Title

PrEP adherence among trans women in Brazil-access needed for this key population - Authors' reply.

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Authors

Sevelius, Jae
Deutsch, Madeline B
Glidden, David V
et al.

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PrEP adherence among trans women in Brazil—access needed for this key population

The recent sub-analysis of iPrEx found that pre-exposure prophylaxis (PrEP) can be an effective HIV prevention tool for trans women.[1] The iPrEx sub-analysis found no seroconversions among trans women with detectable drug concentrations, but 70% of trans women in the sample were taking few or none of their PrEP pills.

The researchers hypothesised that low adherence resulted from past experiences with providers or clinics that were unsupportive of transgender identities or concerns about hormone interactions. To address adherence issues, the authors recommend that PrEP be provided in gender-affirming clinical settings that provide trans health services such as hormone therapy and sexual health services. We could not agree more with the call for culturally competent care for trans women. However, linking PrEP provision to trans health services might, in practice, limit access for many trans women.

HIV epidemics among trans women exist in many places where there are no trans health services, especially in low-income and middle-income countries.[2] Even when available, many trans women may not be interested in such services. We found that only 52% of 345 trans women in a population-based study in Rio de Janeiro were currently using hormones despite the ability to access hormones without a prescription. In fact, those most at risk for HIV were the least likely to use hormones. In another ongoing study we found evidence of positive adherence outcomes among trans women provided PrEP without trans health services. Trans health services were not provided as part of PrEP Brasil—a 48 week multicentre, open-label, PrEP demonstration project to assess the feasibility of PrEP implementation among high-risk MSM and trans women in Brazil. In comparing drug concentrations between trans women and MSM, there was no significant difference in adherence (p=0·49), and over 90% of trans women (n=25) had protective drug concentrations at 4 weeks (72·7% with four or more doses per week, 18·2% with two to three doses per week detected). Adherence at 4 weeks is significantly correlated with longer-term PrEP adherence.[3]

Trans women need immediate access to HIV prevention methods, including PrEP, to address the devastating burden of HIV they bear. Recommending PrEP be provided in combination with trans health services could stymie access for trans women in places where these services are not available. Or worse, in settings where trans identity is criminalised or punished, hinging PrEP to trans health services could create more risk than protection. The authors' recommendation could also result in missing trans women at highest risk of HIV. Equally important, high PrEP adherence among trans women is possible without trans health services. Moving in parallel to increase access to PrEP immediately while working to improve access to trans health services might be the best strategy for meeting the HIV and health needs of trans women in low-income and middle-income countries.

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*Erin C Wilson, Emilia Jalil, Brenda H Siqueira, Ronaldo I Moreira, Valdilea G Veloso, Laylla Monteiro, Beatriz Grinsztejn
erin.wilson@sfdph.org

San Francisco Department of Public Health, San Francisco, CA, USA (ECW); Instituto Nacional de Infectologia Evandro Chagas (IPEC), Fundacao Oswaldo Cruz, Fiocruz, Brazil (EJ, BHS, RIM, VGV, LM, BG).

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Authors' reply

Wilson and colleagues report important new information showing that most transgender women achieved protective concentrations of drugs in an open label pre-exposure prophylaxis (PrEP) demonstration project in Brazil. This is consistent with findings showing that effective use of PrEP is common in clinical practice and demonstration projects in diverse populations.[1]

Lack of access to gender-affirming care is the most commonly cited barrier to health care for trans women.[2,3] Gender-affirming care goes beyond hormone therapy to include clinic environments where chosen names and pronouns are respected, patients feel safe using the bathroom of their choice, and clinic staff have basic cultural fluency. Transgender women and their allies are advocating for gender affirming care around the world, including in Brazil.[4] Furthermore, it is surprising that Wilson and colleagues assume that because only 52% of trans women in one survey were using hormones, the remaining 48% "may not be interested" in trans health services. Certainly not all trans women are interested in hormone therapy; however, the absence of health care that is gender affirming, life instability, and poverty may limit access to hormones, especially among those most at risk for HIV, even in contexts where hormones are available without a prescription.

In the iPrEx open label extension, PrEP drug concentrations were low

among trans women who reported use of feminising hormones; whereas PrEP concentrations in trans women not using hormones and men were much the same.[5] These findings supported our conclusion that participant concerns about PrEP interfering with hormone therapy might have contributed to less effective use of the intervention. Wilson and colleagues do not report any information about hormone use among the trans women enrolled in PrEP Brasil, and given the small numbers who were included (n=25), we think it premature to conclude that PrEP provided without gender affirming services leads to acceptable outcomes for trans women in general.

Advocating for PrEP provision without striving for gender-affirming care environments may excuse health systems from developing programmes for this marginalised and often invisible population. We are disappointed that PrEP Brasil, which was supported by two national governments and a global pharmaceutical company, did not provide trans health care.

*Jae Sevelius, Madeline B Deutsch, David V Glidden, *Robert M Grant*
robert.grant@gladstone.ucsf.edu

University of California, San Francisco, CA, USA (JS, MBD, DVG, RMG); and Gladstone Institutes and San Francisco AIDS Foundation, CA, USA (RMG).

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