

00:30:59.130 --> 00:31:08.620

Sari Reisner (he | him): What does it mean for the science that we do, in terms of the availability of funding, in terms of priorities? And this is the context, you know, in which the epidemic is occurring.

147

00:31:09.140 --> 00:31:33.250

Sari Reisner (he | him): So, I'll present some research now from the CROI conference. The first is really thinking about how these structural policies have threatened progress and response. So, one of the things that we're seeing is exclusion and removal of gender identity data, right, from public surveillance systems, and so this is going to be a real problem as we're thinking about monitoring the epidemic moving forward. So, a few prospective cohorts of

148

00:31:33.250 --> 00:31:58.030

Sari Reisner (he | him): trans women exist in the U.S, and there really is a need for these to understand the epidemic, as I mentioned, particularly as we're losing data in many areas. So this study sought to estimate, new cases of HIV, so HIV incidents, and look at some of those situated vulnerabilities. We used the Light cohort, excuse me, the Encore cohort. Light was the cohort before Encore. Encore cohort is a U.S.-based cohort. It's a hybrid digital community

149

00:31:58.030 --> 00:32:21.950

Sari Reisner (he | him): hub cohort of transgender women and transfeminine people. So there's a digital component, and then there's an in-person component that's connected to community-based hubs, and you can see some of those hubs here that are coverage of some of the HIV... ending the epidemic areas. And we did this because we wanted to make sure that we could engage populations that are facing social and structural disparities, and also increase trust.

150

00:32:22.030 --> 00:32:46.939

Sari Reisner (he | him): So, enrollment was from March 2023 to December 2024, and we did this in the United States and Puerto Rico. We had 24 months of data collection with surveys, as well as HIV testing, lots of self-reported items. In terms of eligibility, eligibility were being an adult, transgender woman or transfeminine, English or Spanish-speaking. We confirmed HIV-negative serostatus at baseline, since this was a cohort

151

00:32:46.940 --> 00:32:56.089

Sari Reisner (he | him): looking at incidents. We utilized, community recruitment methods, including word of mouth. We did use some web-based, geo-targeted, recruitment as well.

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00:32:56.090 --> 00:33:20.660

Sari Reisner (he | him): Our survey measures, you can see here, included demographics, social and structural determinants, such as, for example, housing, sex work, and poverty, healthcare access, like health insurance and gender-affirming care need, violence both in childhood and adulthood, mental and behavioral health factors, for example, stimulant use, and then sexual health and nature prevention, excuse me. And that included, for example, PrEP indication, PrEP use. We utilized

153

00:33:20.660 --> 00:33:37.840

Sari Reisner (he | him): modified Centers for Disease Control algorithm to look at PrEP indication. We also asked about long-acting injectables as well as oral PrEP. And what we did is we looked at and calculated the incidence rate as the number of seroconversions over follow-up, and then we looked at predictors of those from baseline characteristics.

154

00:33:38.420 --> 00:34:02.250

Sari Reisner (he | him): So here you can see we enrolled more than 2,500 transgender women, 64% online exclusively, and 36% via our community hubs. You can see the sample was well distributed across U.S. regions. The mean age was 30... excuse me, the median age was 32, and the sample was diverse racially and ethnically. These are not mutually exclusive categories. 12% identified as Black, 5% as Asian.

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00:34:02.250 --> 00:34:06.140

Sari Reisner (he | him): 10 is other race, 16 is Latina, and 78% is white.

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00:34:06.600 --> 00:34:13.970

Sari Reisner (he | him): On the right, you can see some of the characteristics, 10% being unstably housed, for example, and had engaged in sex work.

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00:34:13.969 --> 00:34:38.670

Sari Reisner (he | him): 49% publicly are uninsured. As far as high prevalence of violence and mental health and behavioral health issues, but also I want to point to the sexual health and prevention here, where 16% were PrEP-indicated. Overall, 18% had used PrEP. Of those, 94% were oral pills, and only 3.4% were long-acting injectables. And 2% actually reported both oral pills and CABLA.

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00:34:39.110 --> 00:34:44.740

Sari Reisner (he | him): 4% had a self-reported bacterial STI, and 3% reported sex with exclusively trans partners.

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00:34:45.139 --> 00:35:09.140

Sari Reisner (he | him): So we identified, these new cases, and what you can see here are disparities. We identified 34 new cases, 25 at baseline, and 14 seroconversions, with the overall incidence about 4 per 1,000 person years. As you can see on the right, there was a disparity for Black trans women, especially, who had a 7.4 times higher risk

160

00:35:09.140 --> 00:35:19.880

Sari Reisner (he | him): of HIV conversion relative to white. That's the green bar there, you can see it at the highest. And HIV incidence was significantly higher for trans women who were PrEP-indicated than those not.

161

00:35:20.760 --> 00:35:45.579

Sari Reisner (he | him): So then we examined baseline predictors of seroconversion, and here we looked at some of the factors that I mentioned previously. So, for example, we found structural vulnerabilities were highly associated with seroconversion, including being unhoused, having engaged in sex work, and poverty. For healthcare access, having public insurance or uninsurance. When we looked at violence, we actually did not see any associations. This could be the way that we measured it, but that

162

00:35:45.580 --> 00:35:59.510

Sari Reisner (he | him): That's what we saw here. Stimulant use, including crack cocaine and methamphetamine use, were very highly associated, as well as all of our sexual health indicators, PrEP indication use, self-reported STI, and having a cis male only exclusively partner.

163

00:35:59.860 --> 00:36:19.600

Sari Reisner (he | him): So, basically, what we found is that HIV incidence remains high among trans women in the U.S. It's on par with a prior study that we did, the LIKE cohort. We saw disparities, unfortunately, that persist by race and ethnicity, with the highest incidence for Black, Latina, and Asian trans women. We did identify some situated vulnerabilities, particularly housing, sex work, poverty.

164

00:36:19.600 --> 00:36:34.090

Sari Reisner (he | him): lack of insurance, stimulant use, and then sexual health and prevention. You know, I think for me, one of the low... the low prevalence of LAI uptake in the sample suggests opportunities for scale-up in this population, although we know that PrEP is not the right tool for everyone.

165

00:36:34.730 --> 00:36:58.200

Sari Reisner (he | him): So trans women need tailored interventions and safe and affirming prevention services. Continued gender-inclusive research such as this and infrastructure

are going to be needed now more than ever, given, as I mentioned, the broader context and removal of data surveillance efforts, and the need for us to be able to continue to understand and intervene on the epidemic using scientific good data.

166

00:36:59.020 --> 00:37:20.890

Sari Reisner (he | him): So, as we're thinking about situated vulnerabilities and resiliencies, then, I want us to also consider, two aspects. The first is developmental considerations, and the second is syndemic dynamics. So, one of the issues is around developmental context. So, situated vulnerabilities occur across the life course, right? They may not occur in the same way, for example, in adolescence as they may in later adulthood.

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00:37:20.890 --> 00:37:27.780

Sari Reisner (he | him): And there's a need to consider how these may differ across developmental periods, as well as the cumulative exposures over the life course.

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00:37:28.020 --> 00:37:48.599

Sari Reisner (he | him): The second consideration has to do with syndemic dynamics. So this is that all of those factors that I showed you don't occur in isolation, right? People may experience poverty, they may experience homelessness, they may experience psychological distress, and they're co-occurring, and they're synergistic, right? So oftentimes, we look at these separately, when in fact, these are all drivers of the epidemic in different ways.

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00:37:48.600 --> 00:37:52.540

Sari Reisner (he | him): And syndemics usually refer to how health and social conditions cluster.

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00:37:52.600 --> 00:38:14.020

Sari Reisner (he | him): So I want to show you some data here. These are from a sample of transgender women in Lima, Peru, young trans women, ages 16 to 24. This is a collaboration with Feminas, Leila Huerta, who's the executive director, which is the largest transgender organization in Peru, and with Drs. Alfonso Silvestipan at University of Peru Cayetano, and Amaya Perez-Brummer at University of Toronto.

171

00:38:14.060 --> 00:38:23.849

Sari Reisner (he | him): You can see already that in this young age sample, HIV prevalence and STI co-infections were high, so, oops, I'm sorry. Let's try that again. I just...

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00:38:24.210 --> 00:38:31.470

Sari Reisner (he | him): Okay, there we go. 41% prevalence, this is laboratory confirmed. Of those, 79% were new diagnoses.

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00:38:31.470 --> 00:38:48.399

Sari Reisner (he | him): 64% had another STI, and 42% reported HIV acquisition or transmission risk behavior. So what we did is we summed up 12 different indicators that would indicate psychosocial vulnerability, and you can see here, the median number of co-occurring conditions was 7 of 10,

174

00:38:48.400 --> 00:39:06.600

Sari Reisner (he | him): And in the, in this box here, which indicates that, sort of, those who had 6 or more, and you can see that the light bars are the presence of HIV acquisition transmission risk, which is higher, right, for each one of those than they are, relative to the other groups, which you can see the non... the absence of that transmission risk.

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00:39:06.600 --> 00:39:29.609

Sari Reisner (he | him): And when we fit some multivariable models, we found that for each co-occurring condition, the risk of HIV acquisition or transmission increased by 16%. And if we looked at the co-occurring conditions of 6 or more, we actually found a 223-fold higher risk, okay? So that's that 3.23 risk ratio, that's what that translates into. So, you know, here this suggests

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00:39:29.610 --> 00:39:54.520

Sari Reisner (he | him): the need to consider these things together, number one. Number two, to think about what did early HIV prevention efforts look like. You know, for me, seeing these data, I feel like we need to even go earlier in the life course, right? And the second thing I'd like to highlight is that, you know, this is a sample of young people, but it's also the case that age may operate in different ways for trans people. So we could potentially, for example, not just think of chronological age.

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00:39:54.520 --> 00:40:11.900

Sari Reisner (he | him): We could think of social age, right? There are some data to suggest that when people come out to themselves and to others, and they're actualizing their gender, that there may be sort of periods of a resurgence of adolescence, right? And so there could be some windows there that are specific for trans folks that are worth attending to in the future as well.

178

00:40:12.820 --> 00:40:31.940

Sari Reisner (he | him): So I've been talking a lot about vulnerabilities, but I want to also kind of bring us to the space of resiliencies, right? And just as these vulnerabilities for HIV are situated, so too are resiliencies, and it's equally important, if not more important, I would suggest, to understand those factors that are salutogenic, or that promote health.

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00:40:31.940 --> 00:40:38.249

Sari Reisner (he | him): So we could think about biobehavioral factors such as, for example, using condoms or uptake of PrEP.

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00:40:38.250 --> 00:40:47.230

Sari Reisner (he | him): You can think of individual factors like self-efficacy, self-acceptance, and gender pride. By the way, all of these, as well as the situated vulnerabilities before, have data that are supporting them.

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00:40:47.340 --> 00:41:00.779

Sari Reisner (he | him): We can think of interpersonal, like gender affirmation, which is very supportive, both in terms of social, medical, and legal. We can think of trauma-informed care, right, and practices that are meeting people where they are based on the experiences that they've had.

182

00:41:00.990 --> 00:41:12.969

Sari Reisner (he | him): At the network level, trans kinship structures are very powerful. This idea of trans mothers, right, having figures in the community, elders, people walking before, mutual aid and support.

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00:41:12.970 --> 00:41:27.320

Sari Reisner (he | him): Community, community connectedness. Trans organizations and programming have been shown to be key. Peer navigation has been shown to be key. Bringing communities together in a way that, like, leverages and situates these vulnerabilities in a way that could be offset.

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00:41:27.320 --> 00:41:36.170

Sari Reisner (he | him): And then lastly, but perhaps most importantly, structural factors. So, human rights, legal gender recognition, and collective resistance against oppression.

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00:41:36.770 --> 00:41:48.660

Sari Reisner (he | him): And these are some photos, from Danielle Villisana, who's a beautiful photojournalist in Peru, just to highlight, like, some of the joy and the experiences of community and the need to leverage these, these factors.

186

00:41:49.480 --> 00:42:12.619

Sari Reisner (he | him): When we think about, you know, one of the most protective factors, like, recently that we've seen some data for, really has to do with, gender affirmation. And gender affirmation, as I mentioned, is multiple dimensions. Here, I want to show you some data that are related specifically to gender-affirming hormones. So these are data from a primary care cohort called Legacy that was in Boston at Family Health, and New York, Call and Lord.

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00:42:12.620 --> 00:42:36.960

Sari Reisner (he | him): And what we found here is we looked across longitudinally from 2016 to 2019. Our cohort was ranging from 6,000 to 8,000 transgender patients, and we found reductions in HIV seropositivity, viral non-suppression for those living with HIV, as well as lower rates of anogenital gonorrhea or chlamydia diagnosis in the last 12 months, due to longitudinally changes in uptake of hormones.

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00:42:36.960 --> 00:42:49.280

Sari Reisner (he | him): You know, so this is sort of powerful data and important data to show, you know, gender affirmation has typically, in a medical sense, been looked at in relation to mental health outcomes, but this also adds to that evidence base.

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00:42:49.460 --> 00:43:14.029

Sari Reisner (he | him): And in fact, if we think globally about care, the World Professional Association for Transgender Health, or WPATH, you know, has standards of care, version 8, that came out in 2022. This is care that provides not just gender-affirming care, but also allows for, kind of, issues around primary care, you know, best practices, for supporting trans people. And one of the things I want to highlight is this last sentence in the standards of care, which says.

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00:43:14.030 --> 00:43:22.779

Sari Reisner (he | him): Healthcare systems should provide medically necessary gender-affirming healthcare for trans people, right? That this is a medical necessity, this is not simply optional.

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00:43:22.780 --> 00:43:26.219

Sari Reisner (he | him): I'd also like to note that, gender affirmation...

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00:43:26.220 --> 00:43:44.639

Sari Reisner (he | him): I don't know where that came from, but okay. But I'd also like to note that, as I mentioned, not everybody wants gender... and feels like medical affirmation is for them, so not assuming that is important, and also that social affirmation and other forms of affirmation, psychological and so forth, are also part of these standards of care.

193

00:43:47.540 --> 00:44:11.930

Sari Reisner (he | him): I have no idea why that line is in the middle of it, and I apologize, there's my red line, but who knows? Okay, so now, moving on, relatedly, you know, to this is this idea around flipping the script. So, you know, part of the historical epidemic framing, the HIV epidemic framing for trans communities, is one that's deficit space, right? These are all the vulnerabilities, these are all of the things that are quote-unquote wrong.

194

00:44:11.930 --> 00:44:23.000

Sari Reisner (he | him): This is the dysphoria, the gender dysphoria that people feel, and the stigma, and while some of that is true, and certainly those are experiences that trans people unfortunately have.

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00:44:23.000 --> 00:44:30.479

Sari Reisner (he | him): You know, it is incorrect to assume that all trans people have those, and that the only thing that we experience is that, right?

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00:44:30.480 --> 00:44:45.940

Sari Reisner (he | him): And so, one of the things that we need to do, then, is to kind of flip that script. And I think an example of this is thinking about the idea of gender euphoria or trans joy, right? So this could refer to things like positive emotions that result from affirmation of identity, in whatever way that happens.

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00:44:45.940 --> 00:45:05.310

Sari Reisner (he | him): In the legacy cohort, we did some work to do some measurement to measure this, and in our cohort, we found high levels of gender euphoria, about a third of the sample. It was associated with reduced odds of gender dysphoria, like discomfort or distress in one's gender, reductions in alcohol misuse, and a higher odds of reported resilience.

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00:45:05.450 --> 00:45:28.819

Sari Reisner (he | him): More recently, in the Encore cohort, which is the one that I showed you previously around the incidence data among transgender women and transfeminine people, we found a higher PrEP uptake in the past 6 months among those with higher levels of gender euphoria. So thinking of this as, for example, a positive intervention target for the future, ways that we could leverage that as we're thinking about PrEP and other service delivery.

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00:45:30.310 --> 00:45:55.289

Sari Reisner (he | him): So, I want to, like, think about here now this framework that I've outlined, which you can actually find in a Lancet piece. It's called the Situated Vulnerabilities Framework. And the call that I want to make to us is a call for integrated strategies, right? I want us to think about what those look like. You know, and firstly, the need to center both HIV prevention and HIV treatment. You know, I think that in the need for status-neutral interventions

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00:45:55.290 --> 00:46:08.370

Sari Reisner (he | him): is an important one. Trans populations do not divide along serostatus lines, right? People are friends, people are connected, and when we look at just prevention or we look at just treatment, we're missing a very important piece of the puzzle.

201

00:46:08.480 --> 00:46:26.380

Sari Reisner (he | him): And so here, thinking about doing that, but also thinking about, as I've mentioned, strengths-based approaches, thinking about the engagement of trans people and the addressing of trans community priorities and placing that at the center of these integrated strategies. As I mentioned, the deployment of status-neutral approaches.

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00:46:26.380 --> 00:46:51.110

Sari Reisner (he | him): The integration of gender affirmation and gender-affirming care. So, as I mentioned, gender-affirming medical care, but also affirmation more broadly, including in the social and legal domains and the psychological domains. And then lastly, but definitely not leastly, is investing in social enablers. And by what I mean here is really thinking about the context, right? Thinking about these structural contexts, thinking about investing in communities that have

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00:46:51.110 --> 00:47:03.720

Sari Reisner (he | him): been disinvested in intentionally. Thinking about investing in protections that protect people's rights to be publicly themselves, to be publicly participating in life and civic engagement.

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00:47:08.530 --> 00:47:26.370

Sari Reisner (he | him): And so lastly, I leave, but, you know, mostly and very importantly, is to think about that we put community at the center, always, as we think about the empowerment, the collaboration, and the drive toward equity to use a participatory perspective that guides our HIV science, our practice, and our policy moving forward.

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00:47:26.370 --> 00:47:46.229

Sari Reisner (he | him): I'd like to thank the Encore team and our amazing participants, as well as our National Community Advisory Board, without whom that study would not be possible, the Feminas and Trans Adolescent and young adult research team, as well as the Legacy Cohort team. I'm just so grateful to be working with all of these people all the time.

206

00:47:46.340 --> 00:48:05.370

Sari Reisner (he | him): I'd also like to lift up one of the interactive symposiums. Some of these, these data and the information that I've shown with you is very complimentary to that. I tried to not duplicate it, but there were three, wonderful speakers, Dr. Steph Barall, Isa Raddix, and Rena Jajuk, whose name I always, mispronounce, and I'm sorry for that, Rina.

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00:48:05.370 --> 00:48:22.359

Sari Reisner (he | him): But they are, these are available online, the whole entire, series, and I can post it in the chat after, and really, presents some of the epidemiology, the clinical care, and also the community context, of the HIV epidemic, and I hope everybody will, will look at that. So thank you so much.

208

00:48:23.660 --> 00:48:46.260

Brian Minalga: Thank you, Sari. Gosh, another incredible presentation, and I love how these are building off of each other. As you noted, you know, starting with more of the biological realm of these... I want to explore more with you this term of situated. We'll get to that in the chat, but, you know, moving then into this presentation of, you know, beyond just the biological and going into this ecosystem.

209

00:48:46.300 --> 00:49:05.469

Brian Minalga: that trans people, you know, have a lived experience, and we need to be, interrogating that lived experience when we think about HIV incidents. And, that's a perfect segue into our next presenter, Yuan Qi Mi, who is going to tell us about how the policy landscape also affects HIV vulnerability. So over to you, Yuan Chi.

210

00:49:07.200 --> 00:49:08.349

Brian Minalga: Thank you, Brian.

211

00:49:16.380 --> 00:49:18.270

Yuanqi Mi: Is this showing on your side?

212

00:49:18.910 --> 00:49:22.869

Brian Minalga: Yeah, and if you just, play, we'll see it... yep, there, perfect.

213

00:49:24.140 --> 00:49:33.629

Yuanqi Mi: Okay, thank you, Brian. My name is Yunximi, and I'm a research data analyst in the Department of Epidemiology at Johns Hopkins Bloomberg School of Public Health.

214

00:49:33.680 --> 00:49:48.180

Yuanqi Mi: Thank you for joining today. I will be presenting our analysis on gender identity stigma and HIV prevention among transgender women under differing state-level LGBTQ healthcare policy environments in the United States.

215

00:49:49.750 --> 00:50:06.720

Yuanqi Mi: Before getting into the study, I want to acknowledge the full study team. This work reflects collaboration between the Johns Hopkins and Emory teams. I also want to acknowledge the TWIST participants whose experience made this, study possible.

216

00:50:08.610 --> 00:50:15.680

Yuanqi Mi: My presentation will cover four aspects of the analysis, background, method, results, and key takeaways.

217

00:50:16.370 --> 00:50:30.410

Yuanqi Mi: Transgender women and transfeminine non-binary people in the United States continue to experience the disproportionate burden of HIV. At the same time, evidence-based HIV prevention services remain underutilized.

218

00:50:30.450 --> 00:50:43.520

Yuanqi Mi: Hiv testing is often an entry point into both prevention and care, while PrEP is a highly effective HIV prevention tool that requires frequent encounters with healthcare providers.

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00:50:43.520 --> 00:50:56.399

Yuanqi Mi: Because both outcomes rely on some level of healthcare engagement, the healthcare setting itself becomes central to prevention. This is where gender identity stigma becomes important.

220

00:50:56.400 --> 00:51:09.119

Yuanqi Mi: Stigma in healthcare settings can impede health-seeking behaviors by shaping whether someone feels safe coming to a clinic, or whether they're able to stay connected to prevention services over time.

221

00:51:09.120 --> 00:51:19.420

Yuanqi Mi: However, the effect of healthcare stigma may not look the same everywhere. A stigmatizing healthcare encounter may have different consequences in a state with

222

00:51:19.440 --> 00:51:34.730

Yuanqi Mi: strong protection for transgender population than a state where access is more restricted, or where fewer protections are in place. For this reason, our study looked at healthcare stigma and state-level policy climate together.

223

00:51:38.250 --> 00:51:54.670

Yuanqi Mi: Our research question was, among transgender women in the United States, is gender identity stigma in healthcare settings associated with lower HIV prevention uptake? We examined two outcomes, HIV testing and PrEP use in the last 12 months.

224

00:51:54.720 --> 00:52:08.610

Yuanqi Mi: We were able to... we were also interested in whether the association between healthcare stigma and these outcomes differed between more protective and more punitive state policy environment.

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00:52:08.700 --> 00:52:21.599

Yuanqi Mi: The findings are intended to inform evidence-based policy and programmatic strategies to reduce healthcare stigma and improve HIV prevention engagement among transgender women.

226

00:52:23.640 --> 00:52:30.310

Yuanqi Mi: The analysis used data from the Transgender Woman's Internet Survey and Testing Study, or TWIST,

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00:52:30.370 --> 00:52:44.199

Yuanqi Mi: TWIST is an annual cross-sectional online HIV behavioral survey of transgender women and trans... feminine non-binary people assigned male at birth in the United States. The study previously included an optimal

228

00:52:44.200 --> 00:52:52.840

Yuanqi Mi: An optional mail-in self-testing kit for HIV and STIs, hepatitis C, and hormone levels.

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00:52:53.270 --> 00:53:06.020

Yuanqi Mi: Twist's aim is to examine the role of gender identity-based and sexual behavior-based stigmas on mental and sexual health resilience and access to care in this population.

230

00:53:11.030 --> 00:53:23.990

Yuanqi Mi: The analysis sample included 5,508 sexual active TWIST participants from 2022 to 2024 who self-reported never having an HIV diagnosis.

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00:53:24.010 --> 00:53:37.160

Yuanqi Mi: The primary exposure was past-year gender identity stigma in healthcare setting, measured as perception, anticipation, or experience of gender identity stigma in healthcare setting in the last 12 months.

232

00:53:37.210 --> 00:53:43.120

Yuanqi Mi: The two outcomes were PrEP use in the last 12 months and HIV testing in the last 12 months.

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00:53:44.730 --> 00:54:02.329

Yuanqi Mi: The effect measure modifier was state-level LGBTQ healthcare policy climate, measured using healthcare-related policy scores from Movement Advancement Projects, or MAP, and dichotomized at the national media into more protective versus more punitive policy environment.

234

00:54:02.360 --> 00:54:18.380

Yuanqi Mi: For the statistical analysis, we used multi-level Poisson regression with robots estimation to estimate adjusted prevalence ratios. The models accounted for state-level clustering and adjusted for age, race, and ethnicity.

235

00:54:18.500 --> 00:54:38.429

Yuanqi Mi: education, employment, food insecurity, non-prescribed injection drug use, health insurance, and homelessness. To assess effect modification, we stratified the models by state-level LGBTQ healthcare policy and climate, and tested the interaction between healthcare stigma and policy climate.

236

00:54:40.240 --> 00:54:46.340

Yuanqi Mi: Because policy indices can feel abstract, it is helpful to clarify what is included

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00:54:46.500 --> 00:55:02.860

Yuanqi Mi: in the healthcare policy climate measure. More protective healthcare policy examples include Medicaid coverage for transgender-related care, private insurance non-discrimination or bans on insurance exclusions, inclusive state

238

00:55:02.910 --> 00:55:20.169

Yuanqi Mi: employee health benefit and shield laws protecting access to transgender healthcare. More punitive healthcare policy examples include bans or restriction on best practice gender-affirming medical care, or for transgender youth, insurance

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00:55:20.170 --> 00:55:32.920

Yuanqi Mi: exclusion or a lack of protection for transgender-related care, absence of healthcare non-discrimination protections and policies that limit access to gender-affirming healthcare.

240

00:55:34.790 --> 00:55:39.789

Yuanqi Mi: Looking at the overall sample, most of the study participants are largely

241

00:55:39.990 --> 00:55:46.059

Yuanqi Mi: Insured, educated, and wage employed, while food insecurity remain common.

242

00:55:48.480 --> 00:56:02.330

Yuanqi Mi: For the key measures, nearly half of the participants reported experiencing healthcare gender identity stigma in the last 12 months. This is a high prevalence and suggests that healthcare stigma remains a common experience in this sample.

243

00:56:02.330 --> 00:56:22.659

Yuanqi Mi: For the HIV prevention outcomes, 1 in 3 participants reported HIV testing in the last year. In contrast, less than 10% reported PrEP use in the last year. This difference points to the prevention linkage gap. Testing was more common than PrEP use, but the proportion used in PrEP was low.

244

00:56:23.980 --> 00:56:38.079

Yuanqi Mi: We then look at geography. The state-level LGBTQ healthcare policy map shows substantial variation across the United States. We use the national median of 1.5 to dichotomize the policy strata.

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00:56:40.450 --> 00:56:52.140

Yuanqi Mi: among TWIST participants, about 40% lived in more punitive policy states, while about 60% lived in the more protective policy states.

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00:56:52.140 --> 00:57:08.399

Yuanqi Mi: The healthcare stigma map on the right was based on TWIST participant-reported stigma dichotomized at a median state prevalence. Descriptively, we observed geographic overlap between more punitive healthcare policy environments and higher prevalence of

247

00:57:08.410 --> 00:57:21.389

Yuanqi Mi: participant-reported healthcare gender identity stigma, especially in part of the South and Midwest, although this does not establish causality, but it helps show why policy contacts is relevant.

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00:57:22.480 --> 00:57:46.999

Yuanqi Mi: The main adjusted results showed that the association between healthcare stigma and HIV prevention engagement differed by policy climate. In the overall adjusted model, healthcare stigma was not significantly associated with PrEP use, but when we stratified by state policy climate, this pattern changed. Participants who reported healthcare stigma in more punitive policy states had the

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00:57:47.690 --> 00:58:00.769

Yuanqi Mi: 26% lower prevalence of PrEP use compared to those who did not report healthcare stigma. In more protective policy states, we did not observe this sample... the same pattern.

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00:58:00.770 --> 00:58:20.660

Yuanqi Mi: For HIV testing, we have... we saw a similar pattern with 12% lower prevalence of last... past year HIV testing among participants reporting healthcare stigma in more punitive states. Both the interaction term p-value were under 0.05, suggesting, in fact measure modification by policy climate.

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00:58:22.600 --> 00:58:41.869

Yuanqi Mi: For this analysis, there are several limitations to consider. First, because data are cross-sectional, cannot establish temporality or make causal claims about the relationship between healthcare stigma and HIV prevention and uptake. Secondly, TWIST used online convenience sample

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00:58:41.910 --> 00:58:50.330

Yuanqi Mi: So, the findings may not be generalizable to all transgender women and transfeminine non-binary people in the United States.

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00:58:50.330 --> 00:59:06.990

Yuanqi Mi: Third, all measures are self-reported, which may introduce recall error or misclassification. In addition, the map policy score was dichotomized at the median, which may mask variation in specific policy and local implementations.

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00:59:06.990 --> 00:59:20.200

Yuanqi Mi: Finally, low PrEP use may have reduced positioning and stratified analysis. Overall, these findings should be interpreted as evidence of association and effect measure modification rather than causal effects.

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00:59:21.460 --> 00:59:23.840

Yuanqi Mi: The key findings that healthcare

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00:59:23.870 --> 00:59:36.589

Yuanqi Mi: gender identity stigma was associated with lower HIV testing and PrEP use only among participants living in a more punitive state, LGBTQ healthcare policy environments. This suggests that

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00:59:36.590 --> 00:59:44.580

Yuanqi Mi: Same type of healthcare stigma may have stronger consequences for prevention engagement when it occurs in a broader

258

00:59:44.580 --> 01:00:00.329

Yuanqi Mi: policy contact that is more harmful. In other words, stigma is not only an interpersonal issue, it is also shaped by systems, policies, and the structural conditions that determine whether healthcare feels safe and accessible.

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01:00:00.330 --> 01:00:11.550

Yuanqi Mi: Therefore, optimizing the real-world impact of healthcare interventions in the United States necessitates being responsive to policy-level barriers and facilitators.

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01:00:14.050 --> 01:00:18.510

Yuanqi Mi: There are several implications. At the policy level, expanding

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01:00:18.610 --> 01:00:26.439

Yuanqi Mi: protections for gender-affirming care and HIV prevention services may help reduce structural barriers.

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01:00:26.440 --> 01:00:38.730

Yuanqi Mi: At the healthcare system level, clinics need to strengthen gender-affirming care through provider training, trans-inclusive clinical environment, and stigma reduction protocols.

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01:00:38.730 --> 01:00:56.039

Yuanqi Mi: At the service delivery level, the gap between HIV testing and PrEP use suggests the need for stronger linkage from testing to PrEP, including same-day PrEP initiation, patient navigation follow-up, and education that directly address

264

01:00:56.040 --> 01:01:02.839

Yuanqi Mi: conception about PrEP and gender-affirming hormones. Community-led and peer-based models are

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01:01:02.840 --> 01:01:21.909

Yuanqi Mi: also important for people who have had negative healthcare experiences, trust may not be rebuilt through standard clinical messaging alone. Trusted providers, peer navigators, and community-led organizations can help create a bridge between prevention services

266

01:01:21.910 --> 01:01:35.790

Yuanqi Mi: and people who may otherwise avoid formal healthcare systems. This is especially important in policy environments where people may already face this... that system are not designed to protect them.

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01:01:37.040 --> 01:01:47.620

Yuanqi Mi: That is all of my presentation. Thank you for listening and for your attention. I will be happy to take any questions. Also, feel free to email me with additional comments.

268

01:01:50.160 --> 01:02:00.830

Brian Minalga: Thank you, Yuan Qi. I have so many thoughts, about everything so far. I've been writing down lots of my own questions that I have here, so we'll be getting to some of those.

269

01:02:00.930 --> 01:02:07.799

Brian Minalga: And I, again, I really appreciate how the three of you have built, this... this pattern, you know, this story about...

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01:02:07.800 --> 01:02:32.150

Brian Minalga: situating the research we do and our HIV-related efforts in the lived experience of trans people, you know, whether in our bodies, you know, our biology, whether in our social environments and in our policy environments as well. So, really excited for the discussion. I'm going to keep an eye to see if anyone's raising their hand. I'm going to withhold some of my questions for now, because we did have a couple

271

01:02:32.150 --> 01:02:47.740

Brian Minalga: that came in through the chat. So first, I wanted to go back to Bocani and, see if you want to answer that first question about kind of comparing trans men to trans men. I know your presentation was more comparing samples from cis women to trans men.

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01:02:47.750 --> 01:03:06.589

Brian Minalga: But were you able to do any comparisons? I know you mentioned, the different time lengths that some of the trans men were on gender-affirming hormone therapy. Did you have any that you were able to compare samples that were not exposed to hormones in trans men to other trans men using hormone therapy?

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01:03:07.540 --> 01:03:18.720

Bokani Nleya: Not at this point. All the, all the cervical explant tissue that we got, was from trans men on gender-affirming hormone therapy.

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01:03:19.400 --> 01:03:21.210

Bokani Nleya: Okay. Yeah.

275

01:03:22.680 --> 01:03:36.369

Brian Minalga: Great. And, this question, I think it was from Simon, I took a picture, so I could keep track of it, was, I think, a really good one for you too, Bokani, to kind of help interpret some of your findings for us. I always love

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01:03:36.370 --> 01:03:45.379

Brian Minalga: listening to this kind of research, I'm a little more familiar with, like, you know, the Phase 3 clinical trial, kind of, of research reporting.

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01:03:45.480 --> 01:04:05.440

Brian Minalga: I'm always so fascinated, and, like, your beautiful graphics and charts and everything are really fascinating to me, but Simon is asking, and he put in here, he said, if he's interpreting it correctly, does your research mean that increased expression of these receptors, these cells that you were looking at.

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01:04:05.440 --> 01:04:14.340

Brian Minalga: That could imply a higher risk or susceptibility of HIV transmission at the biological level for trans men using hormone therapy.

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01:04:14.340 --> 01:04:28.440

Brian Minalga: So first, he wants to know, is that a correct way to interpret your study, and if so, could you comment on the practical interpretation? So, do things like PrEP and U equals U and some of the biomedical interventions,

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01:04:28.440 --> 01:04:35.139

Brian Minalga: do those help us with this element of the biological susceptibility to HIV in trans men?

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01:04:35.740 --> 01:04:36.300

Bokani Nleya: Beautiful.

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01:04:36.630 --> 01:04:47.729

Bokani Nleya: Well, thank you for that question, Simon. So, yes, we do see this increased expression of these HIV core receptors.

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01:04:47.730 --> 01:05:06.190

Bokani Nleya: And then when we did it in the lab to see if this really translated to increased susceptibility, we saw that there seemed to be increased susceptibility in the samples from trans men in how they were able to permit HIV infection, as well as replication in the lab.

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01:05:06.290 --> 01:05:13.169

Bokani Nleya: And then with regards to, I guess, real-world translation.

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01:05:13.490 --> 01:05:28.529

Bokani Nleya: And my take-home would be that it is important to really consider that, trans men are a unique population with unique needs, and that they should not be clustered with all the other different populations, because

286

01:05:28.530 --> 01:05:46.749

Bokani Nleya: the modulation that may happen to the immune system is unique to trans men, so there's need to put that into consideration. And then as, as far as how the interaction with, the interaction of affirming hormone therapy with PrEP,

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01:05:46.820 --> 01:06:01.580

Bokani Nleya: we... we were hoping to take that as, like, our next direction to see, if there's any modulation that then happens, or if these receptors become down-regulated, if you undergo PrEP.

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01:06:01.580 --> 01:06:14.489

Bokani Nleya: But unfortunately, right now, we can't continue doing that, but hopefully, when we get back to it, that was actually the very first thing that we wanted to then investigate. But thank you, that was a brilliant question.

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01:06:15.490 --> 01:06:32.809

Brian Minalga: And thanks for that response, and you know, you're making me think also about, just the exclusion of trans men from a lot of the studies of these biomedical interventions, like PrEP and U equals U. You know, when, I always bring up this Descovy example, when Gilead tested,

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01:06:32.930 --> 01:06:43.959

Brian Minalga: you know, after Truvada, they tested their next pill of Descovy for HIV prevention, and just excluded all people assigned female at birth. And as a result, the FDA, in 2019,

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01:06:43.960 --> 01:06:55.970

Brian Minalga: couldn't approve, you know, this HIV prevention intervention of, you know, around 99-100% efficacy in the trials, but the trials excluded people assigned female at birth, so, you know.

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01:06:56.020 --> 01:07:03.880

Brian Minalga: It's also important to think about the connections. Cis women, trans men, you know, this affects a lot of us, and Sari, I know you want to weigh in here.

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01:07:03.880 --> 01:07:28.859

Sari Reisner (he | him): Yeah, no, I'd love to participate, if that's okay. Yeah, I mean, I feel like the... sort of... when I hear that as well, I think of, like, when you say unique prevention needs, I also think of the fact that, like, you know, there is some sort of gender-based assumption, I think, at least there has been in the past, that, like, trans men who haven't had lower surgery don't use the parts that they have, right? Like, that frontal sex is not something that trans men engage in, because it's not consistent with a gender identity, right? And of course, that's erroneous, right?

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01:07:28.860 --> 01:07:44.530

Sari Reisner (he | him): Right? So even the fact that we're doing this research in Buchani, that you have that, is already sort of fighting back that narrative and changing that narrative of, like, you know, we have bodies. Again, this goes back to this, like, biopsychosocial vulnerabilities, right? Like, there are bodies involved.

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01:07:44.530 --> 01:07:54.819

Sari Reisner (he | him): And, turns out we are able to have pleasure and use our bodies in the way that we want. And so that, I think, to me, makes this research, you know, more important than ever.

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01:07:54.820 --> 01:08:19.629

Sari Reisner (he | him): I have a question, actually, Bocana. You mentioned, sort of, that this may apply to other STI infections, and I was wondering if you had any insights, particularly related to HPV, the high-risk human papillomavirus. I feel like I have known a lot of, and this is completely anecdotal, and I don't have my researcher hat on right now, I'm participating as a community member, but, but, you know, a lot of high-risk HPV strains, right? You know, a lot of trans men that I know have been talking

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01:08:19.630 --> 01:08:24.149

Sari Reisner (he | him): me about that, and I just wondered if you had any insights or could speak to that in any way.

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01:08:24.479 --> 01:08:43.769

Bokani Nleya: Yeah, so unfortunately, no. I wish we had, but, so whenever we get, samples, which we are very grateful for, unfortunately, if there's any indication of HPV, or if, yeah, then we don't get that. That gets sent to pathology, but...

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01:08:43.799 --> 01:08:50.599

Bokani Nleya: hopefully there may be a way to investigate and get that information. But thank you for the question.

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01:08:53.180 --> 01:09:14.710

Brian Minalga: Yeah, thanks for that, that great conversation. I want to come back to some of this, too, because Bocana, you and I had a really interesting discussion, kind of about what Sari was just asking you, about some of the variables in your samples and the limitations to your study as well. So I just wanted to plant that for you to be thinking about, you know, what we talked about with cancer and other types of.

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01:09:14.710 --> 01:09:15.590

Bokani Nleya: Yeah.

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01:09:15.590 --> 01:09:33.759

Brian Minalga: and so forth. But, so while you're thinking about that, I want to bring Yuan Qi into the discussion, because, you know, your research, every time I hear, you know, anything, whether, like, you or, Steph or, you know, presenting on these, things that really bring in policy to the discussion.

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01:09:34.140 --> 01:09:45.800

Brian Minalga: It's so affirming to me because, you know, I've grown up in this, social environment where my community is always blamed for our own suffering.

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01:09:45.890 --> 01:10:08.480

Brian Minalga: And it's, you know, this narrative that, like, the disproportionate impact of HIV on queer people is, like, inherently something about queer people. Like, some... we're doing something wrong that causes, you know, us to... to have this suffering and these health disparities. So, I just... it's so moving to me when I see, you know, this validation

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01:10:08.480 --> 01:10:19.220

Brian Minalga: In evidence, like, in black and white, in the science that's being conducted that shows, no, it's the responsibility of these environments that we're in, these, as you call them, punitive

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01:10:19.340 --> 01:10:24.390

Brian Minalga: Policy environments that actually punish us down to our very health.

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01:10:24.640 --> 01:10:31.760

Brian Minalga: And so, I just want to ask you, you know, maybe to reflect a little bit on that, on that with us, and how...

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01:10:32.080 --> 01:10:38.800

Brian Minalga: How do we kind of, like, square this when we think about, you know, behavior, but then in policy?

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01:10:38.910 --> 01:10:44.799

Brian Minalga: are we limited, you know, by what we can do? We had the question from Simon about PrEP and U equals U.

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01:10:44.800 --> 01:11:01.369

Brian Minalga: But when we're living under this, you know, really punitive policy landscape that's becoming more punitive for many of us, and really for all of us, are there interventions or actions we can take, that your research may suggest, or just that you as a person might suggest for us to confront?

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01:11:01.370 --> 01:11:04.630

Brian Minalga: These, these policy implications for our health.

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01:11:08.740 --> 01:11:13.780

Yuanqi Mi: Thank you for the question. So... Personally, I think,

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01:11:14.080 --> 01:11:32.829

Yuanqi Mi: For this kind of structural barriers for healthcare, behaviors, the... like, on the policy makers, perspective, they're really responsible for, like, conducting intervention and, doing this kind of,

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01:11:34.010 --> 01:11:43.569

Yuanqi Mi: change for the policy environment, but I feel like on the, individual level, there's...

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01:11:44.360 --> 01:12:00.020

Yuanqi Mi: Except for, like, mental health counseling or, other, like, community, support. There's not a lot of things that, like, an individual can do to kind of fight this kind of, punitive environment.

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01:12:00.030 --> 01:12:07.279

Yuanqi Mi: But I feel like the responsibility is for, like, the policy makers and at, like, a structural level.

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01:12:07.510 --> 01:12:09.320

Yuanqi Mi: Does that answer your question?

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01:12:09.620 --> 01:12:25.880

Brian Minalga: Yeah, well, and I'll put this to actually everyone, you know, in the chat and the speakers, too, about the power of community. You know, here we are on Pride Month, and we started Pride with nothing. You know, we had no systems of power, we had no systematic power.

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01:12:25.880 --> 01:12:31.920

Brian Minalga: In the 60s, when all this started, we just had each other, and that's something we still have.

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01:12:32.040 --> 01:12:50.599

Brian Minalga: And so maybe that's something we can think about, too, that I'm grappling with as I hold these meetings, you know, in my day-to-day job about research, where so many of our researchers, you know, and our federal colleagues aren't really being allowed to even use terminology like transgender.

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01:12:50.740 --> 01:13:09.209

Brian Minalga: And so, you know, for someone like me who works in the research landscape, I can't not say trans. It's like, do you know who I am? Do you know, like, where I live and who's in my life? Like, I can't not do that. But, so that's... that's kind of just the question I'm grappling with that as we continue, and I'll... I'll switch to some new questions, but...

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01:13:09.210 --> 01:13:18.770

Brian Minalga: For all of us just to think, during this time and beyond the next 10 minutes, what community power means in the context of this policy landscape, too.

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01:13:20.720 --> 01:13:25.880

Sari Reisner (he | him): Brian, that reminds me of this concept of critical hope. I've been thinking a lot about that lately.

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01:13:26.000 --> 01:13:39.300

Sari Reisner (he | him): Like, this idea, you know, not, like, some toxic positivity type of critical hope, but, like, this idea is that, like, you know, we, like, face reality, right? But we still believe change is possible.

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01:13:39.400 --> 01:14:03.669

Sari Reisner (he | him): And that it's, you know, people and communities, like, rather than a sort of, like, individual resilience stance. I mean, I talked about resiliencies, but I conceptualize these as sort of, like, a broader community thing, and related to that is these taking actions. Like, no matter how small the action, like, even if it's being who we are on any given day, but that commitment to taking actions that's rooted in community together. So, yeah, I guess for me, it's really, like.

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01:14:04.030 --> 01:14:15.670

Sari Reisner (he | him): it requires that we confront the injustice, right? Feel all the things, and, for me, it's been, like, anger, sadness, all of it, and also refusing to surrender

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01:14:15.670 --> 01:14:29.149

Sari Reisner (he | him): our belief in the possibility of transformation, right? And that, for me, has been it, and, you know, fighting against the policies. I'll also say that, you know, some of the grant terminations through the National Institutes of Health the last year, you know, I had, I think, six

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01:14:29.150 --> 01:14:54.079

Sari Reisner (he | him): NIH-funded grants that were terminated. And, in response to that, you know, the American Civil Liberties Union, ACLU, Project Democracy, and others came together and levied a lawsuit, right? The American Public Health Association was part of that lawsuit. I joined as a named plaintiff as part of APHA, and that lawsuit was won, right? It's still in some courts, but a federal judge in Massachusetts ruled that it was discrimination.

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01:14:54.260 --> 01:14:55.340

Sari Reisner (he | him): that these...

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01:14:55.340 --> 01:15:19.390

Sari Reisner (he | him): grants were unlawfully terminated, whether they were... there were trans health grants, there were grants on racial and ethnic disparities, vaccine hesitancy, you know, and declared that that was not, that that was discrimination. So, for me, those kinds of community collaborations are also part of the scientific community, they're part of the HIV community, and, like, the HIV community has a history, a rich history of activism.

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01:15:19.470 --> 01:15:35.329

Sari Reisner (he | him): So if there's any group for me that I feel like can do this, it's the HIV community. But I think we all need to step up, you know, as part of this, and sort of not acquiesce in advance, right, or rest on our laurels. So I just wanted to offer that, Brian, because I really related to what you said.

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01:15:36.550 --> 01:15:41.809

Brian Minalga: And I'm so glad you did, that was, so powerful. I'll be thinking about that for a long time.

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01:15:43.200 --> 01:16:02.359

Brian Minalga: Bokani, there's so many questions for you about, like, inflammation and, you know, the biological level of things. Let me, I'll do two of them maybe together, so you can kind of think about them. So, this one from Devin says, currently there's a lot of focus on HIV and inflammation.

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01:16:02.390 --> 01:16:12.629

Brian Minalga: even when undetectable. So just, you know, focusing on... on inflammation, people living with HIV. So now, Devin's question is about,

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01:16:12.630 --> 01:16:34.019

Brian Minalga: trans men who may be living with HIV and using antiretroviral therapy. So, are you familiar with any data specific to inflammation in trans persons who are using antiretroviral therapy? So, think about that one, but at the same time, I want to read you this one back to Simon about PrEP. So we've got, you know, these two levels.

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01:16:34.020 --> 01:16:41.719

Brian Minalga: Simon's saying in terms of oral PrEP, recent research suggests that efficacy is linked to drug levels in cells.

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01:16:41.830 --> 01:16:51.260

Brian Minalga: Rather than the genital or anal tissue. And so, I'm sure you could say a lot about both of these things, so I'll put those two to you and see where you want to go.

338

01:16:53.060 --> 01:16:59.700

Bokani Nleya: So with inflammation, I guess, maybe that would be a good place to start.

339

01:17:00.200 --> 01:17:07.190

Bokani Nleya: Well, there's really not a lot of research that's been conducted, and in tissue

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01:17:07.220 --> 01:17:16.250

Bokani Nleya: virtually none. And then there's a few studies that have been done in blood. But again, this was without,

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01:17:16.250 --> 01:17:30.349

Bokani Nleya: PrEP, these... these were just individuals that were on a family hormone therapy and no, no, interaction with PrEP, where they saw the increased or sustained

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01:17:30.350 --> 01:17:52.380

Bokani Nleya: chronic inflammation. And so, I guess the suggestion there would be that, during, in people living with HIV and on gender-affirming hormone therapy, that that inflammation that just comes about by, living with HIV and being on PrEP may be further exacerbated

343

01:17:52.380 --> 01:17:57.099

Bokani Nleya: If, you're independently becoming chronically inflamed.

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01:17:57.100 --> 01:18:06.979

Bokani Nleya: By, being on gender assembly hormone therapy, but I haven't seen studies to really support this, but I would think that that could potentially mean,

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01:18:07.640 --> 01:18:15.179

Bokani Nleya: enhanced inflammation. And then, the second question, may you please remind me again? Sorry.

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01:18:15.180 --> 01:18:19.340

Brian Minalga: Yeah, about PrEP and cellular versus tissue immunity.

347

01:18:20.210 --> 01:18:25.770

Bokani Nleya: Mmm. Yeah, so again, I, I haven't come across,

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01:18:27.080 --> 01:18:39.940

Bokani Nleya: the start... the SAID studies, especially in tissue, but that's, great information to... to get to know. If someone doesn't mind, please link me some,

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01:18:40.850 --> 01:18:43.450

Bokani Nleya: Some of these studies of poopers.

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01:18:44.470 --> 01:18:52.769

Brian Minalga: Yeah, please do, because Bokani's, you know, doing additional research right now. She told me a little bit about, kind of, a systematic review that you're doing, so please...

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01:18:52.770 --> 01:18:57.430

Bokani Nleya: I really would love to get those. Yeah.

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01:18:57.800 --> 01:19:15.410

Brian Minalga: I'll say just for reference, too, you know, when we talk about existing research among trans people, I presented this previously on a Choice Agenda webinar, but,

me and Cindra, who's, I think, still here, did an analysis of Phase III HIV clinical trials from 1991 to 2023.

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01:19:15.410 --> 01:19:27.149

Brian Minalga: And guess how many trans men are documented as being included in 41 of the largest, most impactful HIV clinical trials done since 1991?

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01:19:27.440 --> 01:19:30.839

Brian Minalga: I'll give you a hint, it's under 100.

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01:19:31.650 --> 01:19:55.729

Brian Minalga: So, it's 92. There were only 92 trans men who are documented as representing all trans men across... there were almost 200,000 participants in these 41 Phase III clinical trials. So, a super underrepresented population. So when we're asking these questions about, like, well, you know, how does PrEP affect trans men and ARVs, you know, for trans men living with HIV,

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01:19:55.730 --> 01:20:09.809

Brian Minalga: We only have 92 trans men total since 1991 that have even been asked about their gender identity and are documented as being part of these, these major HIV clinical trials. It's not much better for non-binary people if...

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01:20:09.810 --> 01:20:18.739

Brian Minalga: the number in my head is telling me 398 nonbinary people, and it was about 2,000... I want to say 2,042 trans women.

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01:20:19.050 --> 01:20:27.629

Brian Minalga: So, a really, tiny sliver within this, you know, about 200,000 participants in these major trials since 1991.

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01:20:29.490 --> 01:20:40.890

Brian Minalga: With 2 minutes left, I just want to, ask the three presenters if there's anything that, you know, this conversation has brought up with you, or that you didn't get to say, in the brief time that you had to present.

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01:20:41.020 --> 01:20:44.419

Brian Minalga: So any comments from the three of you before we close?

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01:20:51.250 --> 01:21:03.310

Sari Reisner (he | him): I don't have anything, I think I already said my comments, but just want to thank you, Brian, for your amazing moderation and facilitation of this session, and Jim and AVAC for the Choice Agenda for hosting this space for us.

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01:21:04.830 --> 01:21:10.969

Bokani Nleya: Yes, and thank you, for organizing this and the opportunity to just have this discussion.

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01:21:12.490 --> 01:21:15.710

Yuanqi Mi: Thank you for organizing this. This is really nice.

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01:21:17.050 --> 01:21:23.330

Brian Minalga: And I'll just say in my, last minute as moderator, before I turn it over to Jim to close us,

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01:21:23.710 --> 01:21:34.650

Brian Minalga: Bokani, if I did my research correctly, your name, I think, means to be grateful. Yes. And we're so grateful for you, and for the research that you've brought, which is so underrepresented.

366

01:21:35.080 --> 01:21:45.569

Brian Minalga: Sari, I think your name has something to do with nobility, and I know we're in the No Kings era, but... but if we had a king, you would be mine.

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01:21:45.570 --> 01:21:46.520

Jim Pickett: Yes!

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01:21:47.000 --> 01:22:05.280

Brian Minalga: And, yeah, you're definitely a person of noble character, so appreciate you. And Yuan Qi, I believe your name means original or primordial energy, and you have really energized us to think about the landscape that we're in and bring our advocacy forward, so really appreciate the three of you sharing your work with us.

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01:22:07.100 --> 01:22:12.930

Jim Pickett: That is so cool. So, Brian, what does your name mean, Beyond Fabulous?

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01:22:14.430 --> 01:22:19.990

Brian Minalga: I think Brian was a king, too, actually, of Ireland. I was named in a dream, so I always think there was...

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01:22:21.130 --> 01:22:24.880

Brian Minalga: magic going on there. And my other Molly... Oh.

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01:22:25.320 --> 01:22:26.130

Brian Minalga: So there's that.

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01:22:26.130 --> 01:22:39.030

Jim Pickett: Let's give it... let's give it up to a wonderful moderator and equally wonderful presenters. This was a fantastic set of presentations today. Thank you all so much for this really important work.

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01:22:39.080 --> 01:22:55.450

Jim Pickett: TCA is committed to continue amplifying this work, particularly among trans men and trans women. So when you have ideas, if you have ideas, if you think something needs to have more energy or more support, please reach out to us as allies, always.

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01:22:55.450 --> 01:23:15.740

Jim Pickett: Thank you, thank you so much. Thank you all for being here. As I've mentioned, we have recorded the slides, the recording, the transcription, and some of these juicy resources that were shared will be collected and posted on our webpage, and you'll all get a follow-up email in the next day or so.

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01:23:15.740 --> 01:23:27.990

Jim Pickett: And please stay tuned to our upcoming webinars. We have topics related to implementation research, which is the hottest of the hot new things coming from the NIH these days.

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01:23:27.990 --> 01:23:36.259

Jim Pickett: We're going to be talking about the future of behavioral health research and social science research in these very extraordinary

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01:23:36.260 --> 01:24:00.450

Jim Pickett: challenging times. And as I mentioned in the chat, Simon and I are cooking up something on updating PrEP guidance based on the continuing data that shows us, that indeed cis women do not need to be super adherers to achieve strong protection from PrEP, and in fact, the guidance for cis men could very much parallel cis women.

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01:24:00.450 --> 01:24:17.430

Jim Pickett: So we want to have a discussion about that, and lots of other really great things. So all of this will be shared on the Choice Agenda listserv, and of course, if you all have ideas for other topics that we should be covering, whether on the list or in a webinar.

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01:24:17.560 --> 01:24:19.680

Jim Pickett: Please feel free to share that.

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01:24:19.880 --> 01:24:30.310

Jim Pickett: But now, without further ado, I'm going to close out the call. Thank you all again for being here. Thank you all for your great work, and happy Pride!

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01:24:31.240 --> 01:24:32.449

Sari Reisner (he | him): Thanks, everybody.

383

01:24:32.450 --> 01:24:33.330

Brian Minalga: Happy Pride.