Embed: Advancing trans inclusion and integration in the HIV sector in Ontario

A report from the Trans Interweaving Project

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GMSH
GAY MEN'S SEXUAL HEALTH ALLIANCE

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About GMSH

The Gay Men's Sexual Health Alliance (GMSH) is an Ontario-wide network of HIV/AIDS service organizations. GMSH champions the health of 2SGBQ+ men—cisgender and trans men whose identities may include, but are not limited to being, Two Spirit, gay, bisexual, and queer. GMSH does this by leading the development of cutting-edge sexual health promotion resources and collaborating with HIV service organizations and other service providers in Ontario to support 2SGBQ+ men in having the information, supports, and services they need to have the sex they want.

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Land Acknowledgment

The Trans Interweaving Project was conceptualized and developed on Indigenous territorial lands across the province of Ontario. The GMSH maintains offices in Tkaronto (colonially known as “Toronto”) and the unceded Algonquin, Anishinabek territory colonially known as “Ottawa”.

We encourage readers to learn more about the importance of territory acknowledgements as one part of a commitment to truth and reconciliation. Learn more about the importance of land at Native Land Digital.

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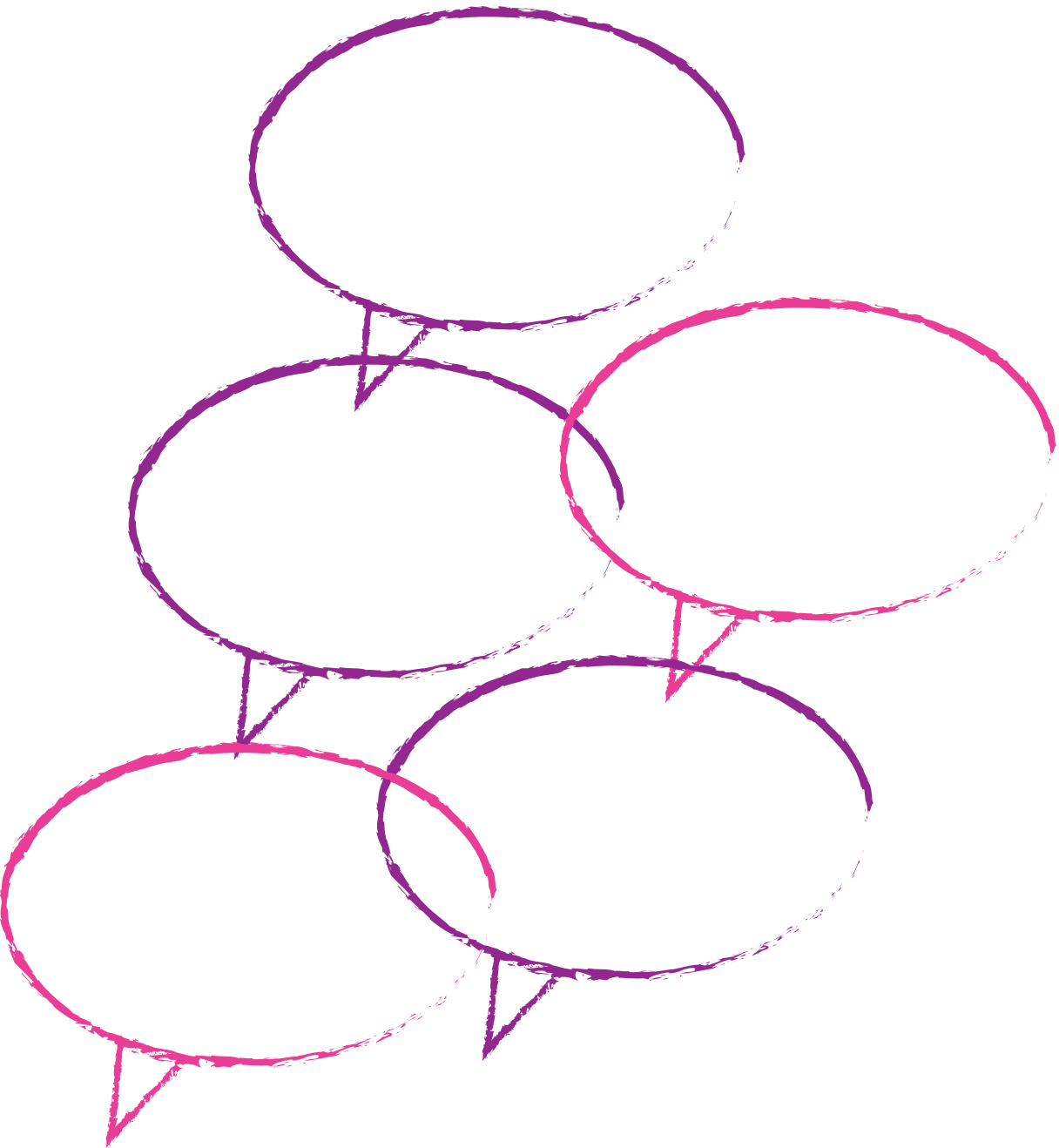
A note on language

For explanations of the most significant terms and abbreviations used in this report, see the Glossary of key terms and abbreviations. In this report, we have bolded glossary items upon first use in the main body of this report.

We recognize that certain words and abbreviations have different meanings across communities. We have also varied our usage of terms like "trans" and various related umbrella terms—not only to suit different contexts, but to reflect the fact that usage of such terms varies across trans communities. Finally, we have tried to use accessible language that also reflects the realities of HIV sector work.



Acknowledgments

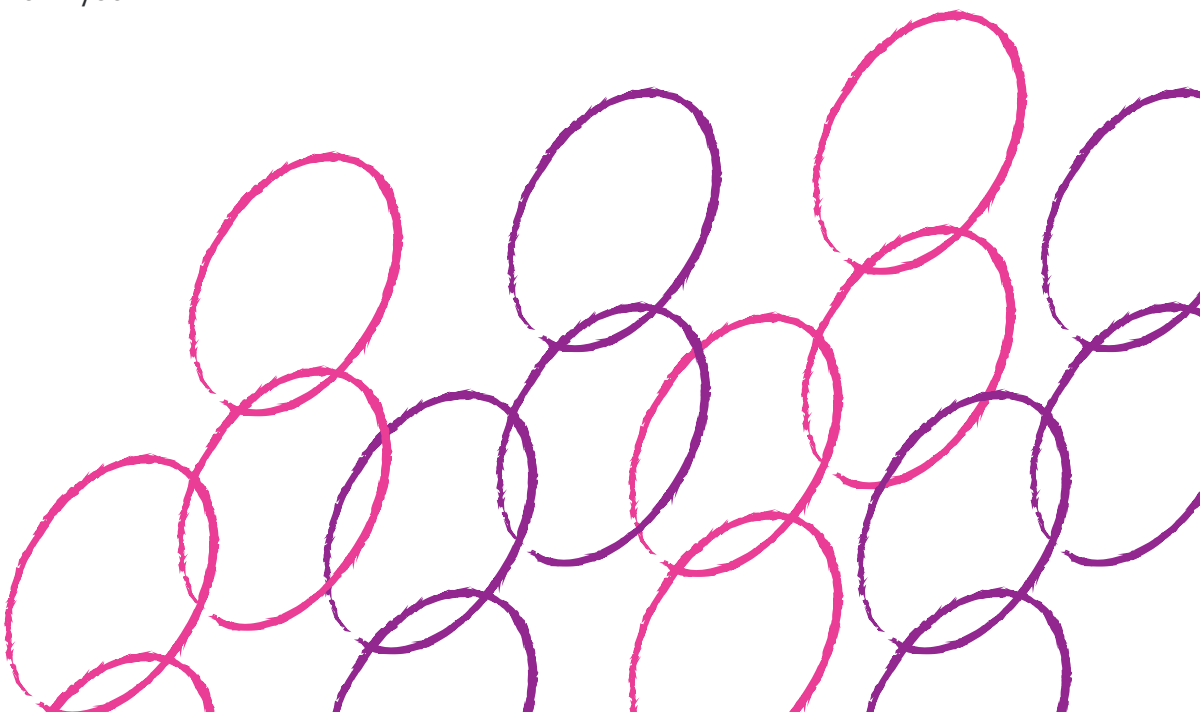
The Trans Interweaving Project team would like to express our gratitude to our amazing communities. You fight for a better world, including in the HIV response, and you help make this work feel worthwhile, especially when it gets hard.

We would like to thank our advisory committee for their generous care and guidance throughout this project. We'd also like to thank the 72 participants who shared their knowledge, experiences, time, and ideas with us in focus groups, interviews, and other conversations for this project. Your perspectives gave us hope in knowing that so much was already being done, and you inspired us to move forward when you shed light on the work that still needs doing.

We also acknowledge the immense efforts of our communities in the response to HIV over the last several decades. In "MSM" (men who have sex with men) work, Lou Sullivan, a US activist and one of the first known trans men to die of AIDS, often comes to mind as a source of inspiration. In Ontario, a wide range of individuals and communities have contributed to the advancement of trans people in the HIV sector and beyond. Specifically, Viviane Namaste's community, policy, and academic contributions helped to give voice and visibility to trans people in the HIV response as early as the 1990s, including trans women, trans men, and people who these days might identify as non binary. The work of Monica Forrester, Mirrha Soleil Ross, and Morgan M. Page was also instrumental in creating so many of the services and resources available for trans people, especially as this work related to HIV, food security, sexual health, sex workers' rights and keeping our stories alive. Additionally, the work of the original Gay/Bisexual/Queer Trans Men's Working Group started in the early 2000s and included the ongoing efforts of Syrus Marcus Ware, Kyle Scanlon, Nik Red, Ayden Scheim, and many others. The group maintained solidarity with trans women and transfeminine people while ensuring that trans men had space in queer men's sexual health work. Their work in Ontario also led us to the first sexual health resource for trans guys into guys in the province: Primed, a resource that continues to evolve and change with our communities.

There are so many other people we would love to thank, especially those who came before us and have made it possible for us to live our lives as the fabulous trans people we are. We know the work is so rarely visible or celebrated. We see it and we know how meaningful it is.

Thank you. Thank you. Thank you.



1. Executive Summary

This section summarises the project's key findings—in particular, it lists our 29 recommendations. We also preview other sections of this report.

1.1 Executive Summary Background

For decades, it has been known that trans, non-binary and Two-Spirit (TNB2S) people have been living with HIV. As early as the 1990s in Canada, activists, HIV-sector workers, and intellectuals were calling on national and provincial funders, researchers, and agencies to respond to the enormous service gaps faced by trans people with regards to HIV prevention, treatment, and care.

Yet recent evidence shows that TNB2S people are still not sufficiently included and integrated within the ongoing response to HIV to receive the opportunities, supports, and services that we need (Lacombe-Duncan et al., 2019, 2022; Rich et al., 2017; Scheim & Travers, 2017). In short, we are not adequately embedded in each and every stage of HIV care.

Moreover, although some agencies in Ontario's HIV sector have been taking significant steps to advance trans inclusion, there has not yet been a concerted sector-wide effort to robustly address and embed trans inclusion and integration in Ontario.

There has not yet been a concerted sector-wide effort to robustly address and embed trans inclusion and integration in Ontario.

1.2 Executive SummaryThe Trans Interweaving Project

In March 2020, planning began for the Trans Interweaving Project. Created by the Gay Men's Sexual Health Alliance (GMSH), this was a trans-led project to advance trans inclusion and integration in Ontario's HIV sector and beyond. Through consultations and analysis, we learned what changes should be brought to GMSH's own work, as well as in GMSH Alliance member agencies, and how to get there.

1.2.1 Project personnel

The project was led by a four-person project team with lived experiences in trans communities and connections to and/or histories in gay, bi, and queer men's communities. The team comprised two trans men, a trans woman, and a non-binary person, with half the team being both racialized and immigrants. Most members of the project team had years of involvement in the HIV sector, and a collective total of over 50 years of involvement in trans communities and trans health.

The project was also guided by a nine-person advisory committee. Two thirds of the committee members were trans (two trans women, two non-binary people, and two trans men), more than two thirds were Indigenous or racialized, and more than two thirds had current or former experience working in the HIV sector (ranging from frontline staff to management).

1.3 Methodology

1.3.1 How we collected data

From mid- to late 2020, we collected data using four methods:

- **a website and strategic plan review:** We analyzed 34 websites and 15 strategic plans of GMSH Alliance member agencies and related organizations.
- **focus groups**: We ran 12 online focus groups that focused on HIV-sector perspectives and trans community perspectives (especially perspectives from trans people who are less likely to be included in "trans work," such as trans people who are sex workers).

- **interviews**: We ran eight online interviews with HIV-sector management and HIV-positive TNB2S people.
- **a deliberative dialogue**: We held two online sessions of strategic dialoguing and prioritizing. The participants were a mix of HIV-sector stakeholders, TNB2S community members, and other professionals connected to the HIV sector.

1.3.2 Participants

A total of 114 people participated in at least one of the data-gathering activities. At least 56 of these people identified as trans and/or non-binary and/or Two-Spirit.

1.4 Five trans priority populations

As well as considering the participants' responses as a whole, we focused on the responses from five trans priority populations: Indigenous people, francophones, racialized people, migrants, and sex workers.

1.5 Three principles to underpin trans inclusion and integration

As we analyzed participants' responses, three principles emerged to underpin trans inclusion and integration in organizations and across Ontario's HIV sector:

- An **intersectional** approach would be embedded in trans inclusion and integration work.
- Trans people would be more involved and be engaged in more meaningful ways.
- Strengths-based, celebratory, and empowering approaches would be the norm.

These principles will provide a foundation for implementing all 29 of our recommendations. In turn, these recommendations will support bringing these principles to life in the work of GMSH and other organizations across the HIV sector.

1.6 Four areas of focus

In analyzing the data that we collected, we focused on four high-level areas:

- **Inclusion indicators:** what would be seen if trans inclusion and integration were embedded in the HIV sector.
- **Strengths:** good work that is already being done to advance trans inclusion and integration in the HIV sector.
- **Barriers:** obstacles and challenges to trans inclusion and integration.
- **Recommendations**: concrete actions for GMSH, HIV-sector organizations, and Indigenous organizations.

In the next three sections, we briefly note some high-level, key points about the inclusion indicators, strengths, and barriers that we identified, and we give some select examples.

1.7 Inclusion indicators

Many participants raised the necessity of taking an intentional approach—a deliberate and strategically considered approach—to trans inclusion and integration. For example, if an intentional approach was in place at the sectoral level, organizational systems would support TNB2S participation in the HIV sector, and TNB2S service users, staff, and volunteers would experience inclusive, supportive, and welcoming environments. Among other inclusion indicators, adopting an intentional approach in the health care system would see health organizations and the health sector taking a deliberate and planned approach to ensuring that trans people experience patientcentred care.

Many participants raised the necessity of taking an intentional approach—a deliberate and strategically considered approach—to trans inclusion and integration.

At the programming and service delivery level, the key inclusion indicator is that sexual health interventions would reflect and be relevant for TNB2S people. This also entails designing interventions for TNB2S people at all stages in our journey of exploration and self-expression as TNB2S—not only the early stages.

1.8 Strengths

The HIV sector has been trying to commit to trans inclusion and integration for some time. The sectoral advances that have already been made will provide a good foundation for future initiatives to advance trans inclusion and intervention. The strengths and experience of staff and management in some HIV-sector organizations, and the leadership actions from some managers and staff in advancing trans inclusion and integration, will add to this foundation.

At an organizational level, there is much scope for management and staff to adopt or adapt the work that is being done in other organizations. This work includes programming and service delivery strengths—for example, trans-inclusive HIV prevention and supports, and resources such as the sexual health guides Primed and Brazen, both of which were singled out as groundbreaking assets.

The existing sectoral advances that have already been made will provide a good foundation for future initiatives to advance trans inclusion and intervention.

1.9 Barriers

The participants raised many barriers to trans inclusion and integration. At a sectoral level, these barriers amount to foundational barriers. For example, we heard time and again from project participants about the need to work from an intersectional perspective. However, siloed funding streams focus on a single facet of a person's identity or experience, and ultimately compromise organizations' ability to serve TNB2S people.

To take another example, our website and strategic plan review found that most of the organizations' websites did not seem to consider trans people as a potential audience, and only a small minority of strategic plans named trans populations as an area of focus. These findings point to another foundational barrier: the broad lack of organizational support across the sector for trans inclusion.

Although the number of barriers identified may feel daunting, if focused efforts are made to address the foundational barriers, many of the downstream barriers, such as barriers in programming and service delivery, will likely be much easier to resolve.

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1.10 Recommendations

These 29 concrete recommendations aim to:

- support the vision—expressed in this report as inclusion indicators—for trans inclusion and integration within GMSH and the broader HIV sector
- leverage existing strengths in trans inclusion and integration
- address barriers to trans inclusion and integration.

There are 22 recommendations for GMSH, six recommendations for HIV-sector organizations, and one recommendation for Indigenous organizations.

1.10.1 Recommendations for GMSH

We have grouped these recommendations into work that will start in the short term (years 1 and 2), medium term (years 3 and 4), and long term (years 5+). Within each timeframe, we have also grouped each set of recommendations under themes.

Work to start in the short term (years 1 and 2)

Advance principles and approaches to support trans inclusion and integration

- **Recommendation 1:** Develop a resource to support GMSH and the HIV sector in consistently advancing intersectionality.
- **Recommendation 2**: Increase the involvement and meaningful engagement of TNB2S people in the HIV sector.

Address structural challenges affecting TNB2S people's participation in the HIV sector

- **Recommendation 3**: Advocate with HIV-sector funders to address issues facing TNB2S people.
- **Recommendation 4:** Embed trans inclusion and integration work in the Ministry of Health Annual Reference Guide.

Support an intentional approach to trans inclusion and integration in organizations and the sector

- **Recommendation 5:** Clearly embed and define trans inclusion in the scope of work and communities served across the GMSH Alliance.

Advance trans inclusion and integration in interventions led by GMSH and GMSH Alliance member agencies

- **Recommendation 6:** Develop English and French style guides to foster trans inclusion and integration in communications, social media engagement, and campaigns.
- **Recommendation 7:** Create guidance to equip GMSH Alliance member agencies to effectively reach and engage with TNB2S people and communities.
- **Recommendation 8:** Build capacity among cisgender people who use HIV-sector services to interact effectively and respectfully with trans people.
- **Recommendation 9:** Create trans-inclusive and trans-focused campaigns, resources, digital content, and interventions in both English and French.

Work to start in the medium term (years 3 and 4)

Build capacity in trans communities

- **Recommendation 10:** Create a pathway for TNB2S people into employment and leadership roles in the HIV sector.
- **Recommendation 11:** Develop and pilot skills development interventions for TNB2S people.
- **Recommendation 12:** Create a trans community knowledge mobilization initiative.
- **Recommendation 13:** Develop mechanisms to support trans people in creating programming and interventions that trans populations need and want.

Expand the accessibility of ASO services

- **Recommendation 14**: Develop means to serve trans people who experience additional barriers to accessing their local ASO.

Develop a competency framework to support capacity building in HIV-sector organizations

- **Recommendation 15:** Develop a competency framework for upskilling HIV-sector personnel in trans inclusion and integration.

Work to start in the long term (years 5+)

Build trans inclusion capacity at board, management, and frontline staff levels

- **Recommendation 16:** Develop knowledge and skills development initiatives in alignment with the competency framework.
- **Recommendation 17:** Establish and support a community of practice focused on trans inclusion and integration in the HIV sector.
- **Recommendation 18:** Cultivate peer-to-peer mentoring and knowledge exchange among HIV-sector executive directors.
- **Recommendation 19**: Develop resources to support HIV-sector management in fostering trans inclusion and integration in their workplaces.

Advance trans inclusion in health care

- **Recommendation 20:** Create online training modules and associated job aids to improve clinical practice in sexual and reproductive health care for trans people.
- **Recommendation 21:** Advocate and raise awareness to encourage increased access to mental health and substance use supports and services that are trans inclusive.
- **Recommendation 22:** Advocate for organizational and systems commitment to trans inclusion in the health care sector.

Recommendations for HIV-sector organizations

- **Recommendation 1:** Provide transparency and clarity in how trans people are served and engaged.
- **Recommendation 2**: Embed TNB2S people and needs in strategic and organizational materials.
- **Recommendation 3:** Partner with groups and agencies within and outside the HIV sector to expand organizational capacity to meet trans people's needs.
- **Recommendation 4**: Create and offer developmental opportunities for trans people.
- **Recommendation 5:** Include TNB2S people and needs in funding proposals.
- **Recommendation 6:** Foster linguistic accessibility.

Recommendation for Indigenous organizations

- **Recommendation 1:** Include Indigenous 2STNB people in a holistic manner in cultural activities, programs, and services.

Reading this report

This report contains rich amounts of detail, including direct quotes from participants. We encourage you to drill down into this detail.

The rest of this report has been organized as follows:

Scope and context

- **Chapter 2** gives an overview of this project.
- **Chapter 3** gives context on trans people and HIV in Ontario.

Methodology and participants

- **Chapter 4** details our methodology.
- **Chapter 5** presents demographic information on the focus group and interview participants who completed an online sociodemographic survey.

Findings

- **Chapter 6** presents results from the website and strategic plan review.
- **Chapter 7** focuses on the five trans priority populations. For each population, we discuss the inclusion indicators, strengths, and barriers to trans inclusion.
- **Chapters 8, 9, and 10** focus on inclusion indicators, strengths, and barriers respectively, as they pertain to the HIV sector, the intervention level, and the health care system.
- **Chapter 11** presents our recommendations, accompanied by detailed descriptions to guide implementation.

Scope and context

2. The Trans Interweaving Project

This chapter introduces the Trans Interweaving Project, including its objectives and its approach.

2.1 About the Trans Interweaving Project

Trans people have always been present in lesbian, gay, bisexual, and queer communities and gay men's sexual spaces and cultures, sometimes by choice and other times by circumstance, but we are often invisible in sexual health conversations and HIV work. This affects trans people's health and wellbeing.

In 2019, GMSH supported a group of trans people to update Primed, a guide originally intended for trans men who are into men, and their cis male partners. The Primed project team recommended that GMSH better integrate trans people in its work, and in that, recognize the fluidity and diversity of experiences within trans communities. Since GMSH recognized that both the provincial GMSH office and many other HIV-sector organizations were working toward or learning about intentional trans inclusion and integration, in 2020 GMSH launched the Trans Interweaving Project.

The Trans Interweaving Project was a trans-led project to advance trans inclusion and integration in Ontario's HIV sector and beyond by discovering what changes should be brought to GMSH's own work as well as in GMSH Alliance member agencies, and how to get there. The project recognized that collaboration is vital: Everyone involved in the sector has a role to play and something that they can do to support trans inclusion and integration.

Planning for the project began in March of 2020. Focus groups and interviews were held during the summer, and a deliberative dialogue, bringing together HIV-sector leaders, took place in December 2020, once preliminary analysis of the focus groups and interviews was complete.

The project recognized that collaboration is vital: Everyone involved in the sector has a role to play and something that they can do to support trans inclusion and integration.

2.2 Who worked on and guided the project?

GMSH commissioned an external team of trans people to lead and work on the Trans Interweaving Project. The four-person project team all have lived experiences in trans communities and connections to and/or histories in gay, bi, and queer men's communities. For a small group of people, the team has a broad mix of experiences. These include racialization, immigration, perspectives from outside of Toronto, and francophone and anglophone perspectives, among others. The team comprised two trans men, a trans woman, and a non-binary person. Most members of the project team had years of involvement in the HIV sector, and the project team had a collective total of over 50 years of involvement in trans communities and trans health.

To guide the project from a broad range of perspectives, a nine-person advisory committee was formed, drawing perspectives from across the province. Two thirds of the members were trans (two trans women, two non-binary people, and two trans men), more than two thirds were Indigenous or racialized, and more than two thirds had current or former experience working in the HIV sector (ranging from frontline staff to management). Some members of the advisory committee were HIV positive, and some had experience accessing HIV-sector services and supports.

GMSH actively supported the project in a range of ways, including working with the project lead on refining the project objectives, co-leading advisory committee meetings, and championing the project with HIV-sector leaders and with GMSH staff.

2.3 Project objectives

The Trans Interweaving Project had five objectives:

1. Explore what GMSH, GMSH Alliance-linked staff, and organizations need to do, to embed engaging, serving, and supporting trans people into their practice, work, and culture.
2. Identify what GMSH's role could be in collaborating and advocating with other parts of the HIV sector in Ontario to address issues and opportunities arising from this project.
3. Develop an understanding of what the HIV sector could do to leverage its power, in order to advocate and advance trans issues in the HIV sector with federal and provincial stakeholders.
4. Develop an understanding of the current state of engaging, serving, and supporting trans people at GMSH, GMSH Alliance member agencies, and within the sector in Ontario, in the context of GMSH's five strategic priority areas.[1]
5. Create recommendations and a roadmap, identifying work that can be completed in the short-, medium-, and longer-term to help agencies move forward in this work.

GMSH leadership, the project team, and the advisory committee recognized that members of trans communities were likely to raise issues that were outside of GMSH's mandate and that were highly relevant to HIV prevention, treatment, and care (e.g., access to affordable housing; barriers to employment). Therefore, the third objective was included as a commitment to advance broader issues that surfaced through the project.

2.4 Commitments and approach

Building on the recommendations of the Primed project team, GMSH leadership and the Trans Interweaving Project team determined that the Trans Interweaving Project would take an inclusive approach regarding the many parts of trans communities for whom HIV prevention and supports are particularly relevant, so that the project could make the biggest difference for trans communities.

In line with these decisions, the project's key commitments were:

To seek out perspectives from trans people (trans men, trans women, non-binary people, and Two-Spirit[2] people) who described themselves as being currently or formerly connected to gay, bisexual, and queer men's communities or sexual cultures.

1. To take an approach grounded in intersectionality, decolonization, liberation, and empowerment.
2. To apply the principle of "Nothing about us without us," in concert with systems change principles that perspectives in the system need to be reflected throughout the project.
3. To use a community-based, participatory action research approach, with the goal of cultivating change through the process as well as the end products.
4. To use a strengths-based and appreciative approach, to identify what is working and could be built upon.

Below, we discuss the two key approaches that we adopted: community-based, participatory action research and a strengths-based and appreciative approach.

[1]These strategic priority areas, all pertaining to the context of gay men's communities, are: testing, PrEP/PEP, online outreach, sexual health information, and harm reduction.
[2] Although not all Two-Spirit or non-binary people identify as trans or align themselves with the term trans, we sought to intentionally include those who do, or who might benefit from a more trans-affirming HIV sector.

2.4.1 Community-based, participatory action research

As trans inclusion and integration work needs to be collaborative, we opted for a participatory and community-based framework. We focused on identifying areas for action by gathering perspectives, from a broad range of people connected to the HIV sector, on questions designed to cultivate change. This kind of approach is often called community-based, participatory action research. It allowed us to identify pragmatic pathways forward that are grounded in the realities of trans peoples' lives as well as the context of the HIV sector.

By action research we mean "a collaborative approach to inquiry or investigation that provides people with a means to take systematic action to resolve specific problems" (Stringer, 2007, p. 8). Moreover, action research intends to create change through the process itself, as well as through the creation and dissemination of a report and other knowledge translation approaches (Stringer, 2007).

By participatory we mean a project where research is done with communities' involvement (participation) and leadership at every level (conception, implementation, knowledge-sharing, etc.). Participatory research happens through an iterative process—in the case of this project, a repeated process of consultation and deliberation. When making key decisions at each step of this project, the project team drafted a proposed approach and consulted with our advisory committee and with GMSH's management; the project team then deliberated on how to incorporate the advice before taking action.

Communities of people living with and affected by HIV/AIDS have had to fight injustice for a long time, including injustice as to who gets to do research on them (Adam, 2005, 2011). Using a community-based participatory framework is one way to ensure that the values of "nothing about us without us," "greater involvement of people living with HIV/AIDS" (GIPA), and "meaningful engagement of people living with HIV/AIDS" (MEPA) are centred in research projects, and it has proven useful in the HIV sector for some time (Rhodes et al., 2010; Travers et al., 2008). The project team was aware that TNB2S people are often studied and consulted, but rarely lead and/or rarely are invited to participate meaningfully in the design and implementation of projects. This leads to research fatigue and disengagement from researchers (Ashley, 2020) and possibly from others doing community-level nonacademic work with trans groups, such as environmental scans, community consultations, or collaborations. Instead, the Trans Interweaving Project used a participatory approach to ensure that trans, non-binary, and Two-Spirit people were not merely consulted, but positioned as leaders and active partners in collaborative problem-solving and creating change.

2.4.2 A strengths-based and appreciative approach

The project team chose to use a strengths-based and appreciative approach to discover what is working in the HIV sector that can be built upon or spread. This approach not only values good work, but also supports a trauma-informed approach (Hall & DeLaney, 2019; munson & Cook-Daniels, 2016). These attributes are especially relevant, given the high levels of trauma collectively experienced by trans people (Kelly et al., 2020) and the limited number of conversations that focus on what is already working for trans people.

A strengths-based and appreciative approach also helps to elicit hope and foster motivation while simultaneously acknowledging how systemic oppressions complicate our relationships to communities, organizations, and ourselves (Day, 2018). As trans people, chronic exposure to antitrans attitudes and beliefs impacts our health and, at times, our ability to imagine a better world (Meyer, 2003). Appreciative and strengths-based approaches help people to see that not only is change possible, but that some change has already occurred, and that there are successes that can already be acknowledged, learned from, and celebrated. Appreciative and strengths-based approaches can also help to identify what is in the way of people and organizations doing good work, what is missing, and what might make the biggest difference in moving forward with what is possible.

3. Context: Trans people and HIV in Ontario

This chapter sets some historical context before discussing several issues that trans people in Ontario face in relation to HIV.

This chapter provides a short historical overview, before briefly discussing the following issues that trans people face in relation to HIV and engagement in the HIV sector, especially in Ontario:

- challenges of binary gender systems
- gaps in information
- unmet health care needs
- social determinants of health
- HIV monitoring in Ontario's trans populations
- engagement in the HIV care cascade.

Where useful, we have also included some information on trans people and HIV, as well as trans people in broader contexts.

The HIV Sector in Ontario

The strengths and needs of trans communities in relation to the HIV sector are deeply connected to how health and social services, HIV-sector organizations, and trans community support and advocacy work are organized. In Ontario, the HIV sector consists primarily of a mix of small community-based organizations focused on HIV/AIDS (ASOs—that is, HIV/AIDS service organizations), as well as HIV-focused primary care providers, sexually transmitted infection (STI) testing and treatment sites, and specialized HIV clinics (Ontario HIV Treatment Network, n.d.-b). The ASOs are supported by HIV Resources Ontario, a network of 12 capacity-building organizations, one of which is GMSH (HIV Resources Ontario, 2019).

3.1 Historical overview: Trans people and communities in Ontario as change agents

We have known for decades that TNB2S people have been living with and have been affected by HIV. There has long been a push from activists, HIV-sector workers, and intellectuals such as Viviane Namaste to increase consultation, funding, and services to trans people in Ontario, especially trans women (K. Namaste, 1995; K. Namaste et al., 1995). In fact, as early as the 1990s in Canada, Viviane Namaste and others were calling on national and provincial funders, researchers, and agencies to respond to the enormous gaps in service faced by trans people with regards to HIV prevention, treatment, and care, including for trans women, trans men, and people who today might identify as non-binary.

From the beginning of the HIV epidemic(s), our communities have advocated for better access to health care, especially health care relating to transition and sexual health, as relationships between HIV, transition-related care and wellbeing have been known for decades (Poteat et al., 2017, 2019; Schulden et al., 2008; Sevelius, 2009). Trans people's work led to the development of resources such as The Happy Transsexual Hooker: A Sexy Resource Guide for Transsexual and Transgendered Sex Workers (Strang & Bourgeau, 2000) and Brazen (Page, 2013; The 519 and CATIE, 2017), the latter being a sexual health guide for trans women. The Gay/Bisexual/Queer Trans Men's Working Group also produced Getting Primed: Informing HIV Prevention with Gay/Bi/Queer Trans Men in Ontario (Adams et al., 2008), a research report supporting the creation of Primed: The Back Pocket Guide for Transmen and the Men Who Dig Them (Gay/Bisexual/Queer Trans Men's Working Group, 2007) a sexual health guide for trans men into men, predating the current structure of the GMSH as a priority population network (PPN).

Outside of sexual health contexts, trans people have created many means to support one another and materially benefit our lives. This has included means to share information, numerous peer support groups, and larger scale initiatives. For instance, trans people working within larger organizations have created initiatives such as the Trans Community Shelter Access Project at The 519, as well as training and support for a broader range of health and social service providers.

On a human rights and policy front, trans people's work resulted in transition-related surgeries being covered by the Ontario Health Insurance Plan (OHIP) in 2008, after a 10-year hiatus. Further work resulted in gender identity and expression being protected grounds under the Ontario Human Rights Act in 2012 and in Ontario banning conversion "therapy" for trans children and youth in 2015. At a federal level, Bill C-16 added gender identity and expression into the Canadian Human Rights Act and into the hate crimes provision of the Criminal Code in 2017.

Community advocacy resulted in reducing the administrative and financial burdens required to secure provincial funding for some trans-related surgeries in Ontario in 2016. This meant that trans Ontarians were no longer required to obtain an evaluation from the Gender Identity Clinic run by the Centre for Addiction and Mental Health (CAMH) in Toronto to qualify for life-affirming surgeries.

Of course, these are only a few of the changes instigated by trans communities organizing. As with all social change movements, so much powerful work is not known by others.

3.2 Challenges of binary gender systems

Generally, societies group people into mutually exclusive western gender categories based on binary, linear, and simplistic ideas of sex-gender that were spread through European colonization. Fitting TNB2S people into binary male/female categories poses several problems. For one, it is virtually impossible to record epidemiological information on these communities when TNB2S people are not accounted for in current measures, or when measurements are clumsy, inconsistent, and incomplete (Perez-Brumer et al., 2016; Poteat, Scheim, et al., 2016; Thompson & King, 2015). In the context of HIV, epidemiological risk categories relating to sex and gender may be based on one or more dimensions: sexual behaviour, identity/social role, biomedical risk, and social networks, to name a few. HIV-sector interventions are typically designed around these binary and simplistic categories of sex and gender, yet trans lives often do not "fit" into these approaches.

Take for example a trans woman who was once part of gay men's communities. Let us say she acquired HIV while living as a gay man, before transitioning. Now she is dating a trans woman and identifies as a lesbian. Where does she fit in the current HIV-sector structures? And how would a couple consisting of a straight trans man and a straight trans woman fit in HIV-sector structures—would it differ if he has had genital surgery and she has not, and their sexual repertoire regularly includes anal sex? This is not an uncommon challenge in how to incorporate trans communities in HIV work. When TNB2S people are not considered in the development of funding streams, provincial strategies, epidemiological tracking tools, programs, interventions, research projects, or treatment, this has consequences for our health and well-being.

HIV work that is only based on current problematic epidemiological data, and resulting funding constraints and interventions, often conflates and collapses the dimensions of sex and gender (Poteat, German, et al., 2016). Viviane Namaste (2000), a long-time HIV scholar, described this systemic problem as "a defining condition of how transsexuality is managed in culture and institutions, a condition that ultimately inscribes transsexuality as impossible" (pp. 4–5). Moreover, in this context and from the early days of the AIDS epidemic, trans women and transfeminine people have often been counted as "MSM" in statistics relating to HIV seroconversions and death, and trans men and transmasculine people have often been counted as "women," perpetuating the invisibility and erasure of trans people in the HIV epidemics. This erasure of bodies and identities is a source of great pain for trans communities, as is the erasure of trans participation in historical accounts of AIDS activism, which also erases women, racialized, Black, and Indigenous people, among others (Gossett, 2014).

3.3 Gaps in information

A lack of funded research done with TNB2S communities as active contributors and investigators has led to gaps in the information that is needed to develop and share effective interventions that are designed or adapted for our communities. With TNB2S people missing from many parts of the HIV response, researchers and HIV activists are increasingly speaking up about the urgency for a more critical approach to epidemiology and criticizing "not only the limitations of categories such as 'MSM' and 'transgender', but also of binary constructions of both gender and sex that render intersex and non-binary gender identities relatively invisible at this stage in HIV research and response" (Perez-Brumer et al., 2016, p. 861; see also Appenroth et al., 2021; Perez-Brumer et al., 2018). For example, little is known about PrEP efficacy in trans men who use their front hole (internal genitals) for receptive sex, which physical barriers are safe and comfortable to use after phalloplasty, or how genital surgery might increase (or reduce) the likelihood of transmitting certain STIs. Do hormones affect how sensitive genital tissues are to microtearing in trans women who have or have not had a vaginoplasty? Does it change depending on surgical technique? What impact does tucking[3] have on the likelihood of STI transmission?

Given this context, TNB2S people, as well as cis people who are sexual partners and allies of TNB2S people, are left with many questions and little resources that provide accurate, up to date, and culturally sensitive information for us to look after ourselves and each other with regards to HIV and other areas of sexual health.

3.4 Unmet health care needs

Trans people experience high rates of unmet health care needs and health care avoidance as compared with the general population, which has implications for HIV prevention, treatment, and care as well as for trans people's health and wellbeing more broadly. For TNB2S people, health care avoidance in particular has been linked with anticipation of discrimination from health care providers (Kcomt et al., 2020).

Trans PULSE Canada found that 45% of trans people have had an unmet health care need in the past year—a rate that is 10 times that of Canada's general population. Notably, 47% of all Trans PULSE respondents reported not yet having accessed all the transition-related medical care they need (The Trans PULSE Canada Team, 2020). A slightly smaller proportion of trans people than the general population have a primary care provider (81%, compared with 84% of the general population). Furthermore, rates of health care avoidance are high among trans people: 12% of trans people avoided going to an emergency department in the past year despite having an urgent health care need (The Trans PULSE Canada Team, 2020). An analysis of trans sex workers who responded to the Trans PULSE Canada survey found even greater disparities: 63% had unmet health care needs, only 74% had a primary care provider, and 20% avoided going to an emergency department even when needed (Arps et al., 2021).

Rates of unmet health needs are similarly high for trans youth in Canada. According to the 2020 Canadian Trans Youth Health Survey, in the past year, almost half (43%) did not receive physical health care when it was needed, and almost three quarters (71%) did not receive mental health care when it was needed. The primary reasons for trans youth not accessing health care when needed were:

- They thought or hoped the problem would go away (75% for a physical health concern and 62% for a mental health concern).
- They were afraid of what the doctor would say or do (51% for both physical and mental health concerns).
- They had had a negative past experience in health care (48% for physical health concerns and 49% for mental health concerns).

Furthermore, trans youth have lower rates of having a family doctor or nurse practitioner (78%) than trans adults responding to the Trans PULSE survey, and 34% of trans youth access walkin clinics as their main source of primary health care (Taylor et al., 2020).

[3]Tucking is the process of intentionally shifting or compressing the external genitals to achieve a flatter outer surface. Frequent compressing of genitals for extended periods of time can cause skin irritation and urinary tract infections.

3.5 Social determinants of health

Structural discrimination impacts trans people across all the social determinants of health. However, the impact of this discrimination may be most visible in the poverty levels that affect trans people and communities. In Canada, while trans and non-binary people who participated in the 2019 Trans PULSE Canada survey were highly educated (about half had a college or university degree and about 20% had completed a graduate or professional degree), unemployment and poverty rates were high. Among trans people 25 and older, just over 2 in 5 were employed in permanent full-time roles, and a similar number (just under 2 in 5) had employment that was structured in a manner other than permanent full-time (e.g., part-time, casual, full-time but not permanent, etc.). Moreover, 16% were not employed or on leave (The Trans PULSE Canada Team, 2020).

While 11% of participants in the Trans PULSE Canada study reported personal incomes over $80,000 in 2019, many other participants were poor. Over a quarter (26%) had incomes under $15,000 per year, and a total of 50% had incomes under $30,000 per year, while the average income for Canadians in 2019 was $49,000 (Statistics Canada, 2016). Moreover, of adults 25 and over, 40% lived in low-income households, as compared with 11.6% of all Canadian adults between the ages of 18 to 64 (Statistics Canada, 2015). In the context of high rates of poverty and barriers to employment, about 10% of trans people experienced housing insecurity, and 15% experienced at least one form of food insecurity (The Trans PULSE Canada Team, 2020).

The Trans PULSE Canada study also found that a large proportion of trans people had experienced harassment or violence in the past 5 years, with the most frequently reported experiences of harassment being verbal harassment (68%), sexual harassment (42%), and physical intimidation or threats (37%). Notably, over 1 in 4 trans people had experienced a sexual assault in the past 5 years. In this context of violence, it is not surprising that 64% of trans people avoided three or more types of public spaces (The Trans PULSE Canada Team, 2020).

3.6 HIV monitoring in Ontario's trans populations

For the Ontario HIV sector to integrate and embed trans inclusion at all levels, we must have a clearer portrait of trans populations' current vulnerabilities to HIV and associated syndemic factors. Although epidemiological data collection for trans Ontarians—and trans people globally—is incomplete at best, a recent meta-analysis in the US found that the overall laboratory-confirmed estimated prevalence of HIV infection was about 9.2% for trans people (14.1% for trans women, 3.2% for trans men) (Becasen et al., 2019). Other reports show trans people worldwide having an estimated prevalence of 19.1% (Baral et al., 2013), while some reports go all the way up to 40% for laboratory-verified HIV status (Poteat, Scheim, et al., 2016). A recent Ontario study that analyzed data from trans people attending a trans clinic with an age-matched random sample of the Ontario population found an HIV prevalence 16 times higher for trans populations compared to the general population: 1.6% compared with 0.1% (Abramovich et al., 2020). Although incomplete, this data helps us to see the need for further resources for trans people in the HIV sector.

Currently in Ontario, we lack HIV monitoring data for trans populations, including information on HIV prevalence and testing behaviours. Both trans men who have sex with cis men and at-risk trans women are named as priority populations in various provincial strategic documents, including the current provincial HIV strategy (Ontario Advisory Committee on HIV/AIDS, 2017). However, current siloing makes it difficult to monitor HIV prevalence, HIV prevention and treatment uptake, and existing interventions for trans people. The current Ontario HIV strategy recognizes the need to focus efforts on meaningful involvement with populations that are living with and affected by HIV:

> We will engage people living with and at risk of HIV in developing and delivering services … on the greater and more meaningful involvement of people living with and at risk of HIV. By recognizing and including the full lived experience of people, we foster a more effective response and a more supportive society. (Ontario Advisory Committee on HIV/AIDS, 2017, p. 20)

Although non-binary people are mentioned in the document, the current HIV provincial strategy only includes trans men and trans women within existing priority populations (i.e., "men who have sex with men" and "at-risk women") (Ontario Advisory Committee on HIV/AIDS, 2017). Moreover, despite the higher HIV prevalence for trans people compared to the general population in Ontario, we still know little about the context in which trans Ontarians acquire HIV, or which interventions are best suited for these populations. Currently, a common assumption is that both trans

men and trans women who have sex with men (cis and/or trans men) have similar trajectories and social contexts as their cis counterparts. This assumption is incorrect and it does not account for how trans people—and, moreover, non-binary people—navigate health care, drug use, and sexual cultures in ways that can differ from cis people. This assumption can also impact on decisionmaking in the HIV sector in relation to policy, funding, and programming.

At the time this report was written, there were still no HIV monitoring data available on trans people, although the Ontario HIV Epidemiology and Surveillance Initiative (2020) did indicate some steps to address these gaps in their 2018 surveillance report: "As of February 2018, the HIV test requisition form also collects information on race/ethnicity, country of birth, transgender identity and PrEP status" (p. 42). Although this change deserves to be celebrated as a demonstration of a commitment to include trans people in the Ontario HIV response, it is important to note that the HIV test requisition form is completed by health providers, who may not ask for this information, and it does not include the option to identify as non-binary (Public Health Ontario, 2018). These forms measure data related to trans identities by asking providers to check boxes from the following options: F, M, TF*, and TM*, followed by the description "TF = transfemale (M to F); TM = transmale (F to M)." In addition to these options, the first two risk factors listed on the form, "Sex with women" and "Sex with men," currently do not address trans populations' contexts. This wording excludes non-binary individuals and may miss important information in reporting risk—for example, in the case of a cis person who, during pre-test counselling with a provider, is reporting condomless sex with a non-binary person, or with a woman or man who happened to be trans.

Although beyond the scope of this project, we feel that a critical and collaborative evaluation of HIV monitoring strategies could help pave the way to better HIV epidemiological data for trans populations. These gaps in monitoring are also reflected in research findings on retrospective cohort studies of people living with HIV in Ontario, as these studies must use available HIV monitoring data which, unfortunately, does not include trans people so far (Wilton et al., 2019).

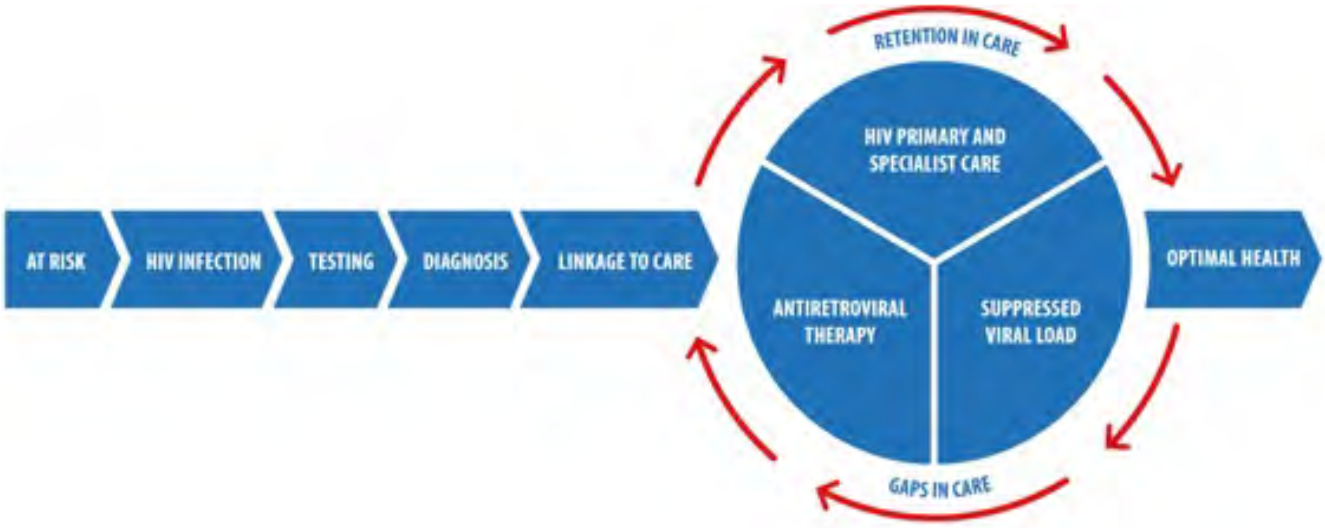
3.7 Engagement in the HIV care cascade

The HIV care cascade, also known as the HIV care continuum, or more recently the HIV prevention, engagement, and care cascade, are all terms used to describe the constellation of opportunities, supports, and services (i.e., care) in the ongoing response to HIV (see Figure 31). This model describes:

> stages of care that people living with HIV encounter from initial diagnosis through antiretroviral treatment and viral suppression. By measuring how many people reach each stage, how quickly they are doing so, and whether or not they are able to maintain improved health measures, the cascade assesses how well care systems are operating. … It can also be used to compare the care that different priority populations receive to identify gaps that disproportionate [sic] affect specific populations (Ontario HIV Treatment Network, n.d.-a).

For trans populations to be fully engaged in this cascade, we must be included, integrated, and embedded at each point. However, we know this is not currently the case. Despite efforts from trans communities and allies, evidence shows that trans people are finding it difficult to find care at each step of the cascade (Lacombe-Duncan et al., 2019, 2022; Rich et al., 2017; Scheim & Travers, 2017).

Figure 3-1: The HIV care cascade



Source: Ontario HIV Epidemiology and Surveillance Initiative (n.d.). Used with permission.

Lack of engagement along the HIV cascade care continuum has consequences on trans people's health. However, this is not only because of discrimination against trans people in the HIV sector: It is related to the systemic erasure of and discrimination against trans people in society overall. Research has increasingly made the case for HIV interventions to address structural and social marginalization of trans people (Lacombe-Duncan et al., 2021), and for these interventions to be seen as an integral part of the HIV care cascade. For example, researchers have recommended initiatives that reduce the stigma that trans people experience, noting that these initiatives may increase engagement in the HIV care cascade (Canoy et al., 2019).

As noted in section 3.4, negative experiences and anticipation of discrimination lead to health care avoidance and poor health outcomes. Gaps in information make it difficult for trans people to make informed choices about our health, including choices about HIV and other areas of our sexual health (see section 3.3). It is not easy to determine which prevention strategies are best adapted to an individual—whether the focus of these strategies is physical (e.g., condoms, dams), pharmaceutical (e.g., PrEP, PEP, TasP), or behavioural (e.g., adapting sexual practices)—when risk assessment models and information resources do not include trans people (see section 3.6).

In terms of testing, there are some barriers that are unique to trans populations and go beyond administrative forms of discrimination (e.g., misgendering via forms and administrative processes). Many trans people fear getting tested as they are under the impression that HIV-positive people cannot access transition-related surgeries or hormones, including in Canada (Lacombe-Duncan et al., 2019). This myth circulates both in trans communities and in health care settings, as noted by one service provider quoted in Munro et al. (2017):

> There's a myth that exists, that trans people can't access hormones or surgery if they are HIV positive. And they are often told this by doctors, which is not true. Even if you are on HIV medication, there are still ways of being on estrogen or testosterone. Personally, I think this is part of what discourages a lot of trans people from getting tested. (p. 714)

We know that in Canada, trans women who have an HIV diagnosis are less likely to be engaged in care, compared to cis women. A cohort study found that 8.3% of trans women living with HIV have never accessed HIV-related care, compared to 2.6% of cis women in the same situation (Persad, 2016). Many trans people also have concerns about the compatibility of transition-related hormone use and HIV medication, including in prevention technologies such as PrEP.

Awareness of these gaps in information and services should not only be seen as a barrier, but as an opportunity: We can leverage what we know about trans communities' access needs, current gaps in services, and natural social and support networks to better engage trans people in HIV prevention, treatment, and care. In fact, leaning

into trans people's current social and health needs has been described as an effective, appropriate strategy to engage trans populations in the HIV care cascade: "Access to gender-affirming health care is a priority for trans communities. Where trans communities are highly networked, these networks may provide a strong infrastructure for disseminating HIV innovations and reaching individuals who are not engaged in HIV services" (Poteat et al., 2019).

In recent years, the HIV sector in Ontario has increasingly been responding to calls by trans communities for more engagement. Research findings and community advocacy have helped to identify and document gaps in supports and services for trans people across the HIV care cascade. In response, trans communities, frontline workers, management, and HIV-sector leadership have been looking for ways to increase capacity to serve trans and non-binary people. Important steps toward trans inclusion have been taken and we are witnessing an exciting shift toward meaningful engagement of trans populations.

This brings some challenges. For example, how might gendered PPNs and programs best serve trans and non-binary people who may (or may not) identify with binary genders? How can we ensure that trans men, trans women, and non-binary populations are not excluded, given rigid gender silos? In the current context of HIV in Ontario and the scope of GMSH's work, the Trans Interweaving Project wanted to explicitly and intentionally disrupt the gendered silos that at times make categories of "gay" or "MSM" HIV work ineffective and perhaps irrelevant for TNB2S people. We aimed to acknowledge the work that the GMSH is currently mandated to do, as well as the combination of overlap and gaps between categories currently used to separate "at-risk" or "priority" populations.

Trans people may have identities, identification documents, sexual behaviours, or biomedical realities that do not fit in the current ciscentric HIV response. For this reason, GMSH supported the Trans Interweaving Project as we explored their work beyond simplistic categories of "MSM" and "gay men," and intentionally included people who might consider themselves to be connected to, belonging in, or participating in gay men's communities and sexual cultures in the past or present.

We … intentionally included people who might consider themselves to be connected to, belonging in, or participating in gay men's communities and sexual cultures in the past or present.

Methodology and Participants

4. Methodology

Among the topics in this chapter, we describe the methods that we used to collect data, and how we analyzed this data. We provide sufficient detail to support other projects that may wish to take a similar approach.

Below, we describe the rationale for and key elements of our methodology. In this project, we collected data via the following methods, listed below in the order they were conducted:

- A website and strategic plan review (see section 4.3.1).
- Focus groups and interviews (see section 4.3.2).
- A deliberative dialogue (see section 4.3.3).

4.1 Rationale

As discussed in sections 2.4 and 2.4.1, trans inclusion and integration work needs to be collaborative, community-based, empowering and pragmatic, so we opted for a participatory and community-based framework. This framework is defined as:

> A collaborative approach to research that involves all stakeholders throughout the research process, from establishing the research question, to developing data collection tools, to analysis and dissemination of findings. It is a research framework that aims to address the practical concerns of people in a community and fundamentally changes the roles of researcher and who is being researched. The CBPAR [Community Based Participatory Action Research] framework begins with a community's issue, proposed action, or strategy and then supports or enhances this action with research that is community based and engaged. (Community Research Lab, 2011, p. 5)

We needed to use methods that worked for trans communities and the HIV sector. These methods needed to enable GMSH and other HIV-sector organizations—as well as HIV-sector staff and members of trans communities—to take action now toward trans inclusion. We know there is a lot to be done and many barriers to trans inclusion and integration. We wanted to focus on what was being done, what worked, and what opportunities for action would make the biggest difference. We wanted to leverage the strengths of trans communities and the HIV sector, instead of focusing on deficits.

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It is from this perspective that our objectives, procedures to protect confidentiality and privacy, interview methods and questions, and analysis were structured. At each phase of the project, methods were reviewed by our advisory committee, our project team, and by GMSH staff through an iterative process of consultation and deliberation (see section 2.4.1). We used preliminary findings from each phase to inform the next.

Note that this project took place during 2020, in the first few months of the COVID19 pandemic. This context also shaped our approach—for instance, we conducted all discussions virtually.

4.2 Protecting confidentiality and anonymity

As trans and HIV-positive people might have previously experienced discrimination through nonconsensual disclosures, we sought to safeguard participants' information by implementing robust procedures relating to data storage, confidentiality, and privacy, and to earn trust through transparency about these safeguards. The steps we took to protect participants' data, confidentiality, and privacy included the following:

- Only the external project team (not GMSH staff) had access to raw data.
- Participant information such as names, contact information, audio recordings, transcripts, coding, and any other identifying information was stored on Canadian-hosted cloud servers from a paid account that is the property of the project lead.
- Confirmed participants were assigned an alphanumeric code to create anonymity even within the project team.[4]
- Only two project team members had regular access to screening data.
- Information about participants was shared within the project team on a need-to-know basis.

4.3 Data collection methods

Our data collection methods comprised a website and strategic plan review and three types of online discussions, as detailed below in Table 41. These data collection methods were supplemented by a sociodemographic survey sent to participants in the discussions. This survey was intended as a measure of accountability to ensure participation from priority trans populations (see chapter 7) as a complement to screening interviews. The survey was not intended to be a quantitative research tool, and so is not described in depth in this chapter. For a discussion of the survey results, see chapter 5.

Table 4-1: Data collection methods and participants

4 In this report, we have used these alphanumeric codes when directly quoting participants.

Data collection method	HIV sector perspective	TNB2S community perspective	Combined HIV-sector and TNB2S community perspectives
Website and strategic plan review	34 websites and 15 strategic plans of GMSH Alliance member agencies and related organizations	N/A	N/A
Focus groups	2 groups for GMSH Alliance-linked frontline staff 1 group with GMSH staff	1 Indigenous group 1 non-binary AMABa group 1 racialized/BIPOCb group 1 sex workers group 2 "open" TNB2S groups	1 trans frontline staff group 1 Primed project team group 1 francophone group
Interviews	4 individual or paired interviews with HIV-sector management (6 representatives interviewed)	4 HIV-positive TNB2S people	N/A
Deliberative dialogue	N/A	N/A	Two afternoons of strategic dialoguing and prioritizing with a mix of HIV-sector stakeholders, TNB2S community members, and other professionals connected to the HIV sector. A total of 52 participants attended one or both afternoons; some participants had also been involved in other elements of the project (e.g., interviews or focus groups, on the advisory committee).

a **AMAB** = Assigned male at birth.

b **BIPOC** = Black, Indigenous, and people of colour.

We discuss each data collection method below.

4.3.1 Website and strategic plan review

For many trans people, websites are not only the front face of organizations, but the primary method through which they seek out resources, programming, as well as information on testing, sexual health, and HIV. Online resources are especially important for trans people who are not comfortable accessing services in person and/or who might wish to restrict who knows they are trans. Websites can be helpful for trans people to make an educated guess about how knowledgeable or inclusive an agency might be in serving trans people.

One of the first steps of the Trans Interweaving Project was to review websites and—where available online—strategic plans of GMSH Alliance member agencies and a few select agencies connected with the HIV and sexual health sectors in Ontario. The sample of reviewed material included a total of 34 websites for:

- 29 HIV, health, and social service organizations (all receiving HIV funding)
- 3 provincial PPNs
- 1 large-scale provincial knowledge transfer and exchange campaign aimed at men, cis and trans, who are GBQMSM (gay, bisexual, queer, men who have sex with men)
- 1 pan-Canadian knowledge transfer and exchange focused organization.

Private clinics that offered HIV testing, treatment, and care, along with HIV service organizations that were not funded to provide services to MSM, were considered outside of the scope of this review, given the project objectives.

Our goal was to develop a general sense of the current state of trans inclusion and integration in HIV-sector organizations, whether it be through programming, organizational mandate, or leadership. The website and strategic plan review also helped us to develop data collection tools (i.e., interview and focus group guides) and deepen our understanding of the diversity of trans inclusion practices.

Within the sample, we identified four websites that were completely or partially available in French, and were connected to the HIV sector (i.e., ASOs, clinics for testing and treatment of STIs, health and social service organizations providing HIV-related services). Websites in our sample also included ethnoculturally specific agencies.

The project team used a shared spreadsheet to collaboratively track general and trans-related content in each of the sampled websites, as well as the 15 strategic plans that were available on these websites. To find trans content on websites and in strategic plans, we used the "site:[website address]" function of the Google search engine, followed by common terms such as "trans," "transgender," "binary" (to capture multiple spellings of "non-binary"), "trans man," "trans woman," and "Two-Spirit." We also used the website's search function when available and checked the "About us" web pages or similar sections with organizational information. To track transinclusive content within GMSH's five strategic priority areas, we searched for terms such as "PrEP," "PEP," "harm reduction," "outreach," "testing," and "sexual health." We also took note of any explicitly transinclusive imagery such as trans flags, colours, symbols, and other visuals that might indicate trans inclusion.

Although several strategies might be used by agencies to indicate trans inclusion, we specifically sought examples of trans inclusion in the following areas:

- organizational structures and strategic direction, including in strategic plans
- leadership, governance, and engagement structures (e.g., boards, staff, advisory committees)
- commitments to GIPA/MEPA principles in trans inclusion work (i.e., centring trans people living with HIV when doing HIV-sector work with trans populations)
- overall inclusivity of language in both English and French (i.e., trans-inclusive tone, terms, and stories)
- commitment to cultural inclusivity and antiracism in trans inclusion work
- programming and GMSH's five strategic priority areas (i.e., testing, PrEP/PEP, online outreach, sexual health information, and harm reduction)

- resources and external links listed on websites
- visuals (e.g., images, posters, symbols).

The review process provided the project team with useful information, but this method had some limits. We know that there is a lot of good work, and some barriers, that were not captured by this exercise. The website and strategic plan review only provided a snapshot in time. Not all strategic plans may be publicly available on websites. Websites may not be fully up to date, may not reflect short-term initiatives, or all trans work, due to constraints on financial and human resources. Trans inclusion on websites may also depend on factors such as the level of awareness of the staff involved in creating content, translating content, or updating the website.

For a summary of our overall findings for the website and strategic plan review, see chapter 6.

4.3.2 Focus groups and interviews

Following the website and strategic plan review, we prepared for the 12 focus groups and 8 interviews with stakeholders. We aimed to centre the experiences of trans people, especially those who are less likely to be included in "trans work" (e.g., Black people, Indigenous people, people of colour, francophones, sex workers, people living with HIV, etc.). We also sought to include perspectives of cis and trans HIV-sector employees and management in identifying opportunities for change.

Running virtual focus groups enabled us to achieve COVIDsafe participation from people across the province. An unexpected advantage was that at times the groups provided opportunities for participants to be reminded of our collective power and commitment to collaboration at a time when many of us felt quite powerless and isolated, due to being in the first few months of the COVID19 pandemic. However, virtual groups created limitations in engaging trans people who were not comfortable with online methods or who did not have internet access.

Promotion, recruitment, and screening

The project team developed a recruitment plan grounded in the project objectives, the website and strategic plan review, and the team's experience with the HIV sector and trans communities; the final plan also incorporated feedback from the advisory committee. We created written materials to inform community members about the project, and had them translated and edited by TNB2S and allied translators who were familiar with language used in francophone trans communities. To attract participation from sex workers, Indigenous and racialized people, francophones, and non-binary AMAB people, we developed and circulated focused recruitment materials.

Before recruitment began, GMSH promoted the Trans Interweaving Project on various virtual platforms (e.g., Facebook, Instagram, TrafficJunky, and Twitter). GMSH also emailed information about the project to its contacts at GMSH Alliance member agencies and other ASOs.

GMSH included a web page about the project, in both English (gmsh.ca/tip) and French (gmsh.ca/tip/fr), on the GMSH website to describe the project's purpose and goals, and to keep people informed on project news. We provided information on the project team members and a detailed Frequently Asked Questions document to build transparency and trust.

We engaged in two streams of recruitment activities: one addressed opportunities to participate from an HIV-sector perspective (e.g., frontline staff, resource development committee members); the other stream addressed trans community perspectives. We recognized that these categories are not mutually exclusive; some of the participants in the "trans community-centred" focus groups had experience working or volunteering in the HIV sector. In this report, we refer to "HIV-sector perspective" and "trans community perspective" in our methods to describe the focus of the conversation, not necessarily the makeup of the participants.

We reached out to our networks, emailed trans and LGBTQ2S-focused groups and organizations, and a range of other organizations that had connections with trans and Two-Spirit communities—including

primary care and mental health focused organizations—in addition to HIV-sector organizations. We asked participants to encourage other TNB2S people they know to participate (also known as snowball sampling). HIV-sector staff were recruited via GMSH as well as through the project team's professional and personal networks. The advisory committee assisted in disseminating calls for participants.

TNB2S community members were asked to complete an online form to express interest in participating. This form explained the project objectives and interview methods (focus groups, and for HIV-positive trans people, the option of participating in an individual interview), and collected some sociodemographic and experience-based information. Our goal was to gather a pool of diverse participants that would allow us to paint a more realistic picture of what trans inclusion and integration might look like. As our communities are often interconnected, this form also listed the project team members by name to support potential participants in making informed choices about sharing information with fellow TNB2S community members.

Upon the recommendation of the advisory committee, we lowered the age threshold for participants from 18 years old to 16 years old. We initially planned a youth focus group, but young participants (under 20) chose to participate in other focus groups. We did not have the time or capacity to meet another advisory committee recommendation, which was to recruit and interview cis men who hook up with trans people; this would be a valuable future initiative.

We scheduled short introductory Zoom-based calls with potential trans community participants to support informed consent, clarify expectations, match people with focus groups that might suit them (recognizing that some people were eligible to attend multiple focus groups), and discuss any accessibility needs. This approach helped participants to develop some familiarity with the Zoom videoconferencing platform that was used for the focus groups and interviews. As to be expected with any community consultation, not all people who expressed interest ended up participating. As the consultations were occurring during the first 6 months of the COVID19 pandemic, the broader social context may have also been a factor.

Prospective participants were informed that compensation would be provided via prepaid credit card (mailed or emailed) once they had participated in a focus group or interview. We did not offer a gift card to sector employees if they participated during paid work time.

Confirmed participants were sent electronic consent and confidentiality forms (available in English and French), outlining the strict data storage and confidentiality practices noted in section 4.2.

Conduct of focus groups and interviews

Our first round of conversations was with people closely connected to GMSH, including GMSH Alliance-linked frontline staff, HIV-sector management, the Primed project team, and GMSH staff. Most of these conversations were held as focus groups, with the conversations that were run as interviews noted below.

We ran a separate focus group with trans frontline staff who worked at ASOs to allow these staff members to speak openly about their experiences in the sector, without feeling constrained by the presence of cis colleagues. Trans staff were also present in several other focus groups. Additionally, we invited key members of management at GMSH Alliance member agencies to participate in an interview; in two cases, an interviewee invited a colleague from their organization to join their interview.

In the trans community perspective stream, we offered trans people living with HIV the choice of either participating in an interview or in a focus group, to ensure they had choice in what they shared and with whom. We sent information packets with discussion questions to participants in focus groups and interviews ahead of time. Participants in trans community focus groups were also given guidelines on participating from a trauma-informed perspective, with an intent of both self-care and being mindful of other participants.

The majority of focus groups and interviews had at least two project team members present, one to facilitate and one to take detailed notes. To support transparency and trust, the note-taker shared their screen so all participants could read the notes as they were taken. Focus groups typically lasted from 90 to 120 minutes, whereas interviews typically lasted from 45 minutes to an hour. To support the note-taker, we audio-recorded on Zoom all interviews and focus groups, where we received unanimous consent from all participants). Interviews with HIV-sector

management and trans community members living with HIV, as well as HIV-sector focus groups, followed a semi-structured interview guide adapted to these populations. Trans community focus groups used photo elicitation as a visual support for questions. For each population-specific focus group, we endeavoured to schedule two project team members who had identities that matched with the focus group to facilitate and take notes (e.g., people of colour facilitated and took notes for the racialized trans people focus group and white team members were not present). The Indigenous focus group and the francophone focus group were exceptions to the norms of having two project team members present. As we did not have an Indigenous person as part of the project team, nor did the project team include two people fluent in French, we hired an Indigenous facilitator for the Indigenous focus group, and a racialized francophone facilitator for the francophone focus group. We did not offer interpretation services in oral or signed languages, nor were their requests; we recognize this may have been a barrier to some.

After the interviews and focus groups, we sent each participant a copy of their electronically submitted consent forms, a resource sheet (including information in English or French about mental health support resources and transition-related supports), the sociodemographic survey (which could be completed in either English or French), and payment.

4.3.3 Deliberative dialogue

To determine what would make the most difference toward trans inclusion in the Ontario HIV sector and beyond, we organized a deliberative dialogue that took place in four-hour blocks on two afternoons, to identify strategic priorities with decision-makers, advisory committee members, and key informants working in sexual health, policy, funding agencies, trans health, and other activities closely related to our objectives. Each session was designed to engage leaders in the HIV sector and other key stakeholders in translating preliminary findings and ideas into impactful and strategic action.

We used preliminary findings from the focus groups and interviews to develop an initial list of priorities and recommendations. We then adapted these findings into a document to be used during the deliberative dialogue and pre-circulated this document.

Prior to the dialogue, the project team recorded a short webinar to provide participants with a brief overview of the project and contemporary issues concerning trans inclusion in Ontario's HIV sector. An external facilitator who identified as trans and non-binary was hired to lead activities for the deliberative dialogue so that the GMSH and Trans Interweaving Project team members could participate, document, and respond to the emerging conversations. We included facilitated activities to encourage collaboration, creative solutions, and to reduce the fatigue often experienced in virtual conferences.

The sociodemographic survey developed for participants in focus groups and interviews was modified for participants in the deliberative dialogue and sent after the second session of the deliberative dialogue. This survey was also intended simply to make visible the demographics of participants, rather than for use as a research tool.

4.4 Coding and analysis

The project team members coded, analyzed, and interpreted the data. We coded the detailed notes from the interviews and focus groups using LiGRE, Canadian qualitative data analysis software that is hosted on secure servers.

We then reviewed all the detailed notes from the focus groups and interviews, as well as the notes from the deliberative dialogue. As part of this process, we recorded actions that:

- were explicitly mentioned to address underlying issues that participants raised
- could be taken to address issues raised in relation to participants' remarks.

This reviewing step contributed to the development of our recommendations (see chapter 11).

When we had prepared preliminary analyses and drafted relevant sections of this report, we invited the external facilitators of the Indigenous and francophone focus groups to contribute to our analysis and interpretation.

Four areas of analysis: Inclusion indicators, strengths, barriers, and recommendations

Early in our analysis, four high-level codes emerged:

- **Inclusion indicators**: what would be seen if trans inclusion and integration were embedded in the HIV sector.
- **Strengths:** good work that is already being done to advance trans inclusion and integration in the HIV sector.
- **Barriers:** obstacles and challenges to trans inclusion and integration.
- **Recommendations:** concrete actions for GMSH, HIV-sector organizations, and Indigenous organizations.

As well as using these codes to analyze our data, we have devoted a chapter in this report to each area of analysis (see chapters 8 to 11).

Five trans priority populations

The project team approached the analysis first by considering the responses as a whole, and then engaging in focused explorations regarding five trans populations that we consider priority populations: **Indigenous people, francophones, racialized people, migrants, and sex workers.**

In these focused explorations, we looked for the inclusion indicators, strengths, barriers, and recommendations that were unique to each population, as well as nuances regarding indicators that were raised across multiple groups. For findings that are specific to the five priority populations, see chapter 7.

5. Sociodemographic data

This chapter presents demographic information on the focus group and interview participants who completed an online sociodemographic survey.

This project consulted with people across a breadth of identities, roles, and types of connection with the HIV sector (e.g., service users, service providers). A total of 114 people participated in at least one of the data-gathering activities of this project. At least 56 of these people identified as trans and/or non-binary and/or Two-Spirit; we determined this by counting up all individuals who either participated in an interview or focus group for TNB2S people, or disclosed their TNB2S identity in a focus group for HIV-sector providers.

As mentioned in the previous chapter, we sent an online sociodemographic survey in English and French to all participants in focus groups and interviews.[5] Below, we present some broad demographic information on the full sample of respondents to this survey, followed by sociodemographic information on the TNB2S survey respondents.

5.1 Demographics of the survey respondents

Of the 76 people who received the survey, 47 completed it (a 62% completion rate). To protect participant anonymity and to avoid repeated participant responses, we made the decision to only send the survey once. All answers were anonymized and we could not track who had completed the survey.

Most of the survey respondents identified their age as being between 26 and 45 (62%), with some respondents aged between 16 and 25 (17%) and between 46 to 55 (15%). Only three survey respondents reported being over 56 (6%).

About half (49%) of the respondents lived in the Greater Toronto Area, and almost a quarter (23%) lived in Eastern Ontario. A few respondents lived in Western Ontario (13%), and a small number in Central (6%) or Northern Ontario (6%). One respondent was living in Quebec but accessing services and/or community or working in Ontario.

Almost all respondents spoke English (98%) and nearly a quarter spoke French (23%). Several people spoke another language besides English or French (19%), and two respondents signed in American Signed Language or Langue des signes québécoise.

5.2 Sociodemographics of the TNB2S survey respondents

Over the next seven subsections, we outline the sociodemographics of the TNB2S people who responded to the survey.

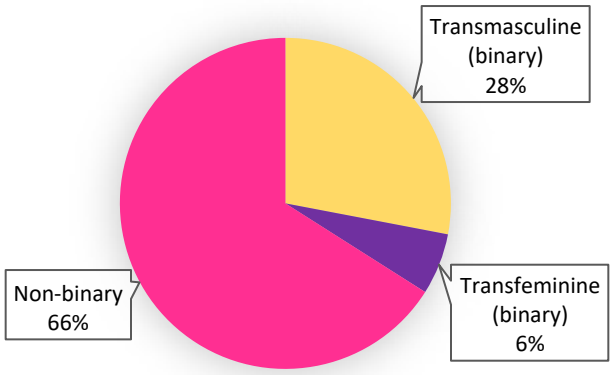
5.2.1 Gender identity and intersex status

TNB2S people who participated in this project identified themselves using a variety of terms. The project focused on TNB2S people connected to gay men's social and sexual spaces, and although it included trans women and transfeminine non-binary people, there were comparatively more trans respondents identifying as trans men, FTM, men of trans experience, or men (see Figure 51). Additionally, although self-described trans women were present in several focus groups and interviews as noted by our team, few survey respondents identified as such.

Respondents could select more than one option for their current gender identity. Grouping answers together, we found that about 34% of TNB2S respondents appeared to have binary identities (e.g., trans man or trans woman, transgender man or transgender woman, or transsexual man or transsexual woman, MTF, or FTM, or simply man or woman). About 66% of TNB2S respondents identified as at least one term under the non-binary umbrella (non-binary, genderqueer, agender, etc.). Of the subgroup that have an identity under the non-binary umbrella, 19% specified that they identified as non-binary AMAB, and 19% as non-binary assigned female at birth (AFAB). The remaining 62% of respondents who identified under the non-binary umbrella did not specify their sex assignment at birth as an aspect of their identity.

[5] Although we sent a sociodemographic survey to the deliberative dialogue participants, we chose not to report on the sociodemographic data from this group of participants due to a very low (10%) response rate.

Figure 5-1: Self-identified genders of TNB2S respondents



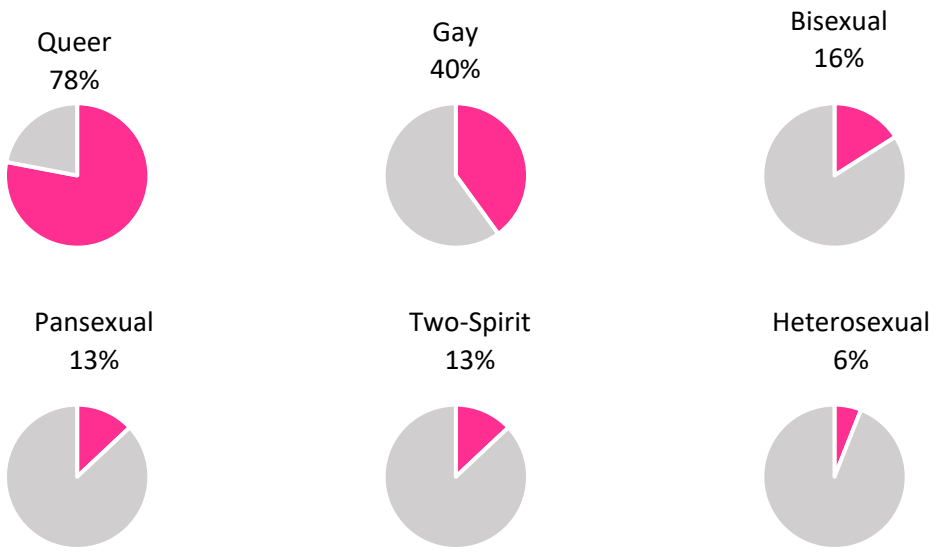
In addition to asking participants about their current gender identity, we asked respondents about their sex assigned at birth, as a way to be clear about the diversity of experiences represented (e.g., intersex people, non-binary people who were AMAB). One person identified as intersex, and two others were unsure whether they were intersex.

Additionally, we asked respondents whether they identified with a "gender identity term that is Indigenous or from a cultural gender minority (e.g., Two-Spirit, stud, agokwe, zom-fam, hijra)." We asked about Two-Spirit and cultural minority identities in not only the gender identity question but also in the sexual orientation question, to make space for looking at sexuality and gender in ways that are not mutually exclusive and hopefully do not flatten diverse experiences outside of mainstream white anglophone identities. All five respondents (16%) who selected this option specified a Two-Spirit identity. No other cultural gender minority terms were described in answer to this question, although some respondents added culturally specific terms later in the survey (e.g., a Black person using the term boi).

5.2.2 Sexual orientation and connection with gay men's social spaces and sexual cultures

TNB2S respondents had a broad range of sexual orientations and connections to gay men's social spaces or sexual cultures (see Figure 52). Again, respondents had the option to select more than one response regarding their sexual orientation. About 40% of TNB2S respondents identified their sexual orientation as gay and 78% as queer. Some identified as bisexual (16%), pansexual (13%), and Two-Spirit (13%). Two (6%) identified as questioning. Two people (6%) identified as heterosexual, although no TNB2S respondents used the term "straight" to describe themselves.

Figure 5-2: Sexual orientation of TNB2S respondents



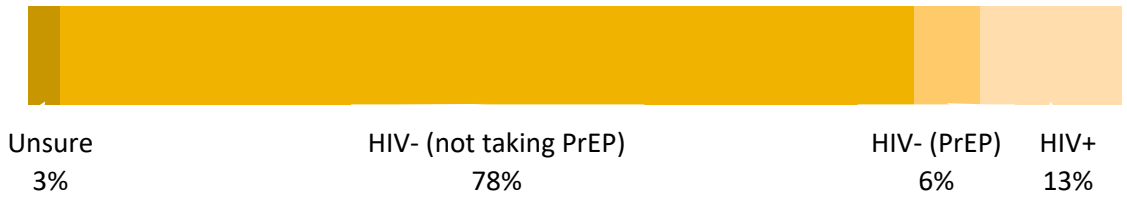
Some TNB2S respondents participated in gay men's social spaces (e.g., book clubs, bars, community centres) often (25%), once in a while (22%), or not as much as they would like (22%). Others had not recently participated in gay men's social spaces (9%), and some had not but would like to (9%). Four respondents had never seen themselves belonging in gay men's social spaces; of these, two had participated in gay men's social spaces, and two had not.

Participation in gay men's sexual cultures (e.g., Grindr, bath houses, leather clubs, PnP) also varied. Some often did (16%), some did occasionally (31%). The rest of the respondents were spread out between not participating in a long time, wanting to participate more, or not being interested.

5.2.3 HIV status and connection to the HIV sector

As reflected in Figure 53, TNB2S respondents included people living with HIV (13%), although most TNB2S respondents were HIV negative (84%), with one person being unsure. All HIV-positive TNB2S respondents reported having an undetectable viral load. Few (6%) TNB2S respondents who were HIV negative were currently taking PrEP.

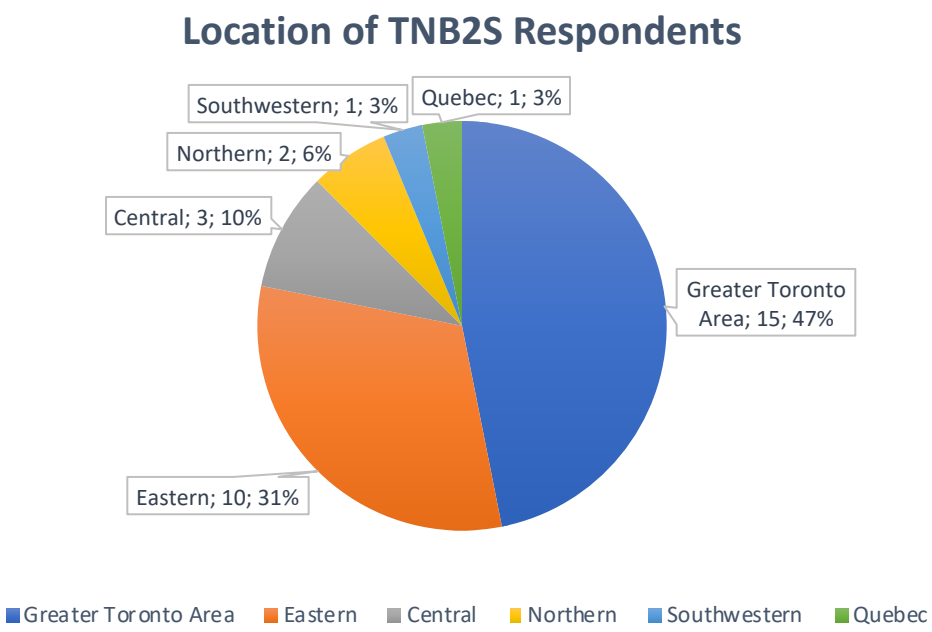
Figure 5-3: HIV status of TNB2S respondents



In relation to accessing ASOs, about half of the TNB2S respondents had done so. While most of this group were HIV negative, all the HIV-positive TNB2S respondents had accessed an ASO, as had 43% of the HIV negative respondents. Several TNB2S respondents (38%) had been frontline providers or program coordinators (28%) in the HIV sector. Many respondents volunteered in the HIV response (41%), and more than half (53%) considered themselves HIV activists. Only three respondents (9%) did not see themselves as connected to the HIV sector. Only one TNB2S respondent had a current or previous senior management role in the HIV sector, and no TNB2S respondents described themselves as clinical staff. One person preferred not to answer.

As reflected in Figure 54, most TNB2S respondents (72%) had to travel less than 10 km to access HIV testing, treatment, support, or sexual health services. They were likely to be living in the Greater Toronto Area (47%), followed by Eastern (31%) and Central (10%) Ontario, with the remainder spread out between Southwestern and Northern Ontario, and one person living outside of Ontario (Quebec). Although there was some regional diversity, 94% of TNB2S respondents lived in large urban areas and 6% in medium population centres; no survey respondents indicated that they lived in a smaller population centre, and only a few participants shared in interviews that they lived in a small population centre.

Figure 5-4: Location of TNB2S respondents



5.2.4 Culture, ethnicity, and country of birth

TNB2S respondents came from a range of backgrounds.

In relation to Indigeneity, 6% of TNB2S respondents identified as members of the Métis Nation, 13% as First Nations, and one person did not know. Most TNB2S respondents did not identify with any of these groups (81%). No respondents identified as Inuk.

- Furthermore, of the TNB2S respondents to the survey:
- 14% described themselves as being Asian Canadian, Asian American, East Asian, Southeast Asian, South Asian, or biracial of Asian descent.
- About 9% were Black Caribbean or Black North American.
- About 6% were West Asian, Middle Eastern, or North African.
- About 9% marked two or more cultural, racial, or ethnic origins, or otherwise described themselves as biracial, multiracial, or mixed.
- About 63% identified as white European and/or white North American, including 9% who also marked an additional cultural, racial, or ethnic origin and/or described themselves as biracial, multiracial or mixed.
- No respondents described themselves as African, Indo-Caribbean, Latina, Latino, or Latinx.

A significant portion (about 25%) of TNB2S respondents were born outside of Canada, all of whom currently had Canadian citizenship or permanent resident status.

5.2.5 Racialization

We asked respondents about their experiences of racialization within a Canadian context, separate from ethnicity and culture. Of the TNB2S respondents, 28% felt they were consistently racialized or perceived as people of colour (not white) and 9% felt that they were sometimes perceived as white and sometimes perceived to be racialized. Some TNB2S respondents indicated being usually perceived as white (6%), despite their ethnicity being more complex. One participant (3%) indicated that they did not know whether they were treated as a racialized person. The majority (54%) of TNB2S respondents were perceived as white and understood themselves to be white, which aligned with the number of TNB2S respondents who solely noted their culture, race, or ethnicity as white European and/or white North American.

Some of the TNB2S respondents reported experiencing anti-Indigenous racism (4%) and anti-Black racism (9%).

5.2.6 Physical, mental, and sensory diversity

We asked respondents a variety of questions around health conditions, disabilities, neurodivergence, and sensory diversity. Notably, 59% of TNB2S respondents described living with a mental illness, 25% had a chronic illness, 22% had chronic pain, 19% had a physical disability, and 13% had a drug or alcohol dependence. Only 16% of TNB2S respondents described themselves as having no disability or condition that impacted their health. Few TNB2S respondents (6%) reported being members of sensory minorities (e.g., Deaf, blind, hard of hearing). Half of TNB2S respondents (50%) described themselves as neurodivergent (e.g., autistic, ADHD), with 6% being unsure.

5.2.7 Additional determinants of health

We asked respondents which type of health insurance they have access to. Of the TNB2S respondents, 94% had OHIP, and a few others were covered through Non-Insured Health Benefits (NIHB) (9%), or—in one case—RAMQ (Quebec). Some TNB2S respondents had additional extended benefits through employment (31%), public programs such as ODB (Ontario Drug Benefit program) and Trillium (9%), or—again, in one case—from their partner or family's insurance.

TNB2S people who answered the survey had various levels of annual personal income before taxes. Many (38%) had incomes of under $20,000. While we did not ask for total household income, this group of respondents might fall below the poverty line, which is based on household size, income, and population size of community or city (Employment and Social Development Canada, 2016). Another 38% had incomes ranging from $20,000 to $50,000, and 13% had an income of $50,000 or more. A few TNB2S respondents (9%) preferred not to answer this question.

Only 9% of TNB2S respondents had not completed some postsecondary education and only 6% of all TNB2S respondents did not have a high school degree. Most TNB2S respondents' highest level of formal education included a postsecondary degree or diploma: 9% graduated from a college or trade school, whereas 50% of TNB2S respondents had a bachelor's degree, and 16% a graduate degree (e.g., a master's degree or PhD).

5.3 Survey limitations

Our survey had a completion rate of 62%, meaning that many focus group and interview participants were not represented in this sociodemographic data. Our sociodemographic survey also did not ask about sex work experience; however, we held a trans sex worker focus group (n = 5), and other participants identified themselves or their partners as having a history of sex work.

Additionally, as noted at the outset of this chapter, this survey was not intended as a quantitative research tool. Finally, percentages are not statistically significant and although we use them in the spirit of transparency, they should not be interpreted as representative of trans populations connected to Ontario's HIV sector.

Findings

6. Findings

Results from the website and strategic plan review

The results from our website and strategic plan review give a broad sense of the current state of trans inclusion and integration in Ontario's HIV-sector organizations.

As mentioned in section 4.3, an early step in the Trans Interweaving Project was to review websites and—where available online—strategic plans for GMSH Alliance member agencies and a few select agencies connected with the HIV and sexual health sectors in Ontario. In total, we reviewed 34 websites; we found 15 strategic plans on these organizations' websites, and we also reviewed these documents.

This chapter addresses content from this website and strategic plan review. The findings, which are divided into two sections, examine:

- overall, whether trans people are being considered in websites and strategic plans
- the extent to which we found indicators of trans inclusion on the websites.

6.1 Are trans people being considered in websites and strategic plans?

6.1.1 Are trans people considered as a potential audience of websites?

Despite several websites providing broad mentions of LGBT (lesbian, gay, bisexual, transgender) inclusion or mentioning trans inclusion via antidiscrimination policies, we found that that the vast majority of websites did not seem to consider trans people as a potential audience. Additionally, with most websites, where trans people were mentioned, it was difficult to determine which parts of trans populations were included. Our findings echo what we heard from participants later in the project: Websites often lack information and resources needed to determine if a service, program, or agency will be inclusive of a diverse range of trans people (see sections 8.2.4 and 9.2.6).

> Websites often lack information and resources needed to determine if a service, program, or agency will be inclusive of a diverse range of trans people.

6.1.2 Are trans and non-binary people mentioned? What parts of trans populations are considered?

As discussed below, several websites did not mention serving trans people as a population and most strategic plans did not name trans populations as an area of focus. Moreover, only a few websites in our sample mentioned serving a range of trans people, including non-binary people.

Websites

Across the websites, several did not explicitly name trans people at all as a population served by the organization via programming, services or campaigns, or resources. Some websites had unclear information, often using a broad mention of "LGBT" without specifying if trans people were included in actuality and not just in an abbreviation. It was also unclear whether trans inclusion was implied when the term "Two-Spirit" was not followed with information specifying if trans or other noncis Indigenous people are welcome. In cases where websites expressed commitment to ending transphobia without mention of trans populations being served, it was still difficult to know who was included in service provision.

From the remaining websites sampled that did name trans people as populations served, there were also some differences in terms of which parts of trans populations were served. A few websites only mentioned inclusion of trans men into men, while a couple of websites specifically limited inclusion to trans women. A few defined inclusion as relating to trans men and trans women (i.e., binary categories only). We recognize that our sample was skewed toward agencies serving "MSM" as per the project objectives. However, trans men, trans women, non-binary people, and Two-Spirit people, as well as our partners, could all potentially need to access resources, services, or programs designed for the broad category of "MSM."

Strategic plans

Out of the available strategic plans, a small minority named trans populations as an area of focus (e.g., "serves the unique needs of trans populations"). Descriptions of who was counted as trans people varied across documents. For example, in strategic plans, we found phrases such as: "Trans, gender nonconforming and non-binary people" and "men, women, female-identified, transgender, non-binary …", and "gay/bi/trans communities." One website included some detailed statements, such as the following:

> For the purposes of this strategic plan, the term "gay men" refers to men (cisgender or transgender) who share a common trait in that they interact with other men sexually and/or romantically. These men may or may not identify as gay, bisexual, queer, Two-Spirit, straight or otherwise.

On rare occasions in the strategic plans, agencies described the impacts of colonialism on gender concepts. Several strategic plans left us unsure whether trans people were included in populations served and/or strategic directions, for the same reasons as listed above: typically, a commitment to ending transphobia or a mention of "LGBT," with no direct mention of trans populations.

6.2 Indicators on websites

Below, we discuss:

- visual indicators
- moving beyond white trans inclusion
- content and language
- resources
- news, announcements, and events
- trans representation at all levels of an organization
- GIPA/MEPA as applied to trans people
- programming and services for trans people
- GMSH's five strategic priority areas.

6.2.1 Visual indicators

Only a minority of websites we reviewed had some type of explicit visual trans inclusion indicator. Out of the few websites with clear positive visual indicators, the most common way to signal trans inclusion was to use a trans flag icon, followed by linking to trans-specific resources or campaigns. Occasionally, websites included videos or photos of trans people as visual supports to trans content or resources.

6.2.2 Moving beyond white trans inclusion

As part of this project, we looked at whether websites were overtly inclusive of Black, Indigenous, and racialized trans people. Some ethnocultural-specific ASOs included images or videos of racialized trans people. Only a few of the websites mentioned trans people from a diversity of ethnocultural groups, and most of these websites were those of ethnocultural-specific ASOs. Of those that did, the most common identities recognized were those of Two-Spirit people, followed by hijra. Websites only rarely recognized trans people in the context of African, Caribbean, and Black trans communities, or trans people of colour broadly. This finding illustrates barriers that may be created virtually as some Indigenous, Black, and racialized trans people may feel unwelcome or unacknowledged without any indications to the contrary.

6.2.3 Content and language

We noted when trans-inclusive and gender-neutral wording or terms were used in content, and for sexual health information that was adapted to trans people, whether that be our bodies, relationships, identities, or experiences. We also looked at whether the terms that were used reflected those that are currently used in trans communities. The question of terminology is complex, as terms have different meanings across time, communities, and generations within those communities, and we do not want to police how trans people self-identify. However, certain terms fall out of favour (e.g., transsexual, FTM, MTF) and might indicate to a trans audience that an organization lacks current knowledge and ongoing connections with trans communities.

Strategies used to signal trans inclusion in content and language mostly related to the use of gender-neutral terminology for bodies, or transspecific terms typically used for body parts that are often gendered (e.g., "front hole" when referring to some transmasculine bodies). While genderneutral language was often used in transspecific sections of websites or within trans resources, most of the sexual health content aimed at both cis and trans audiences still gendered genitals and sexual activities in a way that left little possibility for a trans reader to apply knowledge to themselves. These would have been great opportunities to model the use of accessible, trans-friendly terms for body parts and sexual activities in a way that acknowledges trans people as potential sexual partners deserving of consideration and builds allyship within our communities.

> Most of the sexual health content … gendered genitals and sexual activities in a way that left little possibility for a trans reader to apply knowledge to themselves.

6.2.4 Resources

A few websites hosted or provided links to resources focused on trans populations (e.g., sexual health guides, mental health supports, transition-related health care, etc.), although most did not. When trans-inclusive resources were present, they usually included the Primed guide and/or Brazen, two resources created by and for trans communities with support from HIV-sector organizations. On rare occasions, some websites included video and text content adapted to specific parts of trans communities (e.g., trans women).

6.2.5 News, announcements, and events

On several occasions, we were able to find trans content on websites in the "news" or "announcements" section, or in posts acknowledging specific dates. Trans Day of Remembrance, and associated vigils and other mourning events, were the most common trans events mentioned. Education and skill-building activities related to trans communities were also occasionally present, although these were often intended for a non-trans audience, such as providers. On a few occasions, there was mention of events and learning opportunities for trans people, such as a workshop series for trans women, trans job fairs, and an HIV testing day for trans people, to name a few. Some websites also used the "news" or "announcements" section to promote trans-specific or trans-inclusive services, blogs, resources, or outreach efforts.

6.2.6 Trans representation at all levels of an organization

Effecting trans equity through visible representation is complex, as organizations must also protect individuals' rights to privacy and avoid tokenism, among other challenges. When reviewing the websites, we only looked at trans inclusion in the staffing and governance structures of stand-alone organizations.

Some websites included board members' biographies; mentions of trans self-identification were rare, as were board members noting experience working with trans communities.

Very few websites included staff biographies, and no staff self-disclosed that they were trans. However, one website did include a mention of pronouns, and a staff person at this organization used "they" pronouns. This staff member may or may not be trans and/or non-binary: Pronouns alone do not indicate one's gender identity or trans status. Another site had a staff member share a personal commitment to trans rights and inclusion, which we recorded as an individual display of inclusion beyond organizational policies or culture.

A few agencies noted opportunities for trans people to engage with the organization as contributors—for example, on a consultation basis. Occasionally, organization websites extended invitations for trans communities to inform projects and programming. However, it was unclear whether these were ongoing or one-off opportunities. One website had a clear, ongoing opportunity for **GBQ** (gay, bisexual, queer) trans men to inform strategic planning, in addition to two population-specific advisory groups (trans men and non-binary people, and all trans people affiliated with gay men's communities). According to its website, another organization had partnered with a university on a research project and recruited trans and non-binary participants. On its website, an organization stated that they consulted trans women and non-binary people for resource development. Another organization also recruited participants for projects regarding trans and non-binary people into guys: resource development for trans MSM and a health care needs assessment for trans and non-binary people. Finally, one organization had a broad LGBT advisory opportunity for harm reduction work, but it was unclear if any trans people participated.

In our debriefing, project team members found that a broad range of repeated and ongoing invitations for trans participation at many levels of an agency were likely indicative of a welcoming environment.

The project team also noted that organizations could explore creative means to protect people's privacy while also indicating the presence of trans people in the organization. For instance, organizations might sum up an overall description of the lived experience brought by board and/or staff members in a statement such as:

> Our board members bring a mix of lived, community, and professional experience to the organization. Across the board, some of the lived experience includes …. Some of the community experience includes …. Some of the professional experience includes ….

6.2.7 GIPA/MEPA as applied to trans people

Our team sought out examples from websites about how GIPA/MEPA principles were applied to work with trans people in the HIV sector. It was challenging to identify whether trans people living with HIV were involved and meaningfully engaged within agencies, services, and programs.

We first looked at poz (HIV-positive) programming descriptions to see if trans people were invited to participate in pozcentred spaces. Only on a few occasions were we able to find mentions of HIV-positive trans populations in website content. Occasionally, program descriptions explicitly named that HIV-positive trans people were welcome, sometimes within a broader LGBT umbrella. We saw instances where trans HIV-positive inclusion only mentioned trans women. Notably, we did not find any websites explicitly including non-binary people or trans men living with HIV.

Next, we looked at statements or opportunities related to the importance of trans HIV-positive leadership, involvement, and engagement. Most websites had statements related to the Ontario Accord, and sometimes there was an added description regarding a commitment to equity that rarely named trans people. However, sampled GIPA/MEPA statements also infrequently named other populations. We were unable to find indicators that trans people living with HIV were involved and meaningfully engaged. Given the importance of GIPA/MEPA principles in the HIV sector, our project team was surprised to find little evidence that these principles were applied to work with our communities. This finding also had us questioning the inequities between HIV-positive and HIVnegative trans people involved in the HIV sector as service users, peers, volunteers, and staff.

Given the importance of GIPA/MEPA principles in the HIV sector, our project team was surprised to find little evidence that these principles were applied to work with our communities.

6.2.8 Programming and services for trans people

Almost all organizations in our sample described direct services and programming on their websites. The level of detail provided varied considerably across websites and programs. We reviewed program and service descriptions that were either trans inclusive (aiming to serve both trans and cis people) or trans specific (designed for and offered to trans and non-binary people).

Many agencies did not specify clearly if any of their programs and services were inclusive of trans people. The "trans-inclusive" programs we did find mostly served MSM, while a minority served women, LGBT people of all ages, and youth. Within the MSM programming identified as trans inclusive, the level of access granted to trans men remained unclear. Although some descriptions of MSM programming mentioned serving trans men, we were rarely able to determine if this programming would be inclusive of non-binary people or trans women with a past or present connection to gay men's communities and/or sexual cultures. Some agencies offered multiple programs, with varying degrees of trans-inclusive descriptions for each of them.

A few service agencies offered at least one trans-specific program or service. Some of these were population-specific, including a couple of programs for trans women, others for both trans men and trans women, and some for trans youth. Occasionally, these were open to "all trans people," which may or may not have included non-binary people. Non-binary and Two-Spirit people were rarely named in these program descriptions.

Several websites mentioned programs for trans people that focused on addressing social determinants of health that, although not directly linked to HIV, drive negative health outcomes that lead to or worsen HIVrelated health conditions. These included transspecific programming related to employment, transition support, older LGBTQ+ people, families, and partners of trans people.

Some websites also included mentions of one-time transfocused events or projects such as a national trans testing day, a campaign for racialized trans youth, a trans job fair, and a transmasculine dating event.

6.2.9 GMSH's five strategic priority areas

One of our project objectives (see objective 4, section 2.3) included assessing the state of trans inclusion for GMSH's five strategic priority areas of focus. These priority areas, all focused within the context of gay men's communities, are: testing, PrEP/PEP, online outreach, sexual health information, and harm reduction.

All websites from our sample had details on at least one of GMSH's five priority areas, with some websites having several or all areas present. For each priority area, we looked at whether content on websites was trans inclusive (providing information that explicitly includes trans people) or trans specific (focusing on trans people).

On most websites, we had difficulty finding consistent evidence of trans inclusion in content related to the strategic priority areas, with the exception of online outreach. The degree of inclusion differed, with trans men being mentioned more frequently than trans women. However, non-binary people were usually not named in any of the priority areas.

> Often, it seemed that the information and content … [was] not adapted to trans people's lived experience.

For example, PrEP was only occasionally discussed as it relates to trans people, and these discussions of PrEP only rarely mentioned non-binary people. Sources of information on PrEP typically came from the 2013 edition of Brazen or the 2015 edition of Primed, despite this information no longer being up to date.[6] One website did mention PrEP provider education for staff who work with trans women. Biomedical and access information on PrEP as it relates to trans bodies was rarely mentioned. Often, it seemed that the information and content prepared for cis women or cis men was simply re-used with different words to describe genitals and not adapted to trans people's lived experience. Although this is an attempt at trans inclusion, it does not account for the social and biomedical realities of how trans people have sex.

Few websites with information on harm reduction included mentions of trans people, and those that did mentioned trans women more often than trans men. Online outreach was difficult to measure as many tools are based on apps and were not included on the websites we reviewed. However, we did notice that when mentioned, online outreach tended to most frequently mention trans men, followed by trans women, and only rarely described being of service to non-binary people.

[6] The most recent version of Primed (Gay Men's Sexual Health Alliance, 2020) had not yet been released at the time of the website and strategic plan review.

Finally, website sections that related to testing tended to divide trans men and trans women, which also excluded non-binary people. It is important to remember, once again, that our website and strategic plan review was limited to organizations and campaigns closely connected to GMSH's work. As such, trans women (or any women) were likely to be under-represented.

Overall, we found content relating to GMSH's five priority areas had very limited inclusion of trans people; transinclusive content was largely within materials that seem to have been prepared with cis people in mind. This situation would largely leave trans people wondering whether we can access accurate information, and whether we would be well served, if we were to seek support at most ASOs.

However, a different approach is possible. The most robust example we found of a website that was very clearly trans inclusive:

- explicitly stated that the organization valued "trans and non-binary voices"
- indicated that assessments of trans peoples' needs had not only been done, but described why the work was important
- identified HIV-positive trans women as a priority population
- offered transinclusive and transfocused HIVspecific programming, programming for partners of trans people; and transspecific and transinclusive programming on topics outside of HIV. Posters regarding these groups and initiatives were also available
- included blog posts on topics of relevance to supporting trans people (e.g., importance of respecting pronouns)
- included gender identity in their antiharassment policy
- included materials about transspecific research projects.

7. Trans priority populations in focus

This chapter presents findings that are specific to the five trans priority populations for this project. For each population, we discuss participants' views on what trans inclusion would look like, the good work already being done in this regard, and the barriers still in place.

This chapter focuses on what we heard from—and to a limited extent about—the specific trans priority populations addressed in the Trans Interweaving Project.

The bulk of this chapter presents findings on the five priority populations, each population discussed in turn:

- Indigenous 2STNB[7] (Two-Spirit, trans, and non-binary) people
- trans francophones
- racialized trans people
- trans migrants
- trans sex workers.

Population-specific findings should be considered together with broader sectoral findings

Participants in the consultations that focused on specific populations discussed a mix of population-specific issues and issues facing TNB2S people at large. We advise readers to follow the lead of these participants: Although the specificity and detail of our population-specific findings warrants this separate chapter, readers should consider these findings holistically, in reference to the broader sectoral picture of trans inclusion and integration that we present in chapters 8, 9, and 10. Issues raised in population-specific groups that had some or strong similarities to content from other groups have been woven into these three chapters. All content from the population-specific groups has informed the recommendations.

In this sense at least, the compounding concerns of these priority populations ultimately span more than a single chapter of this report can encompass.

Each population-specific section in this chapter includes subsections on:

- **inclusion indicators:** what would be seen if inclusion were occurring, based on how participants described their best or ideal experiences
- **strengths:** good work that is already happening to further inclusion and supports that are making a difference
- **barriers:** obstacles and challenges to organizations providing really good HIV prevention and support for trans people.

As we engaged additional support for the Indigenous and francophone focus groups, we will first outline how we prepared for these groups and the roles played by the external facilitators.

7.1 Preparing for the Indigenous focus group

The Trans Interweaving Project team made a commitment to include Indigenous 2STNB perspectives throughout the entire project. While the core project team did not include Indigenous 2STNB people, some team members had prior experience working in partnership with Indigenous groups, individuals, and organizations.

[7] In this report, we use the 2STNB abbreviation, often prefaced by "Indigenous," to refer to Indigenous Two-Spirit, trans, and non-binary communities and people (including Indigenous 2STNB participants in this project).

To advance "nothing about us without us" for Indigenous 2STNB people, we structured our work in such a way that Indigenous 2STNB people had continuous opportunities to give input and participate in the project. From the beginning of the project, we reached out to Two-Spirit people who are connected with trans communities, as well as to settler colleagues who work alongside Indigenous 2STNB people. The purpose of these conversations was two-fold: firstly, to identify our areas of ignorance and to seek guidance first regarding how to make the project relevant for Indigenous 2STNB people; and secondly, to begin to reach out beyond our pre-existing networks. As part of this work, we sought Indigenous 2STNB people to join our advisory committee and help guide the project. Our advisory committee had two members who identified as Indigenous, one of whom was quite connected with Indigenous communities and cultures, and one who described themselves as not very connected.

Our project team had enough prior experience in partnering with Indigenous groups and organizations to be aware that a participatory action research approach aligned with decolonizing methodologies and would likely be appropriate (Flicker et al., 2015), but the methods that would work for general groups might not be a cultural fit for a group centring Indigenous 2STNB people. Therefore, we planned from the outset to invite an Indigenous facilitator to lead the Indigenous focus group and to design an approach that would work for Indigenous 2STNB people from a range of different nations and cultures across Turtle Island. The project objectives, questions used for the other focus groups, and other project materials served as resources to support the design of a culturally relevant approach.

7.1.1 Indigenous facilitation, support, and analysis

In developing the approach and materials for this focus group, we consulted with Kole Peplinskie, a Two-Spirit/trans and non-binary Indigenous colleague working in sexual health who is known for their facilitation expertise. We asked them to support us as a facilitator of the Indigenous focus group by engaging with, listening to, and interpreting what Indigenous participants might share with us. We aimed to follow the lead of Indigenous people as experts of their own lives and ways of doing things.

In our earliest conversations with Two-Spirit people, as well as in our conversation with Kole, it was recommended that an Elder co-facilitate this discussion. With Kole's consent and support, we then reached out to Blu Waters, a Two-Spirit Elder who had been recommended to us. Both Kole and Blu guided us and let us know which approaches would be more engaging for Indigenous 2STNB participants. A member of our project team was invited to witness the Indigenous focus group as a note-taker.

Limitations due to COVID19 and a large geographical area to cover made it impossible to safely host an in-person circle for discussion. Blu and Kole opted for a Zoom discussion, without using visual methods used in other focus groups for community members (e.g., photo elicitation), to respect oral traditions of Indigenous knowledge-sharing. The transcribed discussion was then coded by the project team, before being co-analyzed, again with Kole's support.

We found that giving power over to Kole and Blu to lead and make decisions about the approach to use resulted in a positive experience for Indigenous 2STNB participants. One Indigenous 2STNB participant expressed the following in the closing round:

> I have also never shared so openly about my sexuality. [Laughter.] … Also, I am happy we could do this in an Indigenous way. It is better to do things this way rather than being stuck behind western methods. We can use our own ways of communication and coming to conversation with one another. In this format, it allows us to feel really comfortable and share things we wouldn't share in other spaces. (IAT0809)

7.2 Preparing for the francophone focus group

Our project team included a trans francophone, and our advisory committee also included both trans and cis people who are connected to francophone communities. In addition, all promotional, recruitment, and data collection materials were translated into French by TNB2S and allied translators and copyeditors who had a grasp of culturally appropriate language due to their connections with TNB2S communities.

We also sought support from a racialized francophone trans facilitator for the francophone focus group. We did this as we wanted to resist the stereotype that all francophones in Ontario are white, while also avoiding having all-white group facilitation, as we are aware that all-white facilitation can limit what racialized participants might choose to share.

7.3 Trans francophones in Ontario

> On m'a demandé pourquoi pas juste faire ça en anglais. On m'a questionné sur pourquoi je voulais faire des démarches [en lien avec des soins trans-affirmatifs] en français. … C'est aussi plus qu'une traduction, c'est culturel. Quand j'ai voulu avoir des soins en français, c'était de mauvaises expériences. (FRTH1108)
>
> *They asked me why I couldn't just do this in English. I was asked why I would even try to access [transition-related care] in French. … It's more than just a translation issue, it's cultural. Each time I tried to access health care in French, it was a negative experience. (FRTH1108)*

As many readers of this report may not be familiar with the context of francophones in Ontario, and specifically of trans francophones, this section contains information to support readers' understanding of the findings.

The Trans Interweaving Project defines francophone in a way that is similar to the Inclusive Definition of Francophone that was adopted in Ontario in 2009 but is not yet reflected in the French Language Services Act. By this definition, we can include anyone whose first language is not English and lives at least part of their personal life in French—whether or not their mother tongue is French—regardless of nationality, immigration status, or ability to speak additional languages.

Francophones in Ontario are defined as a group not only by geographical pockets of French-speaking communities (e.g., Hearst, Sudbury, rural Eastern Ontario, etc.), but by networks of diverse French-speaking communities sharing similar cultural and linguistic access needs. Francophones do not necessarily have French ancestry, just as not all anglophones have English ancestry. In 2016, over 40% of all francophones in the Greater Toronto Area were born outside of Canada (Ministry of Francophone Affairs, 2021) and this proportion is increasing. Additionally, there are francophones among the Indigenous people in what is colonially defined as Ontario.

Francophones in Ontario—including TNB2S people, and HIV and sexual health sector workers—face various challenges related to their linguistic minority status. These challenges can prevent full inclusion and meaningful engagement. For many francophone TNB2S people in Ontario, the way that the English language and anglophone culture(s) are imposed as the default in trans communities, and in the HIV and sexual health sectors, adds further layers of difficulties in navigating the world.

Many francophones are bilingual or multilingual. Yet, when they are given the choice between French or English services of equal quality, many maintain a preference for communicating in French when accessing community supports or spaces, health services, and information. However, a lack of visibility of francophone-inclusive services and spaces, and a tendency for TNB2S communities and resources to be Anglocentric, can cause francophones to stop asking for French services or community spaces, as they may believe that these do not exist. Francophones often do not ask for services in French because they are unaware such services exist, and anglophones do not offer the option to have services in French (known as making an active offer) because they are unaware that current and potential service users need them. This cycle in turn feeds perceptions that: 1) there are no TNB2S francophones in Ontario, and 2) all francophones in Ontario can comfortably access services and community spaces in English.

In the next five sections, we will present findings on each of the five populations listed at the outset of this chapter. We will then conclude the chapter with a short summary.

7.4 Findings: Indigenous 2STNB people

The findings in this section bring together perspectives from Indigenous 2STNB participants from the Indigenous focus group and interviews, and pertinent perspectives from other participants in the consultations.

Although the Indigenous focus group had relatively small numbers (n = 3), a total of six participants who completed the sociodemographic survey identified as Indigenous (i.e., Inuk or a member of a First Nation or the Métis Nation). This translates to about 8% of the participants in the focus groups and interviews; in comparison, about 2.8% of people in Ontario identify as First Nations, Inuk, or members of the Métis Nation (Ministry of Indigenous Affairs, 2020).

7.4.1 Inclusion indicators

Indigenous 2STNB participants noted a range of best experiences, desired experiences, and ideal states in their experiences in the HIV sector and other related organizations. The project team coded these as inclusion indicators. Themes that emerged included:

- **principles:** solidarity and accountability
- **ways of working:** relationship and partnership building, addressing stigma, outreach in Indigenous spaces, inclusion within Indigenous health and community spaces, and holistic care
- **organizational leadership:** structuring work in a sustainable way, and inclusive approaches to hiring.

Below, we discuss the inclusion indicators in more detail.

Practising solidarity consistently

Participants indicated that solidarity would be practised across the organization, from all programs and all staff. By solidarity, we mean actions that follow an ethical commitment to address antiIndigenous injustices, beyond issuing an apology. Addressing antiIndigenous attitudes and behaviour quickly and transparently would also be an essential element of solidarity.

Being accountable

A recurring theme of what would be in place to support inclusion and integration of Indigenous 2STNB people was a willingness for HIV-sector staff and management, as well as health care providers, to make efforts in relation to both Indigenous and trans inclusion, risking mistakes with the goal of learning and doing better.

Participants were also clear that we need to move beyond apologizing, and instead show commitment to reconciliation by developing action plans with clear steps, timelines, and accountability measures. Furthermore, participants noted that organizations who are late in efforts toward reconciliation need to take responsibility for their inaction and take on additional work to make up for the consequences of this inaction.

One element of accountability that participants wanted to see was increased funding and capacity-building efforts to ensure that Indigenousled work is sustainable, including Indigenousled education about Indigenous 2STNB inclusion. Another desired element of accountability was a means to escalate a complaint or a concern regarding an HIV-sector organization—in a nonpunitive manner—if initial efforts do not result in the problem being addressed.

> I am tired of the apologies. After Stephen Harper's apologies, we noticed Canadians are good at apologies but not good at following up with actions. People don't know next steps because they don't want to know. I want to know when things will get done, what are the timelines, and how will folks be held accountable. … I think organizations who are late with reconciliation or trans inclusion and Two-Spirit inclusion efforts ought to be penalised. If they can't meet timelines, can't accomplish goals determined by community, there needs to be consequences. These need to be determined by community, otherwise the powerful are policing themselves and things won't move forward. (IED0809)

Building meaningful relationships and partnerships

We need family and individuals to cross those lines between communities, and take down barriers—people who are not HIV positive, people who are straight and who are with families and want to learn more about HIV, Indigenous people, Two-Spirit people and trans people. Having to learn the basics of LGBTQ. To learn to break down those barriers that stop others from hating and disliking people who are Two-Spirit and gay, trans and who have HIV. Having HIV adds another layer of stigma. Education and inviting regular people into organizations. Having doors open twice a year to have people come in and learn what programs are offered. (H2)

Indigenous 2STNB participants wanted to see service delivery beyond deliverables and quotas, and toward relationship-building: short-term work is not conducive to building trust or meaningful change. They would like to see outreach to Indigenous communities done in a way that cultivates relationships over time. For example, physical outreach to communities and engaging with Elders. One participant in the Indigenous focus group expressed this as follows: "The thing about outreach and support is that you need to meet people where they are at: physically, in terms of their knowledge, and to use methods that work for them. Whatever is most comfortable" (ILI0809). Meaningful relationship-building also necessitates the HIV sector combatting ageism in relation to sexuality, and valuing what Elders can contribute.

In structuring HIV-sector programs and interventions, participants expressed hope that there would be more work with Indigenousled organizations engaged in sexual health work. Participants valued the practice of consulting and working collaboratively with Indigenous organizations already doing work in relation to Indigenous sexual health, such as Native Youth Sexual Health Network (**NYSHN**) and the Ontario First Nations AIDS/HIV Education Circle (**OFNHAEC**). Participants named friendship centres and other local Indigenous organizations as having the potential to be supportive and share knowledge relating to HIV and sexual health, and to provide services for Indigenous 2STNB people.

One HIV-positive Two-Spirit participant said that they would like families, communities, and allies to be invited into ASOs. This person saw value in involving Indigenous 2STNB people's whole communities and natural support networks.

To facilitate engagement with Indigenous 2STNB people, participants suggested the HIV sector lean into natural community networks of information-sharing as a potential site of referrals to organizations. One of the Two-Spirit participants said, "If I hear of someone doing good work, I will tell other people like me about that service and those great supports" (IED0809). The Indigenous focus group facilitator Kole particularly noted the importance of sharing information about organizations between Indigenous 2STNB community members.

Finally, access to learning opportunities was named as important to foster HIV-sector staff abilities to engage with Indigenous 2STNB communities. Ensuring that staff—at a minimum—are familiar with concepts and current vocabulary that Indigenous people use to describe their experiences as 2STNB reduces barriers to building respectful relationships.

If you are only doing things with your lens or experience, and you don't know what it means to be trans, non-binary, or Two-Spirit, how can you embrace the person you are there to support? How can you have communication and conversation if you don't even know how to approach them respectfully? (IAT0809)

Engaging in outreach in Indigenous spaces

To further engage Indigenous communities, participants would like to see the HIV sector offer more warm outreach—meeting people where they are at, and using approaches that build relationships, build trust, and are culturally relevant—in Indigenous-centred spaces. For example, 2STNB participants described how great it would be to have sexual health and HIV-sector organizations at Indigenous gatherings (e.g., powwows, Two-Spirit gatherings) and in Indigenous community spaces (e.g., bingo halls).

Outreach and engagement should also create a more welcoming environment that clearly indicates that a diverse range of Indigenous 2STNB people have space to connect and share. An older Indigenous participant described their experience, stating:

> I have never felt included with any organization providing HIV/AIDS information. I was aware of risks and transmission, but never really felt like I had a space to sit and talk. I never really felt a calling to join them. I never felt called to share what I know. (IAT0809)

The project team and Kole noted that there may be value in HIV-sector organizations offering intergenerational unstructured connections with Elders or having Elders in Residence initiatives.

In a follow-up conversation with Kole, Kole clarified that if an agency is wishing to engage in outreach in Indigenous contexts, especially in ceremonial contexts (e.g., powwows), it is important to check about protocol and whether it would be appropriate for a nonIndigenous organization to be present. Kole also emphasized the importance of HIV-sector organizations meeting Two-Spirit people where they are at.

> I have worked at a bingo hall on my reserve, and I think that'd be a great place for STI information. … I would love to see GMSH or a public health unit, whoever is doing sexual health, there and having a booth at powwows and gatherings. You can normalize those conversations with Two-Spirit people who are in those communities. (IED0809)

Taking a holistic approach to care

On several occasions, participants named holistic care for Indigenous 2STNB people as an important approach. Participants wanted to have their whole selves recognized (including spirit, culture, body) and to no longer feel compartmentalized.

> My dream is, for any given space, to have staff that are experienced enough to connect all the different aspects of a person's identity, and make sure that they're providing care that's culturally appropriate and respectful of people's identity and experiences. (ND02808)

Structuring work in a sustainable way

> People doing the work need to be supported by a circle or community council to help them in their [own] development [and in program development]. That way, they're not feeling like they are the only Indigenous or trans person on staff [who is invested this work]. [Without that] if anything trans or anything Indigenous comes up, they [the one staff person] get turned to with a question—"What should we do?"—and they get tokenized. As a whole, as an agency, we should all know what the general response should be. (IED0809)

For some nonIndigenous trans people working in HIV-sector organizations, we heard that being the sole trans employee added to their stress and sense of isolation.[8] We heard similar experiences from Indigenous 2STNB people who are employed in the HIV and sexual health sector. However, burnout and exhaustion were more evident in the Indigenous focus group. Typically, burnout and exhaustion were due to agency unresponsiveness to a lack of Indigenous representation and failing to consider—and act upon—steps needed to demonstrate authentic accountability.

At an individual level, burnout and discouragement felt by Indigenous 2STNB people involved in the HIV and sexual health sectors was mentioned several times. In response, some participants mentioned how helpful it would be to have supportive structures to foster sustainability for Indigenous staff and initiatives, such as advisory circles.

[8] We have also woven issues relating to sustainability of work and employment-related challenges for TNB2S people in the HIV sector into the broader findings of this report (e.g., see section 10.1.5, TNB2S staff are not embedded into organizations' support structures).

Participants told us that, at a structural level, Indigenous 2STNB leadership and integration would need to be in place across a whole agency in order to be sustainable; participants hope to see Indigenous 2STNB inclusion built into organizational structures and programs as early as possible. The need and urgency were framed as follows:

> It can't be on the one token trans or Indigenous or diversity coordinator [to foster inclusion]. What happens when their funding is cut or they leave the job? It needs to be built into the infrastructure and thought of from the get-go. (ILI0809)

Taking inclusive approaches to hiring

One nonIndigenous HIV-sector manager noted that the "best way to reach communities, when your work is to connect with those communities, is to hire people from the community" (ED04). He noted that when he is hiring for a role that serves Indigenous communities, he ensures that he has at least two Indigenous people on the hiring panel. Similarly, another HIV-sector manager advised: "Hire trans folks and hire Indigenous folks if you want to be seen as effective in programming and making an impact in these communities" (ED01A).

This same HIV-sector manager also noted that having access to grants has enabled his organization to collaborate with other organizations on initiatives that served Indigenous and/or trans communities, and intentionally build their capacity to hire, engage with, and serve Indigenous people in their communities.

Addressing stigma

Inclusion in HIV-sector work would also entail using local media to build awareness among Indigenous communities and the broader public about Indigenous 2STNB people, and about HIV prevention, treatment, and care. Participants felt that local media could be useful to reduce HIV and trans stigma, especially in smaller communities.

Fostering inclusion within Indigenous health and community spaces

Participants mentioned that trans-inclusive HIV and sexual health access would also mean that Indigenous community programs and services recognize the diversity of 2STNB experiences and understand what cultural practices or ceremonies Indigenous 2STNB people might wish to participate in (e.g., transmasculine people may want to access moon time ceremony). Although some Indigenous organizations do offer services related to trans health, participants noted the importance of including 2STNB people in a holistic manner, including in cultural and spiritual spaces.

7.4.2 Strengths in Indigenous communities and in the HIV sector

Participants in the Indigenous focus group discussed several examples of strengths within the HIV sector and in Indigenous communities and organizations. From this, we have identified two key strengths.

The importance of Elders

Two-Spirit and trans-affirming Elders who are invested in 2STNB inclusion work were identified as an important resource, both in terms of support and access to culturally safe information. Two-Spirit and trans-affirming Elders were also named at various times in the project as positive forces for the well-being of Indigenous participants, whether these participants were community members or frontline workers. In debriefing the Indigenous focus group, project team members expressed how HIVfriendly and trans-friendly ceremony, including sweat-lodges, has had positive impacts on Indigenous 2STNB people in their networks.

> We only have one [name of a Two-Spirit Elder], but we should have 10 more. Imagine how less tired we'd be if we could share that work. (IED0809)

Indigenous-led work and organizations, including integrated approaches

Participants described a few Indigenous-led initiatives and organizations that have expertise in working with Indigenous 2STNB populations. One participant specifically noted that several Indigenous organizations have health and wellness initiatives that already include sexual health and harm reduction material distribution: For example, the Association of Iroquois and Allied Indians. NYSHN and 2Spirited People of the First Nations were named as valuable sources of knowledge and support, both for Indigenous 2STNB people and for the HIV sector as a whole.

Importantly, one Indigenous participant described the "integrated approach" offered by a particular Indigenous cultural, community, and health centre as an ideal:

> [An Indigenous cultural, community, and health centre] has cultural nights, events programming, a mental health clinic, they have housing help. A space like that, where all these different facets of a person's wellbeing—medical, mental health, cultural, safety—can be addressed within one space that's geared to provide that integrated approach is closer to what gets to the ideal situation for me. If everyone's trying to account for your wellbeing in this same network of people, then you don't get aspects of your care that slip through the cracks, where there are two organizations whose mandates don't quite meet, and there are things that you need that aren't addressed. Having spaces that really address that holistically is important. And as an Indigenous person, I feel lucky to have that, but there's not anything like it focused on trans and non-binary people [in Eastern Ontario]. (ND02808)

This ideal of having spaces where care is addressed holistically also recalls the importance of holistic care for Indigenous 2STNB people, as pointed out on several occasions by participants (see section 7.4.1, Taking a holistic approach to care).

7.4.3 Barriers

As with other participants who are part of this project's priority populations, Indigenous participants noted several obstacles to trans inclusion, or to addressing Indigenous 2STNB sexual health. Themes emerging from these conversations primarily related to:

- the impacts of sexual violence occurring through colonization
- the historical and ongoing structural disenfranchisement of Indigenous people, and specifically 2STNB people
- the imposition of western binary-gender systems
- current practices that render invisible, do not consider, or otherwise tokenize Indigenous 2STNB people.

Impacts of sexual violence through colonization

Participants touched on the impacts of residential schools, and noted that in smaller communities, conversations regarding sex and sexuality are taboo. Kole later noted that some residential schools were still open at the beginning of the AIDS epidemic; direct and intergenerational impacts of residential schools continue to affect Two-Spirit people and Indigenous communities more broadly. The ongoing impact of sexual abuse at residential schools can result in some Indigenous people avoiding services due to fear of institutional abuse. These issues, in combination with the sexualization of Indigenous women, and violence directed at Indigenous women and Two-Spirit/LGBTQ2 people, mean that approaches to issues related to sexuality need to be addressed with a great deal of sensitivity. Approaches that may be more familiar to ASOs, such as having a staff person (often white) coming in to talking about sexuality in explicit and "in your face" ways are unlikely to be effective in meeting Indigenous communities or 2STNB people where they are at.

Historical and structural anti-Indigenous racism

Participants reflected on the lasting effects of institutional violence enacted on Indigenous people at the hands of health and social services, and how this continues to contribute to mistrust in institutions, including the HIV sector. Participants in the Indigenous focus group, as well as other focus groups, noted that systemic antiIndigenous racism and cissexism continue to impact people today, as these attitudes are present in agencies serving Indigenous people, including Indigenous 2STNB people:

> It only takes one bad person in your field to leave a bad taste in their mouth. One racist nurse, one transphobic receptionist, has affected trust. Historically, we had Indian hospitals but those had experimentations on Indigenous people. LGBTQ people have been institutionalized. Canada was never built for Indigenous or LGBTQ people. There is generational mistrust. (IED0809)

Participants warned of the consequences associated with continued expressions of antiIndigenous and antitrans attitudes in systems and organizations. Participants noted that if organizations do not address these harms in a consistent manner, there is a risk that people will simply avoid these services, contributing to negative health outcomes.

Participants also noted how structural antiIndigenous oppression can be manifested in challenges in accessing formal education, which is necessary for many HIV-sector jobs. This results in few Indigenous people working in the sector, even fewer of whom are 2STNB. One participant reflected on how these barriers to employment in turn create barriers to reaching Indigenous people: "For me, the short answer would be there is no education or representation from the communities they are supposed to be reaching. Who has access to those systems, that education, or those jobs?" (ILI0809).

> You can't be an ally to Indigenous and trans people just sometimes, while you work [together]. You need to challenge the individuals that are prejudiced towards Indigenous or trans people. Otherwise, we won't access care. Indigenous people will have bad health outcomes if they don't go [to get tested], and we already have low life expectancies. (IED0809)

The imposition of western binary-gender systems

Participants in the Indigenous focus group noted that gender binarism was a cultural imposition from settler colonialism. One participant stated,

> [Gender is] not only visual gender. It's also a spiritual gender, it's an emotional gender, an intellectual and physical gender. It's not just one thing. … If we look at the TRC [Truth and Reconciliation Commission] and traditional ways of doing things, we know that before the binary system was brought in, Two-Spirit people—gender diverse people—held all roles in our communities. They weren't limited to one way of being. (IBE0809)

Kole later verified that common ways of teaching about sex vs. gender (e.g., the Genderbread person that is commonly used in 101 workshops) can erase nonwestern perspectives on gender diversity, and few resources from an Indigenous perspective are available.

A consequence of the cultural imposition of gender binarism is that some Indigenous people and organizations maintain mutually exclusive gender silos in Indigenous spaces with the belief that a binary gender system was traditional. These binary ideas of gender can limit what services and supports Two-Spirit people can access, including in Indigenous organizations. Instead, the participant noted that "services need to be inclusive of all gender identities" (IBE0809).

Ongoing exclusion and tokenism

On several occasions, participants commented on exclusion in the sector. For example, participants indicated that current structures and practices often require Indigenous programs, interventions, and narratives to fit into white cultural norms, and how that contradicted the principles of reconciliation. One participant stated, "If reconciliation is about going to traditional ways, we need to do that. But we can't do that if we are only allowed to exist and do work in a colonial way" (IED0809). This continuing exclusion thus reduces access to culturally relevant services and supports for Indigenous 2STNB people and communities. Kole also noted that governments control where funding is allocated, and Indigenous organizations have to work within colonial or western frameworks to obtain this funding.

Indigenous ways are relational, and colonial ways are short-term and transactional.

Participants asserted that Indigenous 2STNB people often do not feel safe in agencies, with one participant expressing, "If you don't see [Indigenous] representation in demographic surveys in our agency, that is a call to self-reflection to look at what is making it unsafe" (ILI0809). Similarly, an HIV-positive Two-Spirit person observed a lack of Indigenous engagement with large mainstream ASOs. This person also touched on the isolation of their experience:

> A lot of Two-Spirit people won't access services from [large mainstream ASOs]. When I was attending [that ASO], I literally felt like I was the only Indigenous person who was accessing the services from there. I wish I met more peers like me who were accessing those services there, but that is not so, even to this day. (H2)

Tokenism was mentioned multiple times as a practice that simultaneously devalues, exploits, and puts strain on Indigenous people. Some participants said token hires, one-time workshops and short-term projects are detrimental to the HIV sector and to Indigenous people. Participants also described a service delivery focus on deliverables and quotas as a capitalist way of working—and potentially tokenizing, due to an emphasis on numbers, noting that Indigenous ways are relational, and colonial ways are short-term and transactional. Kole later noted that other challenges in developing and maintaining relationships stem from staff turnover, including due to projects being funded for short time frames.

Participants expressed how tokenistic and unsustainable approaches to change work leads to burnout and Indigenous people disengaging. Tokenism was also described as an organizational risk: It creates conditions that lead to gatekeeping, in which only one or few workers can allow (or bar) access to services and community. Participants noted how problematic this is in cases where service users feel they have no choice in who provides services to them, and where workers or volunteers may be enacting lateral violence. In the focus group, one participant mentioned how some trans people are racist or simply do not "believe" in more fluid expressions of gender, such as living part-time as trans:

> A Two-Spirit or trans staff doesn't mean the agency is fully inclusive. Not all trans people are fully inclusive. Some trans people are racist. Some people don't believe in part-time trans. I have known trans people who are looked up to for leadership and guidance [who] say this. … And there is lateral violence. One person could be problematic and block access from community to others. (IED0809)

Without Indigenous leadership in trans inclusion, integration, and sexual health work, the strategies used by nonIndigenous trans communities and cis allies to advocate for trans inclusion may reproduce certain forms of colonialism (e.g., trying to fit Two-Spirit identities into western binarygender frameworks).

7.5 Findings: Trans francophones

The project held one francophone focus group with three participants. In total, 11 people indicated in the sociodemographic survey that they spoke French, five of whom indicated that they preferred to access services in French. We did not assess whether French-speaking participants identified as francophone in the community or cultural sense of the word, or whether they simply indicated fluency in the language. Findings in this section include perspectives from the francophone focus group, content from other focus groups and interviews that addressed the needs of trans francophones, and francophone-specific content from the website and strategic plan review.

7.5.1 Inclusion indicators

Participants in the focus groups, interviews, and deliberative dialogue identified several inclusion indicators specific to TNB2S francophones:

- seeing francophone TNB2S communities from an intersectional perspective
- three inclusion indicators related to language (use of community-vetted language, increased linguistic accessibility within organizations, and an active offer of services in French)
- engaging in practices that protect confidentiality
- addressing service gaps through systems navigation
- collaboration on francophone trans inclusion.

Seeing francophone communities through an intersectional lens

Francophone participants, both cis and trans, indicated that they perceived agencies as inclusive when these agencies approached francophone communities' needs from an intersectional perspective. For some, this meant agencies addressing cultural and linguistic accessibility, while others focused on anglophones expressing solidarity with francophones and taking action regarding francophone linguistic minority struggles.

Inclusion would also entail agencies recognizing francophones in Ontario as a diverse equity-seeking group. Agencies could act on this by first building their understanding of the experiences and inequities faced by francophones, especially in relation to health care access, sexual health, and HIV. Further steps toward inclusion would involve ensuring that language and linguistic minority status is considered as a part of a broader intersectional approach—for instance, within antioppression and antiracism work.

Francophone focus group participants also noted that they would consider agencies with French-language capacity that demonstrate antiracism and affirming representation of racialized people to very likely be inclusive of TNB2S communities. In other words, TNB2S francophones, including those who are white, will often associate BIPOC inclusion with trans inclusion. Thus, if an agency is racially diverse and racially sensitive, TNB2S francophones will assume that it is also trans inclusive, presuming that it is also more likely to have an intersectional approach.

Using language that is vetted by TNB2S communities

Participants appreciated seeing francophone sexual health information materials, interventions, and services that are adapted to TNB2S communities using appropriate language. They also noticed and felt reassured when agencies communicated using language that reflected linguistic strategies[9] used by TNB2S francophone communities to affirm their genders and sexualities.

For example, participants discussed the need for intervention materials and resources that are sensitive and affirm a diversity of French dialects (e.g., North African, European, Northern Ontario), including in the terminology used for TNB2S identities and experiences. They also found it helpful when materials made sure to include terminology used by local TNB2S communities. The project team recognized that different regions use different terminology, and inappropriate terminology could indicate a disconnect from local francophone and/or TNB2S populations. Furthermore, the project team also noted that when transfocused English resources are translated into French, unless an intentional and trans-knowledgeable approach is used, the French version may instead use language that inadvertently upholds binary ideas of gender.

Increasing linguistic accessibility within organizations

Inclusion of TNB2S francophones would be advanced by agencies clearly indicating the language capacity for resources, programs, and services, thus making them easier to navigate.

In line with this idea, the project team suggested that the linguistic abilities of workers could be indicated alongside their pronouns in email signatures and website profiles, and on business cards. For example:

> [Name]
>
> Pronouns: they/them or he/him, Pronom: iel, accords masculins à l'oral
>
> English (spoken, written)/Français (parlé, écrit)/ASL

The project team also suggested including linguistic accessibility information in event and program descriptions alongside other accessibility information, and to be transparent about what participants should expect.

[9] L'écriture inclusive (inclusive writing) is a common strategy that creatively adapts French grammatical rules to reflect and include many genders. Because French has a grammatical structure with both grammatical and personal gender concord, English genderinclusive linguistic strategies cannot be superimposed, and vice versa. Languages with grammatical genders (e.g., French, Spanish, German, etc.) are not inherently more, or less, trans inclusive. However, the Anglocentrism of global trans advocacy has meant that transinclusive strategies in English are typically better known (Baril, 2017).

Participants suggested that organizations seek funding to make materials or programs accessible to francophones. The project team is aware of funding available through a range of federal and provincial sources that build francophone access to health and social services. Participants also saw a role for funders and provincial strategic entities to further support francophone capacity building: They suggested that GMSH and the AIDS Bureau fund translation for the development of resources in French to help GMSH Alliance member agencies increase their Frenchlanguage capacity.

Actively offering services and resources in French

Participants pointed out that agencies need to demonstrate inclusivity and accessibility of their services by making an active offer of French-language resources and services, and warm referrals when these were not available. Frontline workers mentioned instances of inclusion being demonstrated when options to access services, community spaces, and resources in French were available, especially in areas with larger French-speaking populations.

Inclusion of trans francophones can also involve making French-language sexual health and HIV information available on websites, even in agencies without French-language capacity. It was also suggested that information—provided in French—would be clearly and readily available on how to request and access services in French, including in staff profiles for online outreach (e.g., Grindr profiles).

> Here in [city], 40% of the population is francophone. Trans inclusion looks like having francophone resources. It is a gendered language, and it is so difficult finding [trans-]inclusive or nongendered resources. (F2AN3006)

Engaging in practices that protect confidentiality

Inclusion of trans francophones necessitates taking additional steps to protect privacy and confidentiality. Participants who are frontline workers recommended that agencies with French-language capacity provide alternative options for TNB2S francophones about which staff to see. As trans and francophone communities are densely connected, such practices would ensure that trans francophone service users can make informed choices about whom they share sensitive information with. The project team has seen statements such as the following working well for a range of smaller communities:

> This mailbox is monitored by [staff name]. We recognize how small our communities can be and respect your right to privacy. If you prefer seeing another worker for confidentiality reasons, please connect with XYZ, Director of Programming, and we will do our best to find a solution that works for you.

Addressing gaps in services through systems navigation

Inclusion of trans francophones would also entail establishing formal collaborations between agencies to create francophone health navigation supports for TNB2S Ontarians to virtually access HIV-sector services available in French in other communities (e.g., trans francophones from Windsor could virtually visit MAX Ottawa or an ASO in Sudbury to protect their privacy and ensure they have access to services). The project team thinks that careful use of province-wide system navigation approaches could help to address access issues related to confidentiality and linguistic capacity for a range of communities, both trans and cis, as long as this is used in combination with sector-wide inclusion and integration efforts.

Expansive collaboration to advance francophone trans inclusion

To attain the goal of francophone trans inclusion and integration, participants saw value in developing and implementing systems to facilitate collaboration between French-language service providers and francophone communities on a regional, provincial, and broader level. They suggested that the HIV sector engage with francophone stakeholders beyond the HIV sector to assess the needs and opportunities to increase capacity for HIV and sexual health services in French.

Participants also suggested that the sector create communication corridors for francophone frontline workers to connect with and be supported by francophone organizations outside

the HIV sector (e.g., housing, transition-related health, sexual assault, and intimate partner violence resources), as these supports are commonly needed by trans populations.

Participants also recommended collaboration with francophone groups outside of Ontario to share best practices in working with TNB2S francophones and pool resources to develop and promote new materials (e.g., Le guide HoT, recently developed by RÉZO in Montreal, which focuses on the sexual health of trans men).

The project team noted that these suggestions could also reduce the workload and duplication of efforts among HIV-sector organizations.

> La population est petite, donc on n'a pas le choix de collaborer avec des organismes francophones en dehors du secteur du VIH [en Ontario]. On peut collaborer avec des organismes québécois en français, ou avec des organismes francophones en Ontario. Les organismes anglophones qui se disent bilingues ne le sont pas habituellement, en pratique. En collaborant, on peut se partager le travail. … Si on est une si petite population si difficile à rejoindre, on devrait collaborer plus. (FREL2408)

The population is small, so we don't have any other choice but to collaborate with francophone organizations outside of the Ontario HIV sector. We could collaborate in French with organizations from Quebec or France, or with francophone organizations in Ontario. Some anglophone organizations say they are bilingual, but in practice they usually aren't. If we collaborate, we can share the workload. … If we are such a small, hard-to-reach population, we should really collaborate more. (FREL2408)

7.5.2 Strengths in the HIV sector and in francophone organizations

Participants named several small steps that the HIV and sexual health sectors are already taking to embed francophone trans inclusion and engagement. HIV-sector managers provided examples of resources, programs, and services for which programming funding was diverted to hire translators and interpreters, thus enabling access to francophones for whom English-only services are a barrier.

Other participants noted how collaboration between francophone agencies has been helpful in being connected to appropriate services and resources. Frontline workers mentioned how necessary it is to have sexual health materials available in French (e.g., Brazen and Primed), and how useful these resources are. Participants found it helpful when agencies integrated sexual and gender diversity in all French programs, especially for newcomers who should have opportunities to connect with TNB2S communities and vice versa. Participants appreciated flexibility and creativity in finding new ways to embed francophones into various programs, services, and engagement opportunities. Despite challenges, some HIV-sector organizations manage to provide services to francophone TNB2S communities, especially if these organizations are mandated to do so or if they are in a region with more francophones.

> We hired a translator—it cost us $400 for the evening. When I was asked why I did that, I said because … it's community, it's the price that we pay to make sure that people feel connected and supported. The deficit is from the system, not the person not speaking English. (ED03)

7.5.3 Barriers

As with the other four priority populations, francophone TNB2S people in Ontario face significant barriers to reaching full inclusion and integration within the HIV sector and beyond. We have highlighted five areas that can be improved upon:

- inadequate French-language capacity in the HIV sector
- large gaps in services and community spaces

- privacy and confidentiality concerns
- online French content being of lesser quality than English content
- lack of intersectional consideration of francophone issues.

We discuss each in turn below.

Inadequate French-language capacity

Participants—including community members, frontline workers, and HIV-sector managers—found that there is very little French-language capacity in the HIV sector. Frontline workers told us that some ASOs are designated English–French bilingual or offer services in English and French, but do not have the capacity or financial resources needed to oversee translation of English-only resources. As a result, some ASOs are required to do in-house translation. This has a negative impact on the quality of translations and on the agency's capacity to meet deliverables, as it takes time and resources away from employees' other responsibilities. Frontline workers also mentioned that ASOs that are mandated to serve francophone populations are often under-funded and over-capacity, and therefore may not have the ability to increase their capacity to serve TNB2S populations—both francophones and anglophones—despite wanting to. One participant also identified a related challenge—the inaccurate assumption from anglophones that resources in French could be accessed from francophone countries:

> J'ai vécu en France … récemment. J'étais estomaqué du peu de ressources trans en France, en français. Ils puisaient du Québec. Ou ils utilisaient l'anglais. Je croyais finalement avoir une communauté trans francophone … mais non, je devais utiliser les mots en anglais. Même en France. Pas plus la Belgique ou la Suisse. Les canadiens anglais surestiment ce qu'on peut puiser des pays francophones. J'ai été choqué. (FRTH1108)

> *I lived in France recently … I was amazed at how few trans resources there were in France, in French. They were drawing from Quebec. Or they were using English. I thought I finally had a French-speaking trans community … but no, I had to use English words. Even in France. Not Belgium or Switzerland either. English Canadians overestimate what you can get from French-speaking countries. I was shocked. (FRTH1108)*

Participants … found that there is very little French-language capacity in the HIV sector.

Large gaps in services and community spaces for francophones in Ontario

Participants noted that there are very few community spaces, resources, and services accessible to francophones in Ontario. They mentioned large gaps in access to health and social services for francophones regardless of gender or sexual orientation. Additionally, a lack of French-language resources, community spaces, sexual health information, and sexual health services for TNB2S people are significant obstacles. These obstacles can lead to cultural, linguistic, and community disconnect by making it nearly impossible to maintain connection to language while being trans.

> Il n'y a simplement pas de services en français pour les personnes trans. J'ai été forcé de vivre en anglais parce que je suis trans. (FREL2408)
>
> There are simply no French services for trans people. I was forced to live my life in English because I am trans. (FREL2408)

Concerns over privacy and confidentiality

Where services were available in French, several participants and frontline workers experienced concerns over privacy and confidentiality. Francophone TNB2S communities are often smaller and—as noted in section 7.5.1—densely connected, and francophone staff often serve as the go-to person for all French-language referrals. TNB2S francophone staff may know francophone service users socially, which creates ethical challenges that need to be properly managed.

Online French content of lesser quality than English content

Participants described finding online resources in French lacking, containing broken links, or of lesser quality compared to English resources. Participants saw limited to no online outreach in French. They had difficulties navigating services due to lack of information on their French-language capacity and ability to serve TNB2S people, compared to English language services and/or services for cis people.

Lack of intersectional consideration of francophone issues

Whether it comes from within francophone communities or outside of them, a lack of intersectional and cultural perspectives on francophone issues was named as a significant barrier to inclusion. Participants had difficulty with the Anglocentric stereotype that all francophones in Ontario are white. This, in combination with the stereotype that racialized newcomers are cis (and transphobic), is detrimental to people who are racialized, francophone, TNB2S, and any combination of these. Some frontline workers told us that they were pressured to separate white TNB2S and nonheterosexual francophones from racialized newcomers.

We heard from participants, especially those with HIV-sector frontline experience, that these stereotypes also exacerbate the lack of resources and services for TNB2S francophone migrants and refugees, including in regions with higher francophone populations. In addition to this, a lack of knowledge of the cultural diversity in francophone communities, and a lack of familiarity with common French dialects (e.g., Northern or Southern Ontarian, Caribbean, North African, West African, European, New-Brunswickan, Québécois), created participant barriers. The project team also found that linguistic insecurity and intra-community conflict in francophone linguistic minority spaces can make TNB2S francophones question their belonging and discourage them from connecting to one another.

> Quand les organismes francophones me disaient que les immigrants sont transphobes, je sais que c'est faux. Ils ne peuvent pas juste accueillir des immigrants cis straight en tant qu'organismes francophones. Ce sont les blancs qui mettaient des barrières. Avoir travaillé avec la population immigrante a été entièrement positif pour moi. Je ne pouvais pas me sentir plus en sécurité, et je ne peux pas dire ça des organismes francophones. On me disait qu'on pouvait pas mettre des affiches d'espaces positifs [en blâmant les immigrants]. (FRTH1108—personne trans et blanche, ancien travailleur de première ligne)
>
> *When francophone organizations told me immigrants were transphobic, I knew that was false. They can't just serve cis straight immigrants as francophone organizations. It was white people who were putting up these barriers. Working with immigrant populations has been a very positive experience for me. I couldn't feel safer, and I can't say that of francophone organizations in general. I was told I couldn't put up positive space posters [and they were blaming immigrants as an excuse]. (FRTH1108—white, trans, former frontline employee)*

7.6 Findings: Racialized trans people

We held one focus group specifically for racialized trans people. Other racialized people participated in further focus groups for trans community members, as well as focus groups and interviews for staff and management in the HIV sector. Additionally, some Indigenous participants brought up content focused on racialization (e.g., a desire to connect with racialized peers). In this section, we draw together all of this content.

7.6.1 Inclusion indicators

When we reviewed the notes from the racialized focus group, as well as from other participants who were racialized, two inclusion indicators stood out that we had not seen elsewhere. These were: (a) social spaces

for racialized TNB2S people, and (b) involvement of ethnocultural ASO leadership in strategy work for the sector. These and two other inclusion indicators for racialized trans people are touched on below.

Creating spaces and opportunities for social connection between racialized trans people

We heard from some participants in the focus group for racialized trans people that inclusion would entail having some spaces available specifically for racialized trans people, and that there would be multiple ways to engage. Some participants noted the need for social spaces that did not focus overtly on HIV, or on gender identity and transition. Others expressed the need for opportunities for HIV-positive racialized and/or Indigenous people to connect with their peers. One Indigenous participant described the impact of participating in an event where "all aspects" of himself could be valued:

> One of the most transformative experiences I ever had, and certainly one of the best for my mental health, was … a group specifically scheduled for queer and trans people of colour, and specifically queer and trans people of colour with disabilities. And, to be able to be in a room with people who shared all of those identities, or "sites of marginalization" to get academicwanky about it, was really impactful. A lot of the time, if I'm in an Indigenous space, there's no guarantee that people won't say something ignorant about queerness, and I've certainly heard racist comments in queer space when I'm trying to make new friends, and basically any space that's not focused around disability, there are comments or accessibility issues that come up around that. Being able to be seen and valued about all aspects of yourself is incredibly important for one's sense of self and for mental health, rather than having to segment off different aspects of yourself for different contexts. (ND02808)

Involving ethnocultural ASO leadership

One HIV-sector manager noted that to foster inclusive approaches, leaders—and not simply frontline workers—from ethnocultural-specific ASOs need to be involved when PPNs are formulating strategy, in order to be part of making decisions:

> It is important that who we are as [an ethnocultural organization] is integrated intentionally in the decision-making processes at a very high level, so it filters down. We are not a provincial strategy organization. We do service delivery—we are working directly with folks, so we have the knowledge and experience. We should be the first consulted during a process of decision-making. We need to sit at the table and be part of the discussion and part of creating strategies, so that we can look at creating that diversity, especially as it refers to race. (ED03)

Generating inclusion in representation, staffing, and decision-making processes

We heard from participants that inclusion of trans people in the HIV sector must encompass inclusion of BIPOC trans people in images and narratives in HIV-sector work, as well as in consultation processes and decision-making. Several participants noted that having trans people of colour on staff at ASOs can help to build stronger relationships with participants and foster a sense of connection and belonging.

Increasing inclusion in interventions along the HIV care cascade

Participants noted ways to increase inclusion in interventions such as HIV testing and treatment, and harm reduction.

One participant stated that access and inclusion would be improved by "having people that look like us talk about the importance of getting tested, the importance of taking your medications" (RLE2707). This person was specifically referring to racialized health care providers. Similarly, an HIV-sector manager noted that having peer workers who themselves are trans and racialized in the waiting rooms of testing clinics that are focused on trans people and on newcomers has helped people feel more welcomed.

Participants across the consultations identified that inclusion in harm reduction for trans communities

may need to look different than the focus on party drugs that often is centred in gay men's harm reduction work. In the focus group for racialized trans people, participants noted that there may be differences in patterns of substance use specifically for racialized trans people.

> It is important to have conversations around harm reduction in marginalized communities. Having good harm reduction conversations with young trans and non-binary people about drugs and sex is necessary, especially when there is no information for people of colour that is actually rooted in people's real experiences. (RIB1207)

7.6.2 Strengths in the HIV sector

As reflected below, we heard two standout strengths that were raised by participants.

Some ethnocultural organizations are providing HIV supports for racialized TNB2S people

We heard from some staff as well as some community members that there are ethnocultural organizations that provide HIV supports and services that emphasize trans inclusion. This was the primary strength in the sector that participants singled out.

Inclusion of racialized trans and non-binary people on staff in ASOs and related organizations

At least one of the ethnocultural organizations referred to above has multiple trans and non-binary people on their staff team. We also noted that several other ASOs currently have racialized trans and non-binary people on staff, which can help racialized trans and non-binary service users feel more welcome and comfortable in accessing services.

7.6.3 Barriers

We identified five barriers for racialized trans people, which we discuss below. These barriers were:

- racism and white privilege in a range of contexts
- employment-related challenges
- the lack of emphasis on Canadian-born racialized people
- racism and ciscentrism in health care
- challenges related to confidentiality in small communities.

Racism and white privilege

> Racism is kind of real even in niche AIDS community organizations that are supposed to help those who have HIV. I have seen it happen a lot. I used to volunteer at [ethnocultural ASO]. The amount of performativeness and antiBlackness I have seen time and time again. … It is important to put Black and Indigenous people to the front, instead of it being a club. (RAN1207)

Participants noted multiple challenges to trans inclusion and integration stemming from racism and white privilege. White people who are leading HIV-sector organizations—as well as white trans people—may or may not have started their own work to unlearn their own racism and be aware of their white privilege.

> Trans groups and services are primarily led by white trans people, which can make it more difficult for HIV sector organizations to connect with racialized trans people.

We also heard from frontline staff that organizations may not be on top of antiracism/antioppression training and skills development. Frontline staff noted that as understandings of antiracism and antioppression are evolving rapidly and there is significant turnover in the sector, keeping on top of training is needed to provide useful and nonstigmatizing supports and services, and to ensure that racialized trans people can get equitable access to supports and services.

In addition, white trans people are seen to dominate the dialogue about trans issues in the HIV sector. Trans groups and services are primarily led by white trans people, which can make it more difficult for HIV-sector organizations to connect with racialized trans people.

> Many people leading services are white. … Being queer or trans doesn't make you nonracist. When white trans folks associate racialized trans folks as sex workers, that is challenging. They make assumptions based on looks. Health care providers also assume trans women of colour are sex workers, and white trans women are opioid addicts. (F2KE2007)

Employment-related challenges

One frontline staff member described unsustainable approaches to trans inclusion in the HIV sector, saying:

> There is such turnover, and [trans inclusion work] relies on racialized folks, or trans racialized folks, and they are bringing their genders to make change in how these programs should look. We can't rely on [individual trans people for] that, especially due to turnover. (F2J01707)

Participants also identified challenges for racialized trans people who are engaging in contract and freelancing work in the HIV sector. Participants expressed a desire for greater transparency in rates paid by HIV-sector organizations, and clarity that work on trans initiatives is compensated at the same standard rates as work on initiatives focusing on cis gay men. HIV-sector leaders should be aware of how common it may be for racialized trans people to ask for less than the going rate, and to address possible inequities and the sense that racialized trans people may have of being exploited.

> As trans folks, we usually ask for less funding as we don't expect much. … As a racialized person, I am constantly underpaid. Even if I did ask the standard rate, I don't know [if I would be given it]. I pitch things and hope they work. (CTR02007)

Little emphasis on Canadian-born racialized people

One person in a management role with an ethnocultural-specific ASO noted that Canadian-born racialized people, including trans people, may not be well served at ethnocultural ASOs, as the focus and funding is primarily for newcomers. This person stated:

> A part of it is that there is a lot of homophobia that exists within [some ethnocultural] communities here in Canada. As [racialized] folks cross borders and seek refuge, particularly here in Canada … there is a heightened response for immigrants, and I appreciate that as an immigrant myself. However, Canadian-born [racialized] Canadians have nothing for them. As an immigrant, I see all these newcomers have services and funding, including at our organization and others, but not for [racialized] folks from here. When you ask to have a conversation with a funder, and you ask who they're serving, they might say they are serving LGBTQ2S immigrants. And then you ask about the nonimmigrant, Canadian-born [racialized] people, and they will say, "Oh, we don't see them." (ED03)

Racism and ciscentrism in health care

Several racialized (as well as Indigenous) participants brought up racism in health care, and long-standing histories of maltreatment of and experimentation on racialized people. They noted that this, in combination with ciscentrism, leads to warranted distrust of the health system for racialized and Indigenous trans people. The project team also noted that health outcomes can be poorer for racialized people.

Some participants' experiences reflected that good experiences in care are seen as an exception rather than the norm. One racialized trans woman framed this as follows:

> I had good experiences but that is the irony. That is because of my passing privilege. I had very good experiences walking into [two Toronto hospitals] emergency, because they are reading me as a cis woman. That was not like that 5 years ago for me. But—that's wrong. Just because it is better for me now does not mean the system is better. It just means that I have light-skinned privilege, and East Asian features, and I can access what I need to access, but it does not mean it is better for everyone else. I relate to what [participant] said. I had good experiences because it was good for me, but not because the system has changed at all. (02AD0608)

Challenges regarding confidentiality in small communities

A participant in one of the focus groups noted that ethnocultural communities can be too small to protect anonymity. This can result in gay, bi, and queer men (trans and cis) avoiding HIV-sector services rather than, for instance, running the risk of encountering people from their faith community at a particular organization.

7.7 Findings: Trans migrants

We did not hold a focus group specifically for trans migrants (defined broadly in this report as including refugees, international students, immigrants, and other people who have come to live permanently or temporarily in Canada). However, participants shared stories in numerous focus groups and interviews about being migrants and about serving trans and non-binary migrants. Participants focused on the subset of migrants who are experiencing multiple levels of disadvantage (e.g., linguistic barriers, poverty, having grown up in countries where being trans was less socially acceptable and even illegal, etc.) We have drawn this content together in this section. Very little conversation touched on trans migrants who come to Canada with more privilege, such as immigrants coming to Canada from English-speaking "First World" countries, and who do so under economic categories of immigration.

About 25% of the participants who completed the sociodemographic survey indicated that they had been born outside of Canada; all noted they had permanent resident status or were now Canadian citizens.

7.7.1 Inclusion indicators

Two inclusion indicators, each discussed below, emerged from our analysis:

- understanding what it means to be trans from cross-cultural perspectives
- ensuring accessibility of information for trans migrants.

Understanding trans identities cross-culturally

Several participants noted that the ways that "trans" is understood in Canada differ from the ways that it is understood in some other parts of the world. Inclusion entails HIV-sector organizations being able to serve migrants who do not frame their identity in the ways that "trans" is framed in Canada. HIV-sector staff—either from the same or a similar culture, or who can work cross-culturally very effectively—are needed to support trans migrants and to help trans migrants navigate Canadian systems.

Several participants noted that the ways that "trans" is understood in Canada differ from the ways that it is understood in some other parts of the world.

Ensuring accessibility of information for trans migrants

An element of trans inclusion entails providing information and resources that are accessible to trans migrants—not only sexual health information, but information and resources along the HIV care cascade. This accessibility requires critical information to be available in multiple languages to meet the needs of linguistic minorities, and information to be framed in ways that are culturally competent. Information also needs to be accessible in venues where trans migrants might seek information, recognizing that not all migrants will have access to common information sources, such as family doctors.

> Where should I get access to those medicines [PrEP and PEP]? This information is not accessible if you don't search for it. I am an international student and a family doctor is not accessible for me. (RAN1207)

7.7.2 Strengths in the HIV sector

One of the strengths that we heard is that ethnocultural ASOs are largely focused on migrants. We also heard that although people in some ethnocultural communities come from countries where homophobia and transphobia may be deeply entrenched and that this can make trans inclusion work more difficult, it is not a complete barrier. Some staff working in ASOs that served migrants saw a lot of willingness from straight and cis program participants to both learn about and unlearn homophobia and transphobia. In addition, the project team noted that currently there are some HIV-sector staff who are experienced in working with trans migrants.

7.7.3 Barriers

Three themes regarding barriers to inclusion and integration specifically for trans migrants emerged from the consultation:

- western approaches, including western concepts of gender
- linguistic and cultural barriers to information and care
- the lack of interventions tailored to trans migrants.

Western approaches, including western concepts of gender

> When I first moved to Canada, I was an immigrant. I had to assimilate to what transness meant in Canada. It was a barrier to me, I had to convince people about my identity to accommodate [limits] around the English language. How do we accommodate diverse cultural gender identities? (TFBR1407)

We heard from Indigenous participants as well as migrants, including HIV-sector staff, that western concepts of transness, gender identity, and sexual orientation can create barriers to engagement.

One non-binary staff person stated:

> I am connected to racialized trans women who do survival sex work. Transness to them is different to the way transness is defined in Canada. I am able to help them navigate the system as I am able to understand the English language and my own language. (TFBR1507)

Linguistic and cultural barriers to information and care

We heard from multiple participants that language and cultural barriers create additional challenges for trans migrants, and that these barriers can have significant impacts. Language barriers contribute to additional barriers to testing, accurate HIV and sexual health information, and access to medications (PEP, PrEP, HIV medications, and transition-related medications). Migrants may also have less access to coverage for medications, as well as less access to primary care providers.

We also heard that some HIV-positive trans people who have immigrated from Arab countries can be scared to talk about their HIV status, and as a result can "keep a secret life" (RMA3017). For such trans people, the cumulative impacts of migration, language barriers, and being HIV positive can contribute to increased isolation and fear. This speaks to a need to create avenues that are safe enough for all trans migrants to access information, care, and supports.

> In our country they say if you have HIV, you die. When they come here it is the same thing, because there is no knowledge where they can find that [support]. … A lot of my friends are facing that. They have HIV, but they don't find spaces to find out [that they have HIV]. First because of language. In Canada you can have your space and your freedom, but you miss out [on] something if you are trans. (RMA3107)

Lack of interventions tailored to trans migrants

Some participants spoke about the need for tailored responses for trans migrants, including responses that address the types of trauma that trans migrants may have experienced. Several participants noted that some trans women who are racialized migrants may end up doing survival sex work and may use street drugs in this context; these participants spoke to the need for awareness around this, and interventions that reflect these trans migrants' realities. One HIV-sector worker raised the need for harm reduction that addresses the needs of trans migrants who are engaged in survival sex work:

> I feel immigration has a lot to do with people's relationship with substances. I have not seen this before: How trans people are navigating hormones, street drugs could be an important consideration. Most of the trans folks I have connected with who are racialized newcomers do survival sex work. (TFBR1507—GMSH Alliance-linked frontline staff member)

One participant described the experiences of some Muslim trans migrants in their community, as shared by friends of these migrants. These experiences included attempts to seek support from doctors about traumatic experiences, and the doctors' reactions being unhelpful, frustrating, and retraumatizing. This points toward a need for providers to be able to offer culturally safe and trauma-informed care. Similarly, an HIV-sector manager described how some trans migrants can carry trauma from transphobia they have experienced in their former countries—countries where being trans is less socially supported—and yet nonetheless lack sufficient assistance in Canada to address their experiences:

> They come to this country which is freer, and they have to unpack the trauma that they have been through as part of becoming their true selves. But the way things are situated now, there is no kind of organized system that helps facilitate this and helps to support them. (ED03)

7.8 Findings: Trans sex workers

The project held one focus group specifically for sex workers; five people participated in this group. A few participants in other focus groups described themselves as sex workers or stated that they dated sex workers; a few more participants spoke from their experience as staff and peer workers who supported trans sex workers.

7.8.1 Inclusion indicators

Below, we discuss the following inclusion indicators:

- fostering empowerment and agency
- supporting racialized newcomers who are doing survival sex work
- supportive access to HIV testing and harm reduction materials.

Fostering empowerment and agency

Participants in the sex worker focus group addressed various aspects of trans sex worker empowerment, centring primarily around trans sex workers having the knowledge to take care of themselves and being able to make informed choices. One participant described this as follows:

> Being engaged very well [by HIV-sector organizations] … results in trans people taking care of, and having better knowledge about, their own health needs and how to access their own health care in more effective ways. As a sex worker, to me, it is taking the knowledge and empowering myself, and getting tested regularly, or looking up safer sex options that work best for me. Having better knowledge of what is available out there, self-empowerment or anything related to fertility or menstruation. (SWEL1207)

Another participant expressed it as "knowledge is power. … I see our community is getting better at getting more knowledge about the system" (SWTA1207). Participants also described empowerment as having better education—including nuanced information—about PrEP, PEP, and the risks of various types of sexual behaviours, so that they could make informed choices.

Supporting racialized newcomers who are doing survival sex work

Staff and peer volunteers identified the need to support racialized trans newcomers who are engaged in survival sex work. A possible approach identified by one participant was to engage suitably skilled peer volunteers to learn about resources available to trans newcomers and then help trans newcomers who are doing survival sex work to get connected with available supports and programming. This participant, who herself was a migrant whose first language was neither English nor French, suggested that it would be beneficial for these peer volunteers to have a range of language skills. HIV-sector managers who are considering implementing a program like this should consider whether roles like this should be paid positions rather than purely volunteer.

Supportive access to HIV testing and harm reduction materials

Several participants who are engaged in sex work described experiencing stigmatizing and shaming responses from the HIV sector, as well as the health sector. Participants expressed a desire for a professional, empathetic, and empowering approach from providers that instead helped them to gain strategies to better protect themselves and manage their health.

Several participants who are engaged in sex work described experiencing stigmatizing and shaming responses from the HIV sector, as well as the health sector.

7.8.2 Strengths in the HIV sector and in primary care

For trans sex workers, the experience that some health centres have in working respectfully with street-involved trans people and who were knowledgeable enough to meet trans sex workers' health needs was seen as a significant asset, as were organizations that consistently provided education and support that empowered trans sex workers and communities more broadly. Specific examples that were mentioned by sex workers included the Sherbourne Health Bus, and the education and support for trans communities provided by Sherbourne Health and Black CAP (Black Coalition for AIDS Prevention). Some sex workers also mentioned primary care clinics where they had access to respectful and supportive providers who were knowledgeable enough around TNB2S health to meet their needs.

7.8.3 Barriers

Sex workers described some barriers that were similar to those described in broader focus groups. Below, we briefly discuss the following barriers:

- stigma, shaming, and discrimination
- accessing accurate and nuanced information

- being pressured by health care providers to take PrEP
- volunteer turnover
- misgendering and deadnaming.

Stigma, shaming, and discrimination

Stigma, shaming, and discrimination were the primary barriers that trans sex workers raised. Participants described this stigma, shaming and discrimination as being expressed in a number of ways, including in judgemental attitudes, negative comments, insults, and looks given by staff at ASOs as well as by health care providers. Sex workers spoke of stigma, shaming, and discrimination arising in relation to doing sex work and having many sex partners. When asking for harm reduction supplies or related supports and services, sex workers also described experiencing stigma, shaming, and discrimination in relation to drug use.

Accessing accurate and nuanced information

Participants in the sex worker focus group also discussed challenges they experienced in being supported to make decisions about their sexual health, their own behaviour, and their own lives. One such challenge was accessing accurate and nuanced information. They provided examples such as information on the risk of HIV transmission in different circumstances—for instance, whether they should take PEP if they had been orally assaulted.

Being pressured by health care providers to take PrEP

Participants in this focus group also spoke about sex workers being pressured to go on PrEP, rather than being provided information to make a free and informed choice. One participant described this as follows: "I agree with [the other participants in the focus group]. [Health care providers] are trying to make decisions for us, rather than leaving us to make decisions for ourselves" (SWJE0813). The project team noted that work to develop a combination of prevention approaches and tailored messages should be done in partnership with trans sex workers; this could go a long way to building trust and addressing sex workers' needs along the HIV care cascade.

Volunteer turnover

In ASOs, turnover of volunteers was seen by a few sex workers as a challenge for creating a trans-inclusive environment. One participant framed this as follows:

> Often many volunteers are put in placements at an ASO as part of their schooling, or to make their resume look better. Ultimately there is a culture and consistency of knowledge among people who are providing the service that is getting lost. Often the volunteer is the first person you see. There is turnover of volunteers, as well as with staff members at times. But specifically with volunteers, you need to make sure the training is consistent. And, that every new volunteer that comes in is provided that same training to bring them up to speed on organizational principles. (SWEL1207)

Misgendering and deadnaming

Similar to some participants in other focus groups, one person in the sex worker focus group noted the costs associated with a legal name change and changing health cards, and how this contributed to challenges in accessing respectful health care: specifically, being misgendered and called by their dead name (a trans person's birth name or other former name, which is no longer used).

7.9 Conclusion

To advance trans inclusion and integration, it will be necessary for GMSH and HIV-sector organizations to address inclusion and integration for the five priority populations discussed in this chapter: to bring about the unique elements of what inclusion and integration looks like for these populations, to find ways to grow and leverage existing strengths in this regard, and to address population-specific barriers to inclusion and integration. We are optimistic that—with attention and intention—HIV-sector organizations can leverage their own histories and strengths in serving groups that have been "othered" and disenfranchised through societal stigma and discrimination.

8. Inclusion indicators: What trans inclusion and integration in the sector would look like

This chapter describes what would be seen if trans inclusion and integration were embedded in the HIV sector, as envisioned by the project participants.

This chapter and the two chapters that follow it discuss the inclusion indicators, strengths, and barriers that the HIV sector needs to address to effect trans inclusion and integration. Yet these findings not only focus on the sectoral level; we also drill down to present findings pertaining to the organizational level and the intervention level. The current chapter focuses on inclusion indicators, with chapter 9 focusing on strengths, and chapter 10 focusing on barriers.

Drawing from the collective aspirations of the project participants, this current chapter thus describes the key inclusion indicators that the HIV sector must bring into being—that is, we detail what would be observed if trans inclusion and integration were embedded in the HIV sector. We encourage HIV-sector managers and staff to consider where they already have strengths in their organization, what gaps they are seeing, and what their strategic next steps might be. We also encourage managers of HIV-sector organizations to collectively consider this at the sectoral level.

Broader sectoral findings should be considered together with population-specific findings

In chapter 7, we advised readers to view population-specific findings holistically, in reference to the broader sectoral picture of trans inclusion and integration that we are presenting in this report. Similarly, the broader findings in this current chapter and the two chapters after it provide only a partial picture—one that must be considered in light of the population-specific findings in chapter 7. This aligns with one of the key findings of this report: the need to break out of siloed mindsets and to adopt an intersectional approach that recognizes that oppressive systems overlap in multiple and complex ways.

The chapter is organized under four broad themes:

1. The principles underpinning trans inclusion and integration.
2. An intentional approach to trans inclusion and integration in the HIV sector.
3. Trans inclusion and integration within interventions.
4. Trans inclusion and integration in health care.

The first three themes are within the direct responsibility or influence of GMSH, GMSH Alliance member agencies, and others in the HIV sector in Ontario. Although the project team intentionally did not ask questions specifically about the health sector, participants shared quite a bit in relation to health care and the health sector.[10] For this reason, we summarized trans inclusion in health care as a fourth theme.

8.1 The three principles underpinning trans inclusion and integration

In sifting through all that we heard from participants, three principles emerged to underpin trans inclusion and integration in organizations and across the HIV sector:

1. An intersectional approach would be embedded in trans inclusion and integration work.
2. Trans people would be more involved and be engaged in more meaningful ways.
3. Strengths-based, celebratory, and empowering approaches would be the norm.

[10]This was unsurprising to us for three reasons: 1) the HIV sector is closely connected with a number of elements of the health care system that relate to sexual health and HIV care, 2) many trans and non-binary people may seek some form of either transition-related care and/or support to deal with the impacts of transphobia, and 3) trans people commonly report very high levels of unmet health needs (see section 3.4).

The first two principles are closely interconnected and are inspired by GIPA/MEPA principles.

> Trans and non-binary folks exist throughout all ethnicities. … In terms of being engaged, you need everyone on board. You can't just have one party who is important to the conversation to be engaged, and others are not [engaged]. The system just wouldn't work. … It's not going to be a fully engaged system that's going to be fully beneficial to the community that it's serving. (SWME0812)

8.1.1 An intersectional approach would be embedded in trans inclusion and integration work

We heard from participants that the inclusion and integration of trans people would be grounded in an intersectional approach. This approach would help to ensure that trans people and communities who might otherwise be left behind in trans inclusion efforts are in fact benefiting from trans inclusion in the HIV sector. This is particularly important, as some participants noted that it is primarily white trans people who are the points of contact with trans communities and who are already engaging in work in the HIV sector to serve trans communities.

An intersectional approach would foster conditions where Indigenous and other racialized trans people, trans people with disabilities, trans sex workers, older trans people, trans women and non-binary folks assigned male at birth, and trans people embodying any and all combinations of these groups could benefit from work to embed trans people in HIV-sector organizations. The HIV sector would also find innovative ways to serve trans francophones and trans people from additional linguistic minority groups.

Some participants noted that it is primarily white trans people who are the points of contact with trans communities and who are already engaging in work in the HIV sector to serve trans communities.

8.1.2 Trans people would be more involved and be engaged in more meaningful ways

Participants in many of the focus groups and interviews were very clear that it is essential that trans people are involved in work affecting trans communities in the HIV sector and beyond. Participants also made clear that the full diversity of trans people connected with gay men's communities and sexual cultures needs to be included in consultation processes, initiatives that are taking a collaboration and co-creation approach, and other forms of decision-making. Not only do structures need to be in place in organizations that support trans involvement—this approach needs to be embedded across the HIV sector. Moreover, we heard that meaningful involvement of trans people includes having work about trans people and communities being led by trans people.

Practices of GIPA and MEPA are the foundation of the Ontario Accord, which HIV-sector organizations across the province have signed on to. While HIV-positive trans people are included under these principles, participants expressed the need for broader principles regarding trans inclusion. In one focus group with frontline staff, a participant said, "Could there be a GIPA/MEPA but for trans folks? Could organizations sign up for this? We need to make a better effort to include the T in this" (F1ED0710). Other participants in the focus group responded with great interest.

8.1.3 Strengths-based, celebratory, and empowering approaches would be the norm

In one of the focus groups with trans people, and another focus group largely comprised of cis gay men, we heard about the need for strengths-based approaches that celebrate trans people, trans communities, and trans bodies, including in the context of having sex.

For example, in envisioning what trans inclusion could look like, one cis gay man who is a manager in the HIV sector stated, "In the work that we do, trans people and bodies—trans sex—would be celebrated. We'd be using a strengths-based approach" (CONE2920). Another cis member of this focus group responded, "This makes me think of [developing] a campaign called 'Fuck trans guys'. Super, wonderful, trans positive, and saying, 'I am hot, this is what I want you to know about the sex I have'" (COAD2920).

Similarly, in one of the trans community focus groups, a participant said:

> When people start transition medically, if they chose to do that, a doctor could have a conversation with them. It would be cool [for the doctor] to have a conversation with them about trans and cis sex, and how to enjoy it safely and about testing. (RLE2707)

Other participants clearly spoke to the strengths that trans women have modelled for other trans people, with one participant highlighting the trans women who "came before us, who marched and advocated before us to say, 'Yes, I am trans, and I am who I am, and no one can say differently'" (SWTA0813). One HIV-sector manager also noted the richness of what trans women of colour and trans sex workers can bring to the HIV sector:

> It's trans women of colour and [trans] people who have experience with sex work who hold so much knowledge, even in our sector—the HIV sector—in mental health and community care. And this could be brought forward and strengthen all of our work. We need to position trans women of colour and [trans] sex workers as experts, and value their contribution to our field. (ED02B)

The sex worker focus group also emphasized the need for an approach that empowers trans people. Moreover, a HIV-sector manager spoke about the need for work that builds empowerment and self-esteem for trans people, which he saw as necessary in the context of syndemics for trans people. This view was reinforced by a comment, made in one of the trans community focus groups, that also spoke to the need for sexpositive resources for trans people: "I don't see resources that talk about gender dysphoria in regards to [having] sex with other people … basically, how to make sex a positive experience for trans people" (RKY2207).

In reflecting on all of these views, the project team members noted how seldom conversations about strengths, resiliency, and positive experiences relating to sex and sexuality had surfaced in the consultations. In contrast, in cis gay men's sexual health work, a deliberate emphasis has been placed on a strengths-based approach, resiliency, and emphasizing sex as pleasurable. Similarly, in reflecting on the comments regarding trans women as role models and trans women of colour and trans sex workers holding deep expertise, the project team noted how seldom stories are told that affirm and value the contributions of trans people—and in particular, the trans women who also contend on a daily basis with societal issues such as racism and poverty.

The project team noted how seldom stories are told that affirm and value the contributions of trans people.

Instead, the stories that are widely replicated about trans women focus on the vulnerabilities that trans women can experience, due to significant systemic barriers and high levels of violence that make navigating life—including navigating safer sex and engaging with HIV treatment and care—more difficult. But although many trans women are disenfranchised on multiple fronts, focusing on these vulnerabilities to the exclusion of other kinds of stories about trans women results in a single-story narrative (Adichie, 2009) about trans women. This single-story narrative not only gives an incomplete picture of trans women; it amplifies widespread but inaccurate beliefs that trans women—and especially trans women of colour—have very short life expectancies.[11] The belief that trans women have very short life expectancies was raised in two separate focus groups (and project team members have heard this belief many other times). The project team is very concerned about the impact of these beliefs and stories on trans women's sense of having a future. We suggest that, rather than focusing heavily on the vulnerabilities that trans women can experience in navigating a society that is full of systemic barriers, the sector instead focus on the skills, knowledge, resourcefulness, and resiliency that trans women have in navigating these barriers. The HIV sector is skilled in this kind of strengths-based reframing, having flipped narratives on HIV. At the same time, the project team also noted the need for the HIV sector (and others) to take action on the unjust systemic and societal issues that are the root cause of problems that many trans women—and trans people in general—face and result in the need for our resiliency in the first place.

[11]Myths on trans life expectancy have circulated in the context of trans health activism, especially in the 2010s. The associated statistics mostly originated from misunderstanding studies that examined reports of anti-trans murders, and were not based on appropriate epidemiological data (Hanssmann, 2020).

8.2 An intentional approach to trans inclusion and integration in the HIV sector

Many participants raised the necessity of taking an intentional approach—encompassing a deliberate and strategically considered approach—to trans inclusion and trans integration, both within individual organizations and across the sector as a whole. The sector must ensure that inclusion and integration span the breadth of gender identities under the TNB2S umbrella, including Two-Spirit and non-binary people. Commitment from organizations' leaders and management teams would be key, as is attention to organizational culture.

This intentional approach is associated with six key inclusion indicators. That is, as TNB2S people are included and integration occurs under an intentional approach, what would be seen is that:

1. TNB2S service users, staff, and volunteers would experience inclusive, supportive, and welcoming environments.
2. Organizational systems would support TNB2S participation in the HIV sector.
3. Capacity would be in place to act for the benefit of the full breadth of TNB2S communities.
4. Clear intentions would be set for welcoming TNB2S people in gendered interventions.
5. The full diversity of TNB2S communities would be represented in strategic and organizational materials.
6. Physical spaces would be accessible and welcoming.

Below, we discuss these inclusion indicators in turn.

8.2.1 TNB2S service users, staff, and volunteers would experience inclusive, supportive, and welcoming environments

Staff and management in HIV-sector organizations raised a range of points envisioning what an inclusive and welcoming environment would look like for TNB2S service users, staff, and volunteers. We describe these views below.

Foundational elements of welcoming environments would be in place

Being called by the right name and pronouns was widely recognized as a basic element of a welcoming environment, as was cis people having an open and nondefensive response when mistakes happen in this regard. Other basic elements of a welcoming environment included having trans-inclusive intake forms and displaying posters in physical spaces that show a range of TNB2S people.

TNB2S service users would see themselves reflected among staff and volunteers

For some participants, having TNB2S people on staff was indicative of a welcoming environment for TNB2S service users. BIPOC trans people clearly expressed a desire to see racialized trans people on staff. One Indigenous participant articulated this as, "I want to see trans and non-binary people [who are] people of colour in these spaces. I need to see myself there. I need care for all the parts of me, not just one part at a time" (IED0809). Other BIPOC participants noted that having trans people of colour on staff would help to build stronger connections with and a sense of belonging for trans participants who are also racialized. Similarly, a participant in the sex worker focus group noted that a welcoming environment would entail "seeing people who look like me, that make me feel comfortable accessing those services" (SWME0812), and that having staff and volunteers who have lived experience of sex work or substance use helps people feel more comfortable and welcomed.

> It's about ensuring there's space where trans men can fully actualize their whole selves. For instance, in some spaces you need to subtract pieces of you. It may be because it is more comfortable to be Black and not trans, or just trans and nothing else. Parts of you get left behind this way. True inclusivity would mean all of these identities would be actualized in this space that we see as safe. (COIK2920)

Work environments would be supportive of TNB2S staff

Unsurprisingly, some participants commented on how the workplace experiences of trans people in the sector fostered or hindered retention of trans staff.

Participants also identified that organizations' managers should take an intentional approach to addressing antitrans behaviours when they occur. This would entail not just checking in with relevant trans staff members to see if they are OK and/or to apologize, but instead seeking to address the root of the situation. Similarly, participants pointed out that managers should take an intentional approach to addressing antiIndigenous, racist, and other discriminatory behaviours when they occur. This intentional approach will also need to be supported through appropriate organizational systems (see section 8.2.2), such as a clear complaints process.

Participants also reflected that organizations' managers—and the sector—could proactively address workplace challenges that TNB2S staff may commonly experience, especially in roles where TNB2S staff are serving their own communities or where TNB2S people are isolated in their role. Some TNB2S participants who have experience working or volunteering in the sector stated that work environments could be made more supportive and less isolating by:

- having more than one TNB2S person working for an agency, where feasible
- creating structures to facilitate connections between TNB2S staff working at different HIV-sector organizations
- creating circles of advisers for TNB2S staff. This was especially seen as a way to both reduce the likelihood of TNB2S staff feeling tokenized, and to create concrete means to support staff in accessing a wider range of perspectives to inform interventions
- having community advisory committees for initiatives that are trans-focused or are emphasizing trans inclusion.

We also heard that an intentional approach to supporting TNB2S staff reduces the risk that TNB2S people will be or feel tokenized, or have their personal reputation negatively impacted by working for an agency that does not have a positive reputation in TNB2S communities.

A TNB2S participant who had been hired in a number of HIV-sector roles based on their lived experience noted:

> Especially when you're talking about hiring people based on their lived experience, there are things that come up. Often issues around class and other lived experiences that are not shared, in addition to being trans. … Because many of us [trans people] don't have credentials, I think there is a high risk of exploitation, and a very specific need for support. (CTER1807)

This participant described support as having paid time to connect with other trans people who have been hired based on their lived experience, whether at that organization or at another agency. Additionally, this participant described support as having direct links to management for issues arising that related to being a worker who had been hired based on their lived experience.

One organizational manager described how he envisioned his organization intentionally nurturing the growth and development of trans people working for the organization in time-limited roles:

> We'd be giving as much to these communities as what we are taking. I think about when we bring folks on as contractors, these paid opportunities and the talent and skill going into projects: Are we developing people and contributing to their growth? We should not have expectations they will stay with us. We should still work with them and leave [them] with as much as what they provided [the organization]. (CONE2920)

Some participants also noted the need for TNB2S staff to be able to access mental health and wellness supports as part of their employment benefits—supports that would be transaffirming and skilled in working with TNB2S people. One participant noted that mental health supports for staff are particularly important in the context of the ongoing opioid crisis and the COVID19 pandemic.

Several trans and non-binary staff mentioned appreciating cis colleagues raising issues that are relevant to trans people, or proactively educating themselves to be able to educate others so that TNB2S people do not have to do this extra work. This level of active engagement from cis colleagues may also reduce the sense of tokenism that trans staff may experience.

One staff person who came out as non-binary in the workplace appreciated colleagues who demonstrated interest and support via asking appropriate and noninvasive questions. For this staff person, this approach validated their identity and enabled them to feel seen.

> [Trans staff] are asking what you, as an employer, can do to create a healthy work environment so they can produce better work. Some part of it is that staff should be trained and aware of what we can do to create a more supportive work environment. (ED03)

8.2.2 Organizational systems would support TNB2S participation in the HIV sector

Participants envisioned that inclusive environments would have systems in place to support transinclusive processes, policies, and practices. As reflected below, much of this support pertains to managing human resources; another element is in relation to monitoring and evaluating diversity and inclusion.

Managing human resources

Organizational systems would support inclusive hiring practices, such as creating job postings that specifically indicate that TNB2S people are welcome to apply, and effectively sharing job ads with TNB2S people and communities. In hiring for trans-focused roles in particular, people from TNB2S communities would be members of the hiring panel. The breadth of lived experiences of TNB2S people would be valued, and staff teams would also include Indigenous and racialized TNB2S staff. Certain human resources policies were also named as supporting inclusion and integration—for instance, policies that require staff to be referred to by the right names and pronouns, and policies that support transitioning on the job (e.g., having formal staff name change processes and providing time off for transition-related surgeries).

Payment processes and compensation methods would be mutually agreeable for organizations and for TNB2S people who have not legally changed their names or are struggling to have their bank recognize a legal name change. Appropriate payment processes would help to protect trans people's privacy in this regard, and reduce barriers for people who are on financial support programs and cannot accept payment through their bank. At the same time, the agency would inform trans people what constraints exist (e.g., some constraints may be due to what banks and taxation laws allow), in order to explore other options.

Systems would also be in place to address behaviours, attitudes, and approaches that are not conducive to trans inclusion and integration. We heard that staff, volunteers, and clients can express ciscentric, transphobic, and/or racist beliefs. Systems would therefore support processes that enable people to address their areas of ignorance and learn from their mistakes—for example, a clear complaints process.

Monitoring and evaluating diversity and inclusion

Participants in the Indigenous focus group envisioned that agencies' management teams would have systems in place to assess whether diversity and inclusion is actually present in groups, services, and in the agency as a whole. These systems would also allow management to consider participant feedback on programs that is broken down by participants' demographic characteristics, including Indigeneity and gender identity.

8.2.3 Capacity would be in place to act for the benefit of the full breadth of TNB2S communities

A range of participants envisioned there being sufficient capacity for inclusion and integration efforts to benefit the full breadth of TNB2S communities. As reflected below, such capacity would particularly pertain to:

- TNB2S people wielding influence in organizations and across the sector
- ensuring that knowledge and skills regarding TNB2S people are embedded in organizations and the sector

- seeking and acting on input from TNB2S communities
- normalizing and resourcing trans-led projects.

TNB2S people wielding influence

Many participants spoke about the need to have TNB2S people wielding influence at every level of organizations—as volunteers, staff, management, and on boards; some also spoke about the need to have TNB2S people on the board of Ontario AIDS Network (OAN) and in other sector leadership roles. TNB2S people would also be involved in decision-making in organizations and throughout the sector, through consultation, collaboration, and co-creation, as well as through participating in organizations' committees. Finally, structures would be in place to support this breadth of influence.

Knowledge and skills embedded in organizations at all levels

Inclusion would occur in organizations at all levels, through volunteers, staff, management, and board all having the knowledge and skills necessary in their roles in relation to trans people, trans experiences, and trans sexual health. This would include understanding how to work with and include people with culturally diverse gender identities—people who do not frame their gender identities in the ways that "trans" is framed in Canada—including Two-Spirit people. Capacity-building initiatives would be in place to support knowledge and skills being developed at every level of the organization.

Seeking and acting on input from TNB2S communities

Some participants identified that organizations, as well as the HIV sector overall, would have sufficient capacity to seek input from diverse parts of trans communities and act on this input. For several participants, inclusion would look like reaching out to and listening to the trans people who have the most barriers and may therefore be less likely to have the resources/opportunity to be a "squeaky wheel." This outreach would help to ensure that trans inclusion and integration efforts actually benefit the full breadth and diversity of trans communities.

Normalizing and resourcing trans-led projects

Some participants shared that trans inclusion and integration would involve normalizing trans leadership of projects for trans communities. Capacity would be crucial, with these projects being planned in a way that factors in sustainability and lasting impacts. Again, participants also spoke to the need to ensure that these initiatives would be inclusive of the breadth and diversity of trans communities.

An aspect of inclusion—as well as a means to foster action—would be for organizations to find ways to fund and resource projects and initiatives for TNB2S communities. This could entail carving out money from existing budgets or seeking new funding for TNB2S-focused work.

> Having trans-led stuff and people trained to be inclusive of race, gender identity, [and] disability diversity. Because sometimes, we want it to be trans-led, but it doesn't mean we have an oppression free space! Having adequate training and diverse representation. Having that as a goal for the space and materials. (01KH2707)

8.2.4 Clear intentions would be set for welcoming TNB2S people in gendered interventions

> You can't expect one Black worker to bring the Black community into your agency—it has to be the whole agency. Same is true with trans people. If they're not in your volunteer pool, your student pool, on your board. … My board has one of the loudest, most obnoxiously wonderful trans women in the world on it. … She makes a point of always making sure that our work includes trans people, in a really vocal, wonderful way. [Trans inclusion would not occur] without that voice being present all the time—particularly at a board table that has a lot of strong personalities that can steer the vision away from [trans inclusion]. You need to include trans people at every level of the organization. (ED04)

A fundamental element of trans inclusion in the HIV sector involves setting and upholding an intention at a sector-wide level in welcoming TNB2S people in gendered interventions that we see as being relevant to us. We heard from participants that inclusion of trans men who are gay, bi, or queer would very obviously fit in gay men's sexual health work (these individuals being both men and not straight). Participants in the consultations, however, did not discuss whether bi or queer men (cis or trans) in fact are comfortable or feel welcome in gay men's sexual health work, or whether they encounter (or fear encountering) biphobia.

Regardless, inclusion would be broader than gay, bi, and queer trans men being welcomed. It would also include clearly stating what the pathways to participation are for Two-Spirit people, trans women, and non-binary people.

An HIV sector manager expressed his vision that these pathways would be self-directed; trans people themselves would determine what services would be most relevant for them.

> There are many trans women who identify with the gay community far more than they do with [cis] women's communities. And some trans men have spent all their time in lesbian communities. We can't speak in absolutes; this has to be self-directed. The person chooses to access services in one stream or the other or both—this should be allowed! For non-binary folks, [denying them this choice is] forcing someone to be who they're not. [This] is what it comes down to, and I think we forget that when we do broad stroke work. (ED04)

"Broad stroke work" carries the risk of not reflecting, and thus not welcoming, people's needs or connections.

8.2.5 The full diversity of TNB2S communities would be represented in strategic and organizational materials

A few participants envisioned the need for TNB2S people and communities to be named in documents that outline organizations' strategic and organizational plans, priorities, and approaches, since these documents guide organizations' future work.

Moreover, one of the most frequently raised areas for action pertained to how images and language are used in strategic contexts: Throughout the consultations, participants spoke to the need to have images and language that reflect the full diversity of TNB2S communities. This diversity was described not only as a range of gender identities (including Two-Spirit and non-binary identities), but also of cultural and racial backgrounds. Some participants spoke to the need for stories centring trans people of colour to be foregrounded, because "our narratives are so rarely represented" (CTYA1907). Participants noted that attention also needs to be paid to representing diversity in age ranges, body types, disabilities, and whether or not people have had—or even wish to have—any transition-related medical interventions. For participants, diversity of TNB2S communities also meant representing a diversity of sexual practices and contexts for sex (including sex work), and a breadth of forms of dating and relationships.

Throughout the consultations, participants spoke to the need to have images and language that reflect the full diversity of TNB2S communities.

A participant in the sex worker focus group summed up one of the rationales for reflecting the full diversity of TNB2S communities: "You have to make sure that everybody is included … so we are not just getting one mental image of what somebody thinks trans looks like" (SWJE0813).

Participants not only envisioned that the diversity of TNB2S communities would be represented in organizations' strategic documents. We heard from some participants that organizations' websites would be improved for TNB2S people: each organization's website would clearly indicate how that organization includes TNB2S people in the agency's programs and services, and who to contact if there are questions.

> We … use images … that tell a bigger story of who we are and who we are inviting in[to] our space. I hope we can be receptive to that feedback and adapt as the community changes, so we can make the necessary changes and make it even better as we go. (ED02B)

8.2.6 Physical spaces would be accessible and welcoming

Having physical spaces that are accessible was also seen as an important element of inclusion and integration. This includes spaces that are accessible to people who have mobility impairments and use mobility aids such as wheelchairs and scooters. Washrooms would need to be physically accessible as well as either gender neutral or marked as trans inclusive.

Enabling grassroots TNB2S groups to use meeting spaces at HIV-sector organizations was also seen as a means to foster inclusion and integration; some agencies are already taking this step.

8.3 Trans inclusion and integration in programming and service delivery

Within the context of interventions such as programs, services, campaigns, and resources, the key inclusion indicator is that sexual health interventions would reflect and be relevant for TNB2S people. However, three building blocks are needed for sexual health interventions to be able to fully reflect and be relevant for TNB2S people. This section starts with these three foundational indicators and concludes with the key indicator.

1. Inclusive language and approaches would be used in day-to-day programs and services.
2. Confidentiality, privacy, and anonymity would be protected.w
3. TNB2S people who are linguistic minorities would be served in their preferred languages.
4. Sexual health interventions would reflect and be relevant for TNB2S people.

8.3.1 Inclusive language and approaches would be used in day-to-day programs and services

Although use of images and language is important in strategic materials (see section 8.2.4), we also heard that inclusive use of images, stories, and language must extend to the intervention level. In this respect, inclusion would occur in the day-to-day work of both HIV-sector staff, and health care providers who may be working in partnership with HIV-sector organizations.

Online outreach

In online outreach contexts, including and integrating trans people would involve posting on social media about issues that affect trans people, while also including trans people in content that relate to broader communities. Inclusion in online outreach would also entail fostering an online presence that is approachable and welcoming to trans people.

Community outreach

In the context of community outreach, participants envisioned trans inclusion and integration as involving staff and volunteers going to spaces that are frequented by trans people, and supporting and participating in trans-focused community events. Two-Spirit participants also envisioned an approach that would focus on building relationships over time, and—where and when appropriate—participating in Indigenous community and cultural events.

Participants in the sex worker focus group—among others—also described inclusive outreach as reaching TNB2S people who are homeless, which would include doing outreach at shelters. This outreach would incorporate HIV and STI testing, helping people learn about PrEP, and supporting TNB2S people in gaining the knowledge and power they need to look after themselves and make informed choices.

Harm reduction

Participants noted that language around harm reduction would be culturally relevant to engage trans people. This was recognized as being especially important because structural barriers—especially for racialized trans women and trans women who are newcomers—can result in high levels of involvement in survival sex work.

Referrals to health care

While some ASOs offer clinics or partner closely with other organizations to collaborate on clinics, not all do. However, as ASOs provide referrals for testing, treatment, and care, ASO staff can take a

proactive approach to support trans people in being able to access respectful and competent health care. In making referrals, ASO staff can contact agencies and health care providers to advise them on language and approaches that would support inclusive care for an individual who is being referred.

Given the barriers that TNB2S people can face in finding affirming health care and social supports, trans inclusion and integration also entails providing warm referrals to other agencies and individual providers.

> Trans people have to do a lot of self-advocating for their health care, so when completing these referrals, there are two [points where] ASOs could intervene. … [Firstly,] helping to explain to a client what barriers they might face and [the] strategies that will prepare them better when they leave your care to go to someone else's care. Second part, during the referral, if you don't have a list [of trans-competent providers], performing a really warm hand-off. Calling the provider and stepping in as an advocate early on will help [to set up the provider to give good care]. I never had a health care provider or service do it for me. I had to do it for me. Like most of us have. (02R00821)

8.3.2 Confidentiality, privacy, and anonymity would be protected

Inclusion would also involve trans people's confidentiality and privacy being protected, and for trans people to not have to out themselves in order to access services. Staff would not make assumptions about anyone's gender identity; a staff member would also share information about all the services that an agency offers, rather than services that they think might be relevant based on how they are perceiving a person's gender.

Inclusion can also be fostered by first recognizing that trans communities are often small and densely connected, and then finding means to address related confidentiality and privacy concerns.

> De si petites communautés, ça peut être difficile et gênant parce que les choses se font savoir vite. Des fois, on veut un cis si on veut un minimum d'anonymité. Embauchez-nous, mais on ne veut pas seulement se faire servir par quelqu'un de notre communauté. On ne veut pas nécessairement se faire référer à quelqu'un qu'on connait. Des travailleuses de sexe m'ont été référées, alors que j'étais formateur, et ça a divulgué leur statut de travailleuse de sexe. On n'aurait pas dû les référer à moi. (FRTH1108, personne trans qui a déjà travaillé dans le secteur du VIH)
>
> *Such small communities can be difficult and awkward because things get out quickly. Sometimes you want a cis provider if you want a minimum of anonymity. Hire us, but we don't just want to be served by someone in our community. We don't necessarily want to be referred to someone we know. I've had sex workers referred to me, when I was a trainer, and it disclosed their sex worker status. They should not have been referred to me. (FRTH1108, trans person who is a past HIV sector worker)*

8.3.3 TNB2S people who are linguistic minorities would be served in their preferred languages

Inclusion would also entail serving TNB2S people who prefer to communicate in a language other than spoken or written English. This inclusion would involve ensuring that resources are available in French and other languages appropriate to the context, and that funding is sought and/or provided for translation and oral interpretation, including in sign languages.

Inclusion would also entail finding creative means to provide supports and resources for TNB2S linguistic minorities in cases where:

- agencies do not have capacity in-house
- the service user has confidentiality- and privacy-related concerns due to dense connections in their linguistic community (see also sections 7.5.1, Engaging in practices that protect confidentiality, and 7.5.3, Concerns over privacy and confidentiality).

8.3.4 Sexual health interventions would reflect and be relevant for TNB2S people

Trans inclusion would involve providing sexual health programs, services, campaigns, and resources where not only is our existence as trans people acknowledged, but approaches to programming are relevant.

Within this, interventions would be designed for TNB2S people at all stages in our journey of exploration and self-expression as TNB2S—not only the early stages. This is notable because some participants observed that interventions for trans people currently tend to focus more on young people who are in their first few years of exploration and/or transition. Some participants also observed that interventions currently pay less attention to non-binary people. We heard from participants that the HIV sector needs to remember that: (a) non-binary people exist; (b) TNB2S people early in a journey of self-exploration and/or transition may be youth, adults, or older adults; and (c) people may have come out as TNB2S years or decades earlier.

Interventions would be designed for TNB2S people at all stages in our journey of exploration and self-expression as TNB2S—not only the early stages.

HIV prevention, treatment, and care

In the context of HIV prevention, engagement, and the care cascade overall (see section 3.7), we heard that trans inclusion entails providers being knowledgeable about sexual health for trans people, as well as having a combination of expertise in HIV care and transition-related health care. Providers would be able to ask screening questions in ways that build comfort for TNB2S people, including questions about relationship types, body parts, and how these body parts are used during sex (see section 8.4.2 for more discussion on providing relevant and respectful health care). Providers would also be able to ask a TNB2S service user about their HIV status and what they are already doing to prevent transmission of STIs, and make suggestions about what else they could do to prevent STI transmission. Additionally, providers would be competent in other areas of sexual and reproductive health care for trans people, like advising on effective contraception for people on transition-related hormones, knowing where and how to swab a trans guy who has had genital surgery, and how to do a prostate exam for trans women.

Providers would be knowledgeable about how PrEP absorption works for trans people who are having receptive sex, depending on what tissues people have and whether these tissues have been modified via hormones and/or surgeries. Some racialized participants spoke about having trans people and people of colour (trans or cis) involved in PEP and PrEP advocacy, as well as in campaigns and work to expand awareness of PrEP as an option. For participants in the sex worker focus group, inclusion meant that education around PrEP would be more nuanced, consider the realities that not all sex workers have the same degree of risk, and foster informed choices.

One participant who had previously noted that Black and Indigenous people have very good reasons to mistrust the health system spoke about the need for messages coming from Black health care providers about the importance of taking HIV and PrEP medications as prescribed.

Harm reduction

Trans-inclusive harm reduction interventions would be grounded in an awareness of the kinds of substances used by trans people, and the patterns and contexts for substance use. Supplies for hormone injections would be readily available.

An ideal experience in accessing care

We have chosen to close this section by reproducing the thoughts of a participant who detailed their ideal experience in accessing care. This participant, one of the HIV-positive trans people who participated in an interview, conveyed their vision of their ideal experience in a follow-up email:

> Everyone likes to be sincerely greeted when they come through the doors of an agency, and if I were a client, I'd like to be, too. That's the first thing in creating good energy. The next would be kindly being served at reception (if required or if there's a reception) while keeping my privacy intact. Then, there would be the waiting area (if there's a waiting area) and I'd see posters/signs up depicting all populations including

> mine, which would be poz non-binary. In the waiting area, there would be pamphlets about supporting trans, non-binary, and gender diverse people, and about services and resources available to them. …
>
> Afterwards, I'd go in for my appointment with the person I've come to see. It will go well. Let's say that it's an intake for me to become a client of the agency. As soon as I say I'm poz non-binary and use they/them pronouns, that person would accept it as something that's part of their agency. They'd ask me if I'd like to be part of certain groups, but they'd also ask if I'd like to be part of different groups that are open to all clients. They'd tell me who would be privy to my private information and who would have some info about me, like my name and pronouns. Afterwards, the person would thank me for coming in, for sharing a part of my story with them, for building trust with the agency. I'd receive a gift card in a bag with some other goodies and resources. Then they would both tell me and write down when my next appointment would be and with whom – if not them, and who this other person or people might be. Then as I make my way towards the exit, I'd be given a friendly farewell by reception, if they aren't busy with someone else. …

Total case management would be in place for trans and non-binary people. That means peer-led supports; referrals to hospitals, clinics, other ASOs, and agencies; the agency would have meaningful partnerships with clinics for testing and PrEP/PEP, [and with] community health agencies and networks for harm reduction supplies, services, and training; programs and/or resources that promote the sexual health of trans and non-binary individuals from the [point of view] of trans and non-binary communities; housing services connected to organizations that may be trans/non-binary-specific … and everything is framed within a trans/non-binary [point of view] or worldview. I haven't seen case management aligned with trans and non-binary [points of view]. It's not just proper pronoun use. It's safety, comfort, and care. It's unique to the individual trans person or non-binary person. We are not the same. We deserve services and support tailored to our individual needs, wishes, and dreams. Treat us as you would treat every other service user: with compassion and care. (H1, HIV-positive trans person)

8.4 Trans inclusion and integration in health care

The following four inclusion indicators encapsulate what would be seen for trans inclusion and integration to be occurring in health care:

1. The health system and health care organizations would take an intentional approach to trans inclusion.
2. Health care providers would provide respectful care that addresses TNB2S people's clinical needs.
3. Local access to transition-related care would be easy to secure.
4. Trans-competent mental health and addictions interventions would be available.

8.4.1 The health system and health care organizations would take an intentional approach to trans inclusion

As with trans inclusion and integration in the HIV sector (see section 8.2), trans inclusion in the health care system would be characterized by health organizations and the health sector taking a deliberate and planned approach to ensuring that trans people experience highquality, patientcentred care.

Organizations would provide patientcentred care for TNB2S people

Some participants identified that it would be necessary for health care organizations and the health system to take responsibility for ensuring that TNB2S people are receiving patientcentred care that meets their needs. Similarly, one non-binary frontline worker spoke about the need for "normalizing trans health care in the medical system" (TFAB1497).

One non-binary frontline worker spoke about the need for "normalizing trans health care in the medical system."

Organizations would ensure their staff are knowledgeable and skilled

Participants also noted that health care organizations and individual health care providers would be aware of TNB2S people's past experiences and expectations in health care. They would understand that "most trans people walk in with fear and assumptions that [health care organizations] are going to be transphobic unless otherwise proven" (O2RA2807) and that "there is a lot of warranted distrust of the medical system by trans people, especially for Black and Indigenous trans communities" (TFJA2207).

Organizations would also take responsibility for ensuring that health care providers, as well as support staff, are knowledgeable and skilled in working with trans people. Because we asked questions about testing, treatment, and HIV care, participants mostly gave examples in relation to public health, testing, and STI clinics. However, participants also envisioned that providers would be knowledgeable throughout the health system—in hospitals, HIV speciality clinics, labs, and other types of health care settings.

> Sometimes we just want whatever is hurting us to be addressed, and maybe I don't want to talk about Two-Spirit identity and sexual orientation with intake nurses. I had possible kidney stones, where an ambulance picked me up and I was wearing a blouse and long hair, makeup. The paramedic asked me to close my shirt. I just wanted the pain to stop and there was nothing to look at on my chest. In the ER, nurses asked me to close my shirt because it was inappropriate, apparently? I did, but asked them to stop the pain. Hours later, the doctor came up and asked me: "Anatomically … are you …" and I said "Male." He thanked me and walked out. How come that had not been a question before? Why was it delivered that way? It was not the time to jump in and teach these folks. (IED0809)

Complaints processes build trans people's trust

We heard from a few participants that sometimes TNB2S people do not advocate for themselves in health care contexts. The project team noted that an aspect of trans inclusion in health care could involve having a clear complaints process that builds trans people's confidence that they will not encounter further transphobia and/or other discriminatory behaviour while raising a complaint, and that raising a complaint will likely lead to positive change.

8.4.2 Health care providers would provide respectful care that addresses TNB2S people's clinical needs

We have divided the following discussion into two areas:

- Providers would be approachable, respectful, and non-judgemental.
- Providers and clinical staff would have the skills and knowledge to work with TNB2S patients.

Providers would be approachable, respectful, and non-judgemental

We heard from several participants that health care providers would be easy to talk to and take a nonshaming, nonjudgemental approach toward TNB2S people, including those of us who do sex work, use drugs, and/or are homeless. Participants envisioned that providers would be able to communicate respectfully, normalize genital diversity, normalize sex with TNB2S people, and understand not only how, but when to ask—and when not to ask—questions about bodies, gender identities, the kinds of sex that TNB2S people are having, and our sexual partners. When health concerns are related to sexual and reproductive health, the health care provider would either ask the person seeking care what language they use regarding their genitals or open conversations with nongendered language that does not assume what kind of genitals the person or their sexual partner(s) have. The provider would also ask open-ended questions about sexual behaviours, rather than assume how a person is or is not using their body during sex.

Participants also envisioned that health care providers would take care to listen to HIV-positive trans patients, including listening to any fears or reservations that we may hold. This would involve "asking important questions about how we take care of our sexual health" (ILI0809) to elicit our observations and opinions before explaining options for HIV treatment and care. As some trans people hold an inaccurate belief that they cannot both be on hormones and taking medications for HIV, listening for HIV-positive trans people's assumptions, concerns and anxieties will contribute to better outcomes.

Approachable and respectful care can also include addressing trans people's "apprehension/avoidance of [HIV and STI] testing due to [gender] dysphoria [as it] can be a big deterrent" (TFJA2207). For example, many trans people who are unfamiliar with how HIV and STI testing works may avoid testing, due to an assumption that genital swabs are necessary in all forms of HIV and STI testing. Providing approachable and respectful care can therefore include "(1) outlining the entire [testing] process, what to expect and why, and reiterating that [patients] can opt out of anything if they so choose, (2) having trans people do the intake and assess risk factors, leveraging [greater ease] to [build trust and] have more frank and mutually understood conversations about how they should be tested, and (3) … allowing trans people to do their own swab/test, under guidance of a practitioner—i.e., allowing transmasculine people to do … genital swabs themselves" (TFJA2207).

Finally, all forms used in testing and care would also be inclusive of trans people, and providers would check with service users about whether the name they use is the same or different from the name on their medical record.

Providers and clinical staff would have the skills and knowledge to work with TNB2S patients

Several participants gave examples of how providers and clinical staff would be suitably skilled and knowledgeable to work with TNB2S people. For one participant, having trans inclusion in place would mean that if a clinic or health care organization says that it serves trans women, it would ensure that clinical staff have the skills to do prostate exams and STI tests for trans women. Similarly, we heard from two trans men that health care providers would know how to do STI testing and treatment for trans men who have had genital surgeries.

Several trans participants envisioned that providers working specifically in HIV care would be knowledgeable about HIV care for TNB2S people along the care cascade, including interactions between HIV medications, hormones, and medications prescribed for mental health concerns. Providers would also be knowledgeable about PEP and PrEP efficacy for TNB2S people who have had—and who have not had—genital surgeries; this knowledge would account for whether an individual is an insertive and/or receptive partner. Additionally, written resources would be available for both providers and community members in relation to these topics. Several participants noted the need to get this information to cis people who have sex with TNB2S people.

8.4.3 Local access to transition-related care would be easy to secure

Community members and HIV-sector staff, from smaller communities as well as from downtown Toronto, spoke about the challenges they face in finding local family doctors and nurse practitioners who have the knowledge and skills to provide transition-related care. Of these participants, some faced the additional challenge of finding local family doctors and nurse practitioners who understand non-binary identities and experiences. Inclusion would thus look like having easy local access to transition-related care, including for non-binary people.

8.4.4 Trans-competent mental health and addictions interventions would be available

We heard from participants that interventions would exist that promote positive mental health and reduce the likelihood of TNB2S people and communities continuing to experience high rates of poor mental health and problematic substance use due to structural and systemic factors (see, for example, Community-Based Research Centre, 2018; Abramovich et al., 2020; Lam et al., 2021). This would include access to transcompetent—and where demand is large enough, potentially trans-specific—supports and services relating to mental health and substance use.

Participants also noted that the availability of these supports would be highly visible, with the supports actively and prominently welcoming trans people.

> Having access to mental health providers—if people could focus a little bit on that, then maybe there would be less death in our community. Not just from drug use, but also by suicide and things like that. I think the drug use is a symptom sometimes of a deeper issue. And I think the mental issues that our community has to deal with are significant, and access to mental health providers is really important, otherwise we'll just continue to lose people, because people are not in a healthy state mentally. (NCH2808)

8.5 Conclusion

The inclusion indicators in this section span the sector level, the organizational level, and the programs and services level. These inclusion indicators also span actions and interactions involving HIV-sector staff at all levels, volunteers, and service users, whether they are cis or TNB2S. It is clear that GMSH, GMSH Alliance member agencies, and staff all have roles to play in advancing trans inclusion and integration in the HIV sector.

The recommendations in this report (see chapter 11), will support these inclusion indicators being embedded in the HIV sector, especially in GMSH-led work.

> In my lived experience, having grown up and identified as male for the majority of my life, there's a lot that, societally, that goes against expressing emotion and seeking out help. …
>
> In relation to sexual health and substance abuse, it's a by-product of not being able to find resources and find support groups and make these connections with people. The visibility of support is something that's very important. Making it known that these are things that are available and to the best of their abilities, making it easily accessible to people, is really important. (NMT2708, non-binary participant)

9. Strengths in trans inclusion and integration

This chapter discusses good work that is already being done to advance trans inclusion and integration in Ontario's HIV sector, as identified by the project participants.

Despite systemic barriers, some HIV-sector organizations and staff have been working to advance trans inclusion and integration for quite some time. In our consultations, participants shared good work in advancing trans inclusion that is already happening in one or more GMSH Alliance member agencies, as well as examples from other sectors that could be adopted or adapted by the HIV sector in Ontario. Participants also shared other structural strengths in the HIV sector that could be leveraged to further trans inclusion and integration. Additionally, given that HIV follows oppression, the HIV sector has been doing important work to serve disenfranchised communities for a long time, and trans inclusion and integration aligns with the pre-existing values of the sector, such as "social justice/human rights," "choice and self-determination," and "respect for diversity" (HIV Resources Ontario, n.d.). The sector may have a degree of readiness to take on trans inclusion work in a robust way that may not yet be common in other sectors.

We hope that this chapter will build awareness of useful practices or innovative programming that are inclusive of or focus on TNB2S people, as many of these practices may not yet be widespread.

This chapter is organized under five broad themes:

1. Strengths and experience in employees and management.
2. Leadership actions that support inclusion and integration.
3. Strengths in programs and services.
4. Structural strengths.
5. Strengths in accessing health care.

The project team has two cautionary notes relating to the content in this chapter. First, trans people and communities may have some anxiety about celebrating good work, due to the risk of allies then thinking that the work is done, rather than seeing that we are celebrating progress. Second, what works from an organizational perspective can still result in barriers for trans people.

> Some of my best experiences were volunteering with ASOs because they were the first places I saw trans people being centred, if not by the agency [then] by the people. That creates a lot of safety in rural areas. The first trans people I met were working in ASOs. Holding that space is important and revolutionary for trans and non-binary people, because there is no space for our community [in rural areas]. (02R00821)

9.1 Strengths and experience in employees and management

It is clear that the HIV sector has been trying to commit to trans inclusion and integration for some time, and that the sector does not lack people who care about trans inclusion and integration. Additionally, there are quite a number of staff and management who already have skills and experience in aspects of trans inclusion and integration.

Trans people of a range of gender identities are already working and volunteering in the HIV sector, including on boards. This can enable trans employees to consult with trans colleagues working at other organizations, or in their own organization (if they are not the sole trans employee). Moreover, trans staff and volunteers can foster a more welcoming environment for trans service users, as well as service users more broadly. A member of the management team described the impact of having a trans person on staff:

> One of the [part-time contract workers] has been in a nontrans specific role, and as a result of having a trans person being in that role, I think the program was enhanced. It increased our ability to offer these services due to [this person's] skillset and experiences.

> It helped the program move forward with additional skills brought into it. I don't think it would have happened if a cis person would have been in that role. (ED02B)

We heard in the consultations that some executive directors and management team members already have substantial experience working with trans people and volunteers, including supporting trans people who are transitioning on the job, and leading initiatives to advance trans inclusion and integration. One of these HIV-sector managers noted that such executive directors and management team members can be a resource to others in the sector.

Participants also noted that these strengths could be further leveraged. A few trans staff members at GMSH Alliance member agencies recalled the Gay/Bisexual/Queer Trans Men's Working Group, which pre-dated the formation of GMSH and whose work led to the creation of the Primed sexual health guide (Gay/Bisexual/Queer Trans Men's Working Group, 2007) (for details of this history, see section 3.1). These staff members suggested that reviving that group or establishing something similar could leverage the efforts of people already working in the HIV sector. This would "[utilize] the expertise and individuals already supporting the work of GMSH" (TFJA2207), which could be a sustainable and effective means to respond to the changing needs of trans communities. This participant suggested that if a group like this were re-introduced, GMSH could pay these GMSH Alliance-linked staff members to update resources. The project team noted that this may be especially feasible if these Working Group members were working part-time at GMSH Alliance member agencies and could have their hours topped up to allow for participation in GMSH project-based work.

Another former staff member observed, "We have lots of trans people who are willing to work, but they lack access to education and proper lingo to get into paid positions. They end up volunteering … and doing peer-run work" (CTIC2007). Initiatives to help trans people bridge from volunteering or otherwise prepare for employment in the sector could leverage this energy and interest in the sector's work.

9.2 Leadership actions that support inclusion and integration

We heard from HIV-sector managers and some frontline staff about the ways—both formal and informal—that some managers and staff are advancing trans inclusion and integration. These actions, briefly discussed below, fall under eight themes:

1. Securing board support.
2. Securing funding.
3. Creating committee structures.
4. Working across internal silos; pooling resources.
5. Using human resources and staff development practices.
6. Cultivating inclusive and welcoming environments.
7. Practising active allyship.
8. Creating partnerships and collaborations.

9.2.1 Securing board support

Some HIV-sector managers are working with their boards to create board support for work on trans inclusion in programming. This work includes educating boards about:

- the issues that trans people face in the context of HIV
- the rationale for addressing trans inclusion in programming.

9.2.2 Securing funding

We heard from several HIV-sector managers that they are finding ways to start doing trans-focused work even in the absence of HIV-sector funding. One manager noted that although funding tends to flow once evidence

is in place, the needs of trans people are so significant that ethically he felt that he could not wait for evidence and HIV-sector funding. These managers found creative ways to move forward on projects of various types and scales, and as a result their agencies attracted trans people whom they had not previously connected with.

> We don't get funding for this, but I created a budget line and went and found the money, and so we started a dropin for trans men. It was successful: We had over 15 people come. And I thought, where have all these guys been all this time? But we hadn't created space. Once we intentionally created space, they came. (ED03)

9.2.3 Creating committee structures

An HIV-sector manager set up committee structures in his organization, resulting in two committees that review everything the organization proposes and creates. These committees help to ensure that the organization's work is useful for the people and communities that it serves, with one of the committees focusing on inclusive policy and practice:

> The GIPA committee reviews everything we produce, from policy, to job descriptions, to posters, to make sure it is empowering for PHAs [people with HIV/AIDs]. The CIPP committee is the Committee for Inclusive Policy and Practice. It looks at the same stuff through a lens of antioppression, antiracism, homophobia, and transphobia, and also ability level, so that all the text is at grade 6 or lower, so that the graphics include people of different ages, abilities, colours, and so forth. (ED04)

9.2.4 Working across internal silos; pooling resources

We heard from a couple of participants about ways that management supported staff to work together across silos or supported the pooling of resources on initiatives. One executive director stated:

> I don't believe in siloing. If we're focusing on a specific population, then everyone who is working in that population is at the table. If we are doing Black work that is general? Then the MSM worker and women's workers, and the harm reduction worker and the youth worker are there. If we're doing trans women's work, then the **WHAI** [Women and HIV/AIDS Initiative] worker is there, the GMSH worker is there, and the youth worker and **ACCHO** [African and Caribbean Council on HIV/AIDS in Ontario] worker also need to be there. (ED04)

A frontline staff person described how, at his organization,

> the GMSH program funds and provides support to a local group of trans and non-binary folks doing capacity-building training for service providers. This was done by my predecessor and another [colleague] working with youth. The ability of the youth sexual health sector to better support trans and non-binary youth—compared to the GMSH sector—has been helpful. The GMSH sector is very well funded, compared to the youth sector, so sharing has allowed us to work better together. This is a success story based on our program dollars being funnelled to support these initiatives. (F2BE1707)

9.2.5 Using human resources and staff development practices

We heard from staff and management in different organizations about a range of human resources and staff development practices to support trans inclusion.

One HIV-sector manager described the steps he had taken within hiring processes to create strong diversity on his staff team, including having trans and non-binary people on staff. These steps included:

- on job postings, clear language conveys that people from specific disenfranchised groups are strongly encouraged to apply

- having a bonus points system in job interviews so that equity factors and lived experience are addressed in a way that is not tokenizing
- having two service users on hiring committees, and if a position works with a specific population, ensuring that the two service users are from the population in question.

Another HIV-sector manager had been able to hire trans people into some time-limited and project-based roles. In this context, he seeks to ensure that contractors have the opportunity to learn and gain skills, as well as contribute to the organization's work.

A trans frontline worker witnessed one HIV-sector organization mentoring trans workers who were new to the sector:

> [The organization] mentored folks getting into [HIV-sector] work. There needs to be capacity building for trans people to do this work. I really appreciate [a larger ASO] mentoring folks and taking the time late at night to help trans folks learn how to do outreach work. I think more cis workers need to do the work of building capacity in trans people. … This mentoring was wonderful and helpful. (CTRO2007)

At the deliberative dialogue, participants suggested additional tools and resources that could be built upon:

- OAN's workbook on how to include trauma-informed care in organization policy
- the trans inclusion policy from the Centre for Women and Trans People at University of Toronto (The Centre for Women and Trans People, 2008)
- multiple relationship policies to support staff in ethically navigating small and densely connected communities. MAX Ottawa and Sherbourne Health were mentioned as having such policies; both of these policies were developed based on an article (Everett et al., 2013) to support LGBT2SQ addiction counsellors who are working in their own communities.

> Even a simple paragraph at the end of a job description that says, "Trans people, people who have used injection drugs, people of colour are strongly encouraged to apply." A simple paragraph, nice and bold, not at the bottom, has people think "Oh? People like me are strongly encouraged to apply. Why is that?" (ED04)

9.2.6 Cultivating inclusive and welcoming environments

Some HIV sector managers spoke about cultivating an inclusive culture and environment, and being intentional about what people would see in materials about the organization "to tell a bigger story of who we are and who we are inviting into our space" (ED02B). At another organization, "when you come in the lobby, it says 'We are waiting for you.' It is not specific to gays, straights, trans, or non-binary [people]. That signage reflects our culture and our approaches in these services and programs" (ED01A).

Some participants noted that websites can convey an organization's intention to welcome and include trans people, by clearly indicating which programs welcome trans people as participants, and which populations a program or intervention is meant to serve.

9.2.7 Practising active allyship

We heard that active allyship can have many forms, not only including the behaviours of individual cisgender staff members toward trans colleagues, clients, and populations, but also being demonstrated in the ways that agencies, especially in smaller communities, can step up in support of trans people. Moreover, active allyship can occur among TNB2S people.

Practising allyship with Indigenous and Two-Spirit people as a holistic commitment

Participants in the Indigenous focus group expressed the importance of being in allyship with Indigenous and Two-Spirit people as a commitment across all domains of one's life, not just in the context of one's day-to-day work.

The Indigenous focus group expressed the importance of being in allyship with Indigenous and Two-Spirit people as a commitment across all domains of one's life.

Being willing to make and learn from mistakes

We also heard from several participants that being willing to make mistakes or fail, and to learn from these experiences was a vital element of people practising active allyship with trans people.

> It's just the learning that comes through not being afraid to fail. The trick is not to fail at the cost of someone's life. You fail, and you own it, and you go to the person who's been affected, and you say, "I fucked up, and how do I fix it?" That can be tricky for people who have massive egos, and eDs typically have big egos. That can be hard. (ED04)

Cis staff practising allyship with trans people

Trans participants described allyship coming from cis staff in several ways. One participant described a cis colleague noticing in an organizational strategy session that a critical statement did not include trans and non-binary people; this observation and the subsequent revision of the statement kept problems from arising later.

One trans peer worker really appreciated those occasions

> when [cis] colleagues step up and back up trans individuals when they see anything wrong within the agency, or with community partners. … An organization has to be an ally, so I don't have to be a trans person who is educating bunch of cisgender workers or addressing any incidents in the workplace, because [cis] allies are heard more than trans individuals. (TFBL0715)

Organizations practising active allyship with TNB2S people

Another trans staff member appreciated how a particular organization structured training and education work. This organization has

> a facilitator for safer spaces [trainings on LGBT inclusion]. He is a cis guy, but he has done a lot of learning and taken an educational role [in relation to trans issues]. It was helpful not to have a trans person take the brunt of all the work. Having a white cis man taking on the work and using his privilege is helpful, so that trans people don't feel drained taking on that emotional labour. (TFAL0710)

This same staff person also described their organization's shift to more trans-inclusive language and its wider benefits for that organization's culture and program delivery:

> I have been seeing a really cool shift away from [gender-]based language. For instance, we are no longer associating periods solely with women. We can have conversations about people who menstruate. It seems little but it makes a big difference. It changes the culture day-to-day. It creates a culture of correcting. It is nicely correcting. It allows people to practice making mistakes. It translates [in] the way we deliver our programming. It helps cis people too, and in a way that benefits the trans people represented. For instance, our GMSH worker had a full conversation with his clients about how it is not just women who menstruate. It is a heartwarming thing to see it happening so openly. (TFAL0710)

Organizations can also play important roles in their regions to foster trans inclusion more broadly. An HIV-sector manager described how his agency has stepped up to raise trans visibility in the region in a variety of ways, including through media work and policy work. The organization has also stepped up to support local trans people who have encountered discrimination within the LGBT community, as well as from other agencies.

Intra-community allyship among TNB2S people

Some participants noted the importance of intra-community allyship—specifically allyship in which trans women and trans men (as well as cis people) speak out against gender binarism and instead affirm all the ways that transness can be manifested.

9.2.8 Creating partnerships and collaborations

HIV-sector managers and staff mentioned several examples in which their organizations were partnering with others to foster trans inclusion and integration. In one case, an executive director noted that he sat at a region-wide multi-agency committee that focused on advocating for and collaboratively developing new services and supports for trans people. This points toward opportunities for collaboration and coordination in other regions where multiple agencies are engaged in some form of work focusing on trans people and communities.

A couple of the participants described approaches that helped partner agencies, as well as individual staff, grow in relation to trans inclusion. One HIV-sector manager described a community–clinical partnership to provide innovative and integrated programming for gay men:

> In the partnership, we are working to align some values. … It's been interesting working with partners to agree to go beyond cis gay men. To include trans and non-binary folks who may want to be integrated in this space. It has been an educational opportunity for them. (ED02A)

Similarly, a frontline staff member at an ASO that partners with their local public health unit on HIV and STI testing described how they prepare the staff from the public health unit:

> In providing training to Public Health testing staff, we have A LOT of discussions about how to ask about the kinds of sex someone might be having without making assumptions based on (1) their body and how they use it and (2) their partners, which people love to do with trans folks. (TFJA2207)

Most of the other examples involved partnerships that expanded an agency's ability to meet client needs, such as partnerships to address social supports for trans people. One HIV-sector manager noted that his agency had partnered with two other ASOs in their part of the province to secure funding to work with LGBT2SQ seniors; an emphasis of the project was to advance peer-driven programming for Indigenous and trans older adults. Another agency partners with a PFLAG (Parents, Families and Friends of Lesbians and Gays) Canada chapter to create social supports for LGBT youth, many of whom are trans or gender questioning; one of the supports included providing a trunk of clothing for trans youth to try on, including chest binders.

Some partnerships focused on trans people's basic needs. In response to WHAI's priority of addressing violence against women, one agency's WHAI worker provided training and support to local women's shelters to enable them to welcome and serve trans women. Another ASO partnered with Dress for Success, an organization that provides women with professional clothing to help secure employment. This partnership enabled trans women to access clothing for work; this ASO also built other partnerships that supported trans women who were early in their journey to experiment and build skills and confidence in relation to their gender expression.

One HIV-sector manager noted that people in the HIV sector can support trans community groups and organizations by leveraging "their experience and skills. We can support groups in getting funding with the federal government" (ED02A). The project team noted that this could include mentoring leaders of trans community groups in grant writing, partnering on projects with grassroots groups, as well as serving as the agency of record for grassroots groups.

9.3 Strengths in programming and service delivery

Active trans inclusion and integration by staff and management has carried through into delivering a growing range of programs and services, as well as developing resources and campaigns. Transspecific and transinclusive initiatives have not only occurred in downtown Toronto and other large cities, but also in smaller centres.

As well as observing that more programs and services are becoming trans inclusive, current and former staff, management, and some volunteers noted that some transspecific programs and services have been developed. In many instances, participants mentioned that having trans and non-binary staff as facilitators and program developers led to more TNB2S engagement, better sexual health information for TNB2S folks, and more relevant supports and services.

The strengths in this section are divided into ten subsections:

1. Multi-year trans initiatives making a longer-term difference.
2. Intake appointments and initial meetings with new clients.
3. Trans-inclusive HIV prevention and supports.
4. Trans-specific interventions.
5. Accessing trans clinics, and HIV testing, treatment, and care.
6. Outreach and engagement.
7. Ongoing engagement in consultation and evaluation.
8. Conferences.
9. Leadership development initiatives.
10. Resources, campaigns, tools, and supplies.

> Now, we have workshops about lube, sex, and toys. I now know when I put workshops together, I cannot only speak about male genitalia. I have to talk about insertive genitalia as well in men who have sex with men. This creates a shock, but also an understanding and education [opportunity] for cis men. It helps them avoid making assumptions. It has created better conversations with trans folks and has positively impacted our work with trans youth. We have hired [racialized] trans youth to lead and take charge of the program, so it is not whitesplained or mansplained, and they are students. It gave them space to lead and create workshops. They facilitate and I cofacilitate. (F2KE2007)

9.3.1 Multi-year trans initiatives making a longer-term difference

We heard from participants in one smaller community that although funding has typically been for time-limited initiatives, multi-year projects to address the needs of trans communities have made a lasting difference beyond the period where funding was available. Multi-year trans initiatives can cultivate trust and demonstrate commitment; as one HIV-sector leader noted about such an initiative, community members "saw that we were willing to involve ourselves in [the] trans community in a significant way" (ED01A).

9.3.2 Intake appointments and initial meetings with new clients

Trans inclusion can also be fostered in intake appointments and first meetings with new clients. One former staff member described offering new clients many options, including gender-designated options, without assuming whether the client will or will not need them:

> I name all services that I am enlisted to provide and give the person options. I'll list services or information, even when I don't think the person will need them. … I am giving even more options than I think is necessary, because you deserve to know, and because maybe you know someone that needs a thing. This strategy has been so helpful, especially when [programs, services, or resources] are assigned to [people seeking services, based on their perceived gender] or [are] gender designated. (H4, HIV-positive participant who is a past HIV-sector employee)

9.3.3 Trans-inclusive HIV prevention and supports

Some agencies have already developed workshops on sexuality and relationships that are inclusive of trans people. Some capacity-building programs regarding health promotion and sexual health for gay, bi, and queer men (cis and trans) were identified as being very inclusive of trans men, creating spaces where participants could learn from each other, and where transphobic myths could be challenged and broken down.

We heard in the francophone focus group about how content regarding gender diversity and sexual orientation was included in broader initiatives for newcomers. In one such initiative, participants selected discussion topics, and sexual orientation and gender identity was a topic that they wanted to learn about. The group leader co-facilitated a session with a staff person from the local public health unit.

One participant also mentioned Rainbow Services, an addiction program for LGBT2SQ people at CAMH, as a service that could be useful for trans people, given the high rates of addictions in our communities. However, this participant indicated that it seems as though Rainbow Services is seldom used by trans people who want surgery, due to a widespread but inaccurate belief that being diagnosed with an addiction or mental health concern prevents access to any form of transition-related surgery.

9.3.4 Trans-specific interventions

Participants—primarily staff and management—gave examples of transspecific interventions that already exist, such as a drop-in program for trans men, initiatives that support exploring gender transition, and initiatives that support trans people in their gender presentation. We also heard about some onetoone and group interventions to support mental health, a comprehensive trans peer support program, and shorterterm projects such as multigenerational digital storytelling projects.

9.3.5 Accessing trans clinics, and HIV testing, treatment, and care

We heard from participants about a range of current strengths in accessing transition-related care, other primary care, and HIV testing, treatment, and care. These include:

- overtly transinclusive testing initiatives
- access for trans people to primary care and sexual health clinics, as offered by or in partnership with HIV-sector organizations.

One agency has a trans program where participants have access to counselling, HIV and STI testing, referrals to HIV specialists, PrEP and PEP as appropriate, a comprehensive peer program, and a trans clinic that provides access to hormone care.

As most agencies do not have trans care available in-house, some HIV-sector staff are:

- building networks of transaffirming health care providers
- making warm referrals to:
- primary care clinics that serve trans people
- HIV care
- a broad range of other providers and services that trans people may need, such as transaffirming STI testing, fertility services, and counselling.

HIV testing

An HIV-sector manager whose organization had engaged in consultations and then made changes to how they run their testing initiatives stated, “We are getting a lot of newcomers and trans people who have never been tested before access our clinic, because of how we market and develop services” (ED02A).

A couple of participants mentioned the Dean Street Clinic in London, UK as an ideal model in terms of how it runs its testing:

- Anonymity is maintained.
- A client can input information about their gender identity and body into a computer, and the appropriate self-swabbing kits are dispensed.
- It is optional as to whether trans people need to interact with staff.

HIV care

Some HIV-positive trans people spoke about the strengths they saw in their HIV care:

- The care was easy to access.
- The appointments did not feel rushed: There was time for conversation with their doctor, and their doctor took the time to explain things to them.
- Their doctor was consistent in asking them which treatment options they wanted to pursue.

One HIV-positive participant noted that her doctor is trained in both HIV care and trans primary care, and that this combination of skills made a positive difference for her.

> I would say my health care team is very good. They get that I am non-binary. … And also with HIV, choice is really important. They make sure that at every step, whatever I come in for, that I have choice. I think it is very important, because to take away choice in [a] health care setting is, it disempowers you, disenfranchises you. (H1)

9.3.6 Outreach and engagement

A participant who travels into smaller communities as part of their work mentioned that agencies having profiles on hookup apps lets people who are travelling know that there is safety and resources available in the area if needed. This form of outreach also boosts the reputation of the agency.

Trans people who were street-involved mentioned that they valued mobile health outreach vans that are run by organizations that are seen as being welcoming to trans people. The Sherbourne Health Bus, in particular, was mentioned.

Other strengths mentioned by staff included partnership and engagement with local trans-driven groups.

9.3.7 Ongoing engagement in consultation and evaluation

Some staff and management spoke about the importance of consulting with trans people and communities in developing new initiatives and regularly evaluating existing initiatives.

For instance, one HIV-sector manager described a community–clinical partnership that is under development and is intentionally taking a trans-inclusive approach. In developing the initiative, the partners consulted with people from a range of groups, including trans people. The input has shaped the initiative overall and also resulted in a thoughtful approach to the initiative's name and the language used to describe the initiative.

An organization that has an extensive trans program engages in "annual community consultations and surveys for trans, non-binary, and Two-Spirit communities to share their feedback about our programming directly" (TFJA2207). The agency also engages in "annual peer worker reviews where peers can provide their feedback [on trans initiatives] anonymously and/or directly to program coordinators" (TFJA2207).

> Trans people continue to tell the HIV sector what to do about trans people. That's what gives me hope. (H4, HIV-positive, non-binary person)

9.3.8 Conferences

We also heard that some conferences run by HIV-sector organizations are taking an intentional approach to trans inclusion. For example, one annual conference has a program track that is specifically focused on trans populations.

9.3.9 Leadership development initiatives

Two HIV-sector managers mentioned the existing leadership development initiatives Totally Outright and the Positive Leadership Development Institute (PLDI). One of these managers mentioned Totally Outright, in the context of this initiative being inclusive of young trans men at that manager's organization. The other HIV-sector manager noted that PLDI could be adapted to be trans-specific and could focus on preparing trans people to work in the HIV sector.

9.3.10 Resources, campaigns, tools, and supplies

The sexual health guides Primed and Brazen were seen as groundbreaking assets. Both frontline workers and community members noted that these were the only resources that they knew of and trusted. As one participant observed, these resources enable frontline workers to provide factual information that uses inclusive language, in both in-person work and online outreach:

> Sexual health information like the Primed guide is working well. It's fantastic for frontline workers like myself, to educate myself and make sure my language is accurate and inclusive. It helps me with the messaging I can use online and in other outreach to make sure it's factual and appropriate and correct. (F1L00207)

The Sex You Want website and campaign was also noted as having some content for trans guys: "An ask from queer trans guys was for it to be woven in the content. They wanted to see themselves reflected in the project and not as an additional campaign or chapter" (CONE2920).

Beyond these campaigns and resources, participants described some pragmatic ways that harm reduction and safer sex supplies have been made available to TNB2S people. One approach was to modify the packaging of safer sex supplies to make it more trans inclusive—for instance, by placing stickers on the packaging for insertive condoms, covering up "female condom" so that instead it read "internal condom." Staff from some agencies also noted that trans people could access hormone injection supplies through their harm reduction programs.

A trans sex worker also described a recent positive experience that was nonshaming about the volume of supplies that he needed:

> I went to the gay men's sexual health department because there is a lack of large condoms in my region. I told them I needed some and they told me to come back Thursday. …They didn't just have a few large condoms—they gave me a box of 100, which is what I needed. I appreciated they were generous with that offer right off the bat. I don't know I would have felt comfortable asking for this much, or more if they offered less. (01LA3007)

9.4 Structural strengths

As well as sharing examples of existing good work to advance trans inclusion, some participants shared structural strengths in the HIV sector that could be leveraged in service of trans inclusion and integration. These structural strengths fall under four areas:

1. Organizational learning and capacity building.
2. Building evidence through the OHTN Cohort Study.

3. Understandings of syndemics.
4. Leverage available to GMSH.

> We have our own health care clinic, which was originally only for HIV, but now we also serve trans folks. We are the only transspecific health care clinic in our area for any health concerns, including transition care, hormones, etc. Because of these two things, we really built our work around trans folks, including providing them with harm reduction materials, sexual health information, and direct clinical care. Because there's that direct link to a clinic, we also can provide trans people with direct access to testing, PrEP, and PEP as needed. Having that comprehensive approach to health care allows us to address the clinical side and the support side of care. (F1JU3006)

9.4.1 Organizational learning and capacity building

We heard from participants about several strengths in relation to learning and capacity building, not only within the HIV sector but outside of it.

Examples within the HIV sector

For ASO staff working in gay men's health, GMSH already has an approach for onboarding staff and supporting their ongoing development. HIV-sector managers in particular noted that this could be leveraged to advance trans inclusion and integration. Firstly, some modules, such as those focusing on online outreach, could be updated and expanded to be more trans inclusive. Secondly, for any future training materials focused on working with trans people and communities, GMSH could make them available to staff working in any role in the HIV sector.

In the deliberative dialogue, one participant wrote that a GMSH Alliance member agency "has started to include resources in staff training to focus on power and privilege, along with trans inclusion." Another participant suggested building on OAN's workshops for board chairs, to help advance trans inclusion at the board level.

Examples from outside the HIV sector

Some participants raised examples of how some nonprofit organizations outside the HIV sector address ongoing skills development around equity and inclusion.

One participant's role includes advancing equity and sexual health education. This person described how their organization was getting aligned internally before doing training for other agencies:

> I am [in a position related to equity] in my agency. I was supposed to educate other agencies, but we can't do that if we are not doing it internally. … So we are creating [a resource] as a 101 for new staff. We are also creating a sister workshop that goes more in-depth and more [into the] context of the work we do. (ILI0809)

Another participant who had worked in both sexual health and HIV-sector organizations described three different approaches they had either been exposed to or led themselves that fostered sustainable learning and skills development:

- One agency had a series of about 10 workshops on equity-related issues and sexual health issues that staff needed to revisit regularly to keep their knowledge fresh; the workshops themselves were also updated regularly.
- Another agency had a regular lunch and learn series.
- When this participant was leading a team, they shared readings within their team and fostered focused conversations that enabled their team to think more about the philosophical approach to the work that they were doing.

Some participants also mentioned Rainbow Health Ontario's trainings and resources, such as the Service Provider Directory and the Trans Health Knowledge Base, as being useful for staff and clients in the HIV sector.

> One of the things I loved about working with that previous supervisor was … a requirement of "unlearning" workshops. It was a series of consciousness raising and skill building around specific issues of relevance to communities we are serving. Unlearning ableism, misogyny, racism, and homophobia. There were maybe 10 different topics, and you'd need to complete at least seven in the first two years of employment. They were offered cyclically. All of them had to be done in the first three years. You also had to do them again, this was understood. There was a 3- to 5-year limit of competency and it was understood you needed to go back to this again after. (H4)

9.4.2 Building evidence through the OHTN Cohort Study

The OHTN (Ontario HIV Treatment Network) Cohort Study was identified as a strength that could be leveraged, given its infrastructure and resourcing, although there is work to be done to connect HIV-positive TNB2S people with the study. One HIV-sector manager noted, "We need to work with the OHTN and work with the [OHTN] Cohort Study that tracks positive people" (ED04). The OHTN Cohort Study is used to not only look at medical outcomes but quality of life for HIV-positive people. This HIV-sector manager noted that while few TNB2S people are currently connected with the study, there are HIV-positive TNB2S people who could potentially be connected with this study or similar studies. This would maximize opportunities for existing studies to generate evidence to support the development and funding of interventions for TNB2S people.

9.4.3 Understandings of syndemics

Two HIV-sector managers suggested leveraging the approach of understanding syndemics to support trans people. One of these managers noted that an evidence-based approach rooted in understanding syndemics for gay men has allowed the HIV sector to broaden its approaches to HIV prevention in gay men beyond testing and condom distribution. Exploring what the syndemic factors are for trans people could be very useful to being able to identify interventions that address the root issues.

The project team noted that an interconnected set of myths and misperceptions may contribute to syndemic factors for trans people. These myths and misperceptions can lead to an avoidance of seeking support or care, especially by people who are considering or seeking transition-related surgery. Among these myths is the idea previously noted in section 3.7: that a trans person who is HIV positive cannot access such surgeries. This myth may cause some trans people to avoid testing. Another myth, which was raised in section 9.3.3, is that trans people will not be approved for transition-related surgeries if they have an addiction or have any mental health diagnoses. Finally, there is a widespread belief that trans men are not at risk for HIV, without any consideration of what sexual practices and partners are involved.

> We know that young people, their frontal cortex is the last part of their brain that develops. This is where your decision-making and risk assessment things come from. Young people believe that they're immortal because this doesn't develop until you're 25 or 26. … [For trans people,] if you couple that with low self-esteem, if you couple that with lack of opportunity. … We may have someone who feels bad about themselves, they've been rejected, they may have suffered physical, emotional abuse from their parents because of their transition, they may have experienced violence because of their transition, they may have experienced alcohol use or drug use. … Well, that's like a cardboard cut-out of "Here's how you get HIV." (ED04)

9.4.4 Leverage available to GMSH

We asked HIV-sector managers what sources of leverage they saw in the HIV sector to advance trans inclusion. One spoke about the leverage that GMSH itself could use with governments, stating:

> The GMSH has a stronger voice than they know. By the very fact that GMSH represents the majority of people with new infections and already living with HIV, that has weight. Because you can say, "Yes, trans people are a part of this, they are a small part of the overall piece." But as gay men—the entirety of gay men [comprise] over 60% of new infections, 50% of the [HIV-positive] population across the entire country, and in Toronto about 75%. … There is statistical

> weight there that you can bring to bear as an organization. I think GMSH is not aware that they have a big club in their hands and they can use that club any time they want. (ED04)

This same manager noted that "GMSH does have the authority to say to its workers that they will do x, y, and z this year, but that that must include trans work," which could "include measurable interventions and impacts around engaging trans communities as part of the workplan" (ED04).

9.5 Strengths in accessing health care

Participants provided several examples of strengths related to accessing health care. Some of these strengths involved partnering:

- on a local trans clinic run by a community health centre
- with local transaffirming physicians to improve access to care
- to jointly offer groups that support trans people's mental and social wellbeing. A CMHA (Canadian Mental Health Association) office was mentioned as one of the partnering agencies.

Staff at several agencies mentioned that they provide capacity-building training for staff at other agencies, including health care providers such as public health units that do HIV and STI testing in partnership with ASOs. One HIV-positive participant noted that she was involved in training medical students, including in relation to HIV testing, as part of a local partnership between a university and an ASO.

In relation to trans health more broadly, participants noted several strengths and opportunities for leverage. For example, there are community health centres, Aboriginal health centres, family health teams, and other health care organizations across the province that are already doing trans inclusion work. Several participants also mentioned Rainbow Health Ontario's role, which focuses on capacity building in the health sector and has a strong emphasis on trans health. There may be possibilities of developing partnerships with these organizations and their programs. Furthermore, one participant noted that there are "plenty of trans people working in health care who are perhaps very well connected" (CONE2920) and that GMSH could connect with these individuals to see if or where it might make sense to join existing conversations and initiatives to advance trans inclusion in health care.

9.6 Conclusion

The existing strengths and experience of staff and management in some HIV-sector organizations, along with sectoral advances in inclusion and integration that have already been made, provide a good foundation for future robust initiatives to advance trans inclusion and integration in the HIV sector. These strengths can be leveraged through sector-wide approaches. At an organizational level, we also hope that management and staff are inspired by work happening in other organizations, and choose to adopt or adapt the approaches illuminated in this chapter for their local context, thus catalyzing further work to benefit TNB2S people.

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10. Barriers to inclusion and integration

This chapter focuses on the obstacles and challenges that the participants identified as barriers to trans inclusion and integration.

In the consultations, participants raised many barriers to trans inclusion and integration. These barriers are densely connected, and they include barriers specific to the HIV sector as well as broader societal issues such as racism and misogyny. In this chapter, we have grouped the barriers to trans inclusion and integration, as identified by the participants, into four broad dimensions:

1. Foundational barriers.
2. Barriers in programming and service delivery.
3. Barriers for TNB2S people who might consider HIV-sector resources, programs, and services.
4. Barriers in health care.

While the number of barriers that have been identified by participants may feel daunting, the project team believes that it is easier to take action on these barriers once they are identified and understood. In the consultations, we also asked participants for solutions and suggestions for overcoming these barriers, along with other means to move forward on trans inclusion and integration. In some cases, the solutions and suggestions are noted in this chapter; they have also informed the development of our recommendations (see chapter 11). If focused efforts are made to address the foundational barriers, it is likely that many of the downstream barriers in programming and service delivery—and some of the barriers for TNB2S people who might be considering HIV sector services—will subsequently be much easier to resolve.

10.1 Foundational barriers

Below, we discuss the following seven interconnected foundational barriers to trans inclusion and integration:

1. A siloed landscape.
2. Other funding constraints.
3. A lack of research, evidence, and information about TNB2S people enables myths and inaccuracies.
4. A broad lack of organizational support across the sector.
5. Staffing and workforce barriers in the HIV sector.
6. Sectoral and organizational culture.
7. Competitiveness between agencies obstructs collaboration.

10.1.1 A siloed landscape

In Ontario, most funding for direct services in community organizations is targeted through PPNs and initiatives. As discussed below, this creates a siloed landscape, not only in terms of how these population-based networks and initiatives operate and are funded, but the siloed mindsets that this population-based approach gives rise to.

Among the organizations in this landscape are GMSH and ACCHO, which both have outreach workers/educators in ASOs to respond to the needs of their associated populations. WHAI has a network of community development workers in ASOs that strengthen the abilities of other health and social service organizations to serve women who are living with or at high risk of HIV. Oahas (Ontario Aboriginal HIV/AIDS Strategy) supports the capacity of Indigenous communities in relation to HIV (Ontario Advisory Committee on HIV/AIDS, 2017). Injection drug user (IDU) outreach programs also employ outreach workers and peers in harm reduction work to connect people to relevant services. IDU outreach programs are supported through the Ontario Harm Reduction Network, which also provides training, networking opportunities,

and consultation to service providers and agencies (Ontario Harm Reduction Network, n.d.). Finally, the Committee for Accessible AIDS Treatment (CAAT) works with HIV services and the HIV sector to advance their ability to respond to the needs of migrants with and without status in Canada (Ontario Advisory Committee on HIV/AIDS, 2017).

Silos compromise organizations' ability to serve TNB2S people

> When I was a volunteer, I saw people in our agency struggle [with] restrictions placed by their funders. There was a gay men's counsellor, a women's counsellor, and [an] Indigenous counsellor which was all great, but for trans and non-binary folks … [the counsellors] would always do their best to make sure people are included, but [the counsellors] almost could not say it or advertise themselves as being totally open to trans and non-binary people because it falls outside of what their original mandate is. (O2R00821)

Participants saw the siloed way in which these population-based networks and initiatives are currently funded, and the way these initiatives themselves operate as silos, as one of the biggest challenges to trans inclusion and integration. The distinctions based on gender were seen as particularly problematic. One HIV-sector manager noted that a key staff member at a funding agency had provided direction to the sector that trans men were to be served by GMSH, and trans women by WHAI; however, this does not necessarily work for all binaryidentified trans people, much less non-binary and Two-Spirit people. Instead, this manager noted that a better approach would be supporting service users to determine what programs and services are relevant for their own needs. The project team noted that this funding agency's direction, provided some years ago, was likely intended as a constructive effort to ensure that trans men and trans women would be considered and included in the work of PPNs; however, as more nuanced understandings of TNB2S people develop, policy guidance also needs to adapt.

Staff also struggle in determining whether and how trans people should be included in GMSH-related programming. In the absence of GMSH defining how TNB2S people should be included and integrated in programming for GBQMSM, "it winds up going under the workers' own interpretation" (TFAL0710). This results in both inconsistency in access for TNB2S people across the province, and outright denials of service to TNB2S people (see section 10.2.3).

A lack of intersectional approaches

> We heard time and again from project participants about the need to work from an intersectional perspective.

We heard time and again from project participants about the need to work from an intersectional perspective. In contrast, the siloed funding streams, while addressing population diversity, focus on a single facet of a person's identity or experience. If we think about an HIV-positive Indigenous trans woman who lives in an urban centre and primarily dates gay men, where would she go for relevant support, education, and services—and where would she feel welcomed and included? How about a non-binary refugee who engages in survival sex work? One HIV-sector manager expressed the patterns he saw across the HIV sector as follows:

> The more we do this work and the more we see the intersectionalities, the more we see we are leaving people behind and we see people are hurting because they don't connect. We go for who floats to the top—the easy catch. Nobody wants to dig deep and go beyond the surface. (ED03)

Gender-based silos create siloed mindsets and leave some trans populations unaddressed

As one frontline staff member observed, gender-based silos can also lead to siloed mindsets among people working in the HIV sector:

> I think a big issue in how ASOs work is how our work is so siloed. The expectation to have trans folks taking on [trans] programming is because our staff are already siloed: GMSH staff working with MSM, women's staff working with women, etc. And so, we all work

> in our little silos, responsible for our own programming. Given this, it's easy to expect [trans] folks to take care of [programming for trans people] solely. (F1JU3006)

However, because there are currently no funding pockets designated to address trans people's sexual health, this mindset also contributes to barriers to embedding trans people in HIV-sector work. We recognize that that if designated funding to address trans people's sexual health was available, a carefully considered approach would be needed as to how to implement this, in order maximize benefits and minimize potential drawbacks. Trans-specific funding could inadvertently reinforce gender-based funding and funding silos, which might create new challenges for trans people's ability to access the supports and services that would work best for them.

The gender-based silos also play out in ways that render non-binary people AMAB invisible and thus unaddressed. A non-binary person who used to work in the HIV sector expressed frustration with how non-binary AMAB people are addressed in the sector:

> While I understand that AMAB non-binary folks don't fall under the remit of the services the GMSH provides to "2 Spirit, gay, bisexual, queer, and other transgender and cisgender men who have sex with men," it has always rubbed me the wrong way that AMAB non-binary folks are included as MSM for sexual health statistics, due to their basis in sex, but not in services provided to MSM—since AMAB non-binary folks aren't "MSM" based on gender. For example, I'm considered [part of] a "high risk" group due to my body and sexual partners, but no one is making any materials directed to me as part of this "high risk" group, such as info on PrEP, harm reduction practices, etc. (NBLA2208)

Two further related factors amplify the challenges:

- A norm in the HIV sector is to emphasize the importance of lived experience for staff—that is, it is expected that staff can bring their first-hand experience to the engagement and services that they are providing. However, where trans inclusion and integration is concerned, this norm of lived experience appears to create a mindset among cis staff of "It's not my job."
- Skills-building for all staff in relation to working with trans communities is not yet in place (see also section 10.1.5, Cis staff and volunteers lack knowledge about TNB2S people and needs).

These factors leave individual workers with varying degrees of knowledge, comfort, and experience working with trans people. Cis staff may feel underprepared and underequipped for serving trans people, as illustrated by one cisgender participant commenting on his experience of first starting to work in the sector: "I didn't feel comfortable caring for trans folks because there was such an emphasis on working from my lived experience, and I didn't want to offend anybody and I didn't know how to connect with them" (F1JU3006).

> Given my 2 years of work in the sector, and having worked with a trans colleague who left the organization, [I'm reflecting that] .... when I was onboarded, there was no process to check my biases around trans folks or knowledge of trans sexual health. Being recruited on lived experience is good, but whose lived experience? (F2J01707)

10.1.2 Other funding constraints

In addition to funding silos, participants mentioned the following funding constraints:

- Most trans-focused work has been funded from sources other than the AIDS Bureau. As the AIDS Bureau is a major funder of the sector, we inferred that its lack of attention to trans communities might be one of the most impactful drivers of underfunding for trans-focused HIV and sexual health work.
- Funding for trans-focused work is typically project funding that lasts for a few years at most.
- HIV-sector funders can have very limited ideas of what HIV prevention entails. In turn, this can impact the willingness of these funders to invest in HIVprevention work that is related to trans communities.

- Inadequate evidence can compromise organizations' ability to secure HIV funding for trans-focused work. A breakout group at the deliberative dialogue specifically singled out:
    - limited evidence on TNB2S people and HIV, especially from the lens of syndemics
    - misattribution of HIV among non-binary people AMAB to HIV among MSM.

10.1.3 A lack of research, evidence, and information about TNB2S people enables myths and inaccuracies

We heard that there was a lack of evidence—including research—and limited knowledge translation of any existing research on TNB2S people. In turn, this opens up spaces within the sector for narrow assumptions or outright inaccurate ideas to emerge, such as:

- the belief that there are no TNB2S people present in an organization, when TNB2S people may in fact already be there—including in staff roles—and may prefer not to disclose
- myths about the issues that TNB2S people face
- the broadly held belief that trans men are not at risk for HIV or other STIs
- assumptions about the needs that TNB2S communities would prioritize in relation to action on sexual health and HIV
- narrow assumptions of what TNB2S people look like.

The perpetuation of these myths and inaccuracies reflects a further finding: There is a lack of knowledge among cis staff about TNB2S people and our needs. We discuss this barrier in section 10.1.5.

Finally, some participants remarked that with regard to research, the sample sizes of TNB2S people are said to be too small, especially when considering populations of HIV-positive TNB2S people or TNB2S people who have had genital surgeries. These participants wondered, though, if there could be creative ways to advance research, despite these challenges. For instance, one participant noted that there may be ways to link more HIV-positive trans people to cohort studies. Qualitative research is also an effective means to develop useful knowledge through in-depth engagement with smaller numbers of people.

10.1.4 A broad lack of organizational support across the sector

There needs to be buy-in from organizations, otherwise this won't happen. We have seen time and time again where folks pay lip service to these issues, but organizations need to feel this is important and they need to be supported for this to happen. Otherwise, staff may burn out or leave. (ED02A)

While some agencies are clearly committed to trans inclusion and have been taking significant steps in this regard, both staff and management acknowledged that there has not yet been concerted effort across the sector to robustly address trans inclusion and integration in a meaningful way. One HIV-sector manager also noted that some agencies are struggling to stay afloat; in this context, addressing trans inclusion and integration is not likely to be an organizational priority.

Unfortunately, a range of staff and volunteers perceived their respective organizations to not be doing the work to meaningfully advance trans inclusion and integration, or to be doing the bare minimum. Some participants also said that their agency and the sector are not openly discussing challenges or shortcomings in relation to trans inclusion, which limits the opportunities for learning across organizations.

One staff person spoke about the need to:

> Not just [tack] trans people [onto] existing programming. We're told we won't turn trans people away, [but we can't include] trans people as an afterthought. It is hard to engage trans people into existing programming [if it does not speak to their experience]—there's so much work to do, to go back and edit what's already there. (TFAL0710)

As reflected below, a lack of organizational support across the sector is occurring at multiple levels within organizations, including the very upper levels of organizations.

Lack of support at leadership levels

Both staff and management spoke about the impact that a lack of upper-level organizational support, including at the board level, has on staff who are committed to trans inclusion and integration work. For example, a participant at the deliberative dialogue noted that without permission of an organization's executive director to spend time on trans inclusion and integration work, staff cannot focus on this. In the absence of active support from those in leadership roles, staff—trans or cis—who are eager to do this work will not be able to move forward.

> The ASO I engage with is mainly white-cis-men-centred. Leadership plays a role in that. It's the same problematic dynamic of inclusion. It betrays the lack of priority given to trans folks. It's the appeasement that is embedded in the idea of inclusion, in my opinion, such that inclusion sort of becomes about good optics. Minoritized people settling for crumbs. (CTT01707)

Lack of TNB2S involvement, representation, and decision-making power

Organizations may engage TNB2S people via consultations and yet TNB2S people can remain absent from actual roles within these organizations.

Trans inclusion and integration not only need support from cis people at leadership levels; as some participants pointed out, more TNB2S people need to be in leadership roles. Some participants spoke about the limited leadership of trans work by trans people. Additionally, participants noted the need for trans people to undertake a range of leadership roles, including board roles. As one trans frontline worker stated:

> In my organization, I don't think there is [trans] representation on the board of directors. I think it is a flaw. If there are trans frontline workers, and [no trans people] on the board, it creates a lot of strain. (TFGR0715)

Beyond the lack of TNB2S people in leadership roles, participants also commented on the absence of TNB2S people in staff roles more broadly. Indeed, the very consultations that we ran drew attention to the fact that organizations may engage TNB2S people via consultations and yet TNB2S people can remain absent from actual roles within these organizations. This barrier—likely also a further consequence of the sector's gender-based silos (see section 10.1.1)—was articulated by one participant as follows:

Trans people are always called on to consult with, but never really worked into the frameworks of organizations. … A lot of organizations use [the Trans PULSE] project to look at trans people and say "Here are stats," but I would rather not be a statistic but [would] rather [be] within the organization to tell them about my experiences and the experiences of my peers. (02MA0821)

Along with the lack of TNB2S staff across the sector, participants pointed out the failure to represent TNB2S people in promoting programs. Bringing these two themes together, a trans person working in the HIV sector wrote:

> If [trans] communities aren't reflected in the way you talk about your programming or promote it, why would they assume that their needs would be considered in your programming? … If there are no staff who reflect trans/non-binary experience, why is this group claiming to speak to/about me? (TFJA2207)

Similarly, a cis staff member noted:

> If we look at the GMSH Alliance as a whole, most folks organizing [gay men's sexual health programs] are cis males. This creates structural barriers for trans and non-binary folks who identify under that umbrella term of "gay men's programming." That is a barrier. The language we are using [for] promoting and doing marketing for programs reflects this. (F2BE1707)

With TNB2S involvement and representation broadly lacking across the sector, and limited leadership of trans-related work by trans people, what participants ultimately spoke to was a lack of TNB2S people holding decision-making power. For example, in a telling reflection of this barrier, a number of racialized TNB2S people said throughout the consultations that they did not want to just see themselves reflected in images; they also wanted to be reflected and involved in decision-making processes.

What participants ultimately spoke to was a lack of TNB2S people holding decision-making power.

> There are many groups created so we can talk, like this [focus group], but I feel like I want those folks [who organize consultations] to make it so trans people are making the decisions. … Until we have the power to create space, occupy space, there is not going to be any future for us. (CTYA1907)

Limited diversity of TNB2S people, particularly Indigenous and racialized people

On top of the lack of TNB2S involvement and representation, the diversity of TNB2S people who have input into work intended to serve trans communities is often limited. Racism and the centring of white trans experiences emerged clearly as key concerns in this context.

One non-binary staff member thus commented on the two biggest challenges to trans inclusion and integration that they saw:

> [One of the biggest challenges is] whitesplaining [of trans experiences]. Most of our trans folks here are people of colour. We see white folks taking over, even at the GMSH symposium. This is a big barrier. [Additionally,] the things we do for trans folks rarely are led by trans folks. It is a nontrans person pushing an agenda on trans people. (F2KE2007)

We particularly heard from Indigenous and racialized participants that not seeing themselves reflected among the staff, peers, volunteers, and boards of organizations created barriers to access, and led them to feel that they needed to prioritize or compartmentalize parts of their experience.

Similarly, participants also expressed concern that when input is sought from trans communities, it is most often sought from white trans men who have completed at least one university degree, and that the priorities, concerns, and perspectives of a much broader range of trans people who are facing additional barriers are thus overlooked. When the perspectives of Indigenous and racialized trans people are neglected, trans inclusion efforts are significantly limited. Ultimately, when the perspectives of Indigenous and racialized trans people are neglected, trans inclusion efforts are—unwittingly or not—reinforcing white supremacy.

10.1.5 Staffing and workforce barriers in the HIV sector

Beyond a broad lack of sector-wide organizational support that obstructs trans inclusion and integration, participants noted several barriers specifically related to staffing and workforce issues in the sector.

Tokenism and turnover

> Being the sole trans person doing trans work at an agency can be really, really lonely and we can feel unsupported because we are the go-to trans person. That can be exhausting. (CTIC2007)

Participants described a range of tokenizing approaches to engagement and their detrimental impacts. For example, not having a diverse range of trans people on staff, and/or only having trans people involved as volunteers or in roles in which they receive honorariums for their work, may be tokenizing. One staff member stated, "Tokenizing [approaches] diminish the sense of worth and self-esteem. [Trans people] feel like they'll only ever be able to do work on an honorarium basis" (F2KE2007).

Offering roles and other opportunities to a single trans person can also create unjust concentrations of power (a barrier also raised in the Indigenous focus group; see section 7.4.3, Ongoing exclusion and tokenism). Thus, an HIV-positive non-binary participant noted that:

> with HIV-specific organizations, there is such a desperation for organizations to find a trans person to be a public voice or a fundraising token. That person is put in a position, whether they chose [it] or not, of being a gatekeeper for that organization. If you don't have good personal relationships with that person, you then can't access services. … [One trans woman] created a barrier to folks participating and spoke to transness in a way that was so binaristic, and I felt excluded every time she opened her mouth. (H4)

TNB2S people who are tokenized, especially those who are the only TNB2S person working in their organization, may also be turned to by colleagues and management for everything trans-related. Several participants described how this could be both isolating and draining.

We also heard that while some trans people may prefer trans-specific opportunities, others may prefer to work in other aspects of an ASO's work, such as harm reduction. However, trans people may be pigeonholed and seen as being only a fit for trans-related work. The project team noted that pigeonholing trans people, as well as appointing trans people as token hires, may also contribute to precarious employment and economic insecurity, as most trans-focused work in the sector is funded on a short-term basis, while other kinds of opportunities in ASOs may be longer term or permanent.

Participants also mentioned high turnover in staff and volunteers—whether cis or trans—as a key barrier to trans inclusion and integration, both generally and specifically in relation to work serving trans communities. This turnover results in organizations needing to continuously rebuild the baseline knowledge and skills of new staff and volunteers in relation to trans inclusion and integration. If organizations do not have the time, skills, and capacity to do this, institutional knowledge can be lost. As one frontline staff person noted, "The turnover is so quick that there isn't a lot of institutional knowledge [about trans inclusion and integration]" (F1LO0207).

With most GMSH Alliance-linked staff being cis gay men, and tokenism of TNB2S staff often occurring across the HIV sector, this impact of turnover can be exacerbated. As a participant in the Indigenous focus group expressed:

> It is also expensive to have a token, because when they leave, unless there is a transition plan, they leave with so much information. So the agency hires a new person, trains them. And knowledge is lost and fellow staff don't know what is going on. (IED0809)

Cis staff and volunteers lack knowledge about TNB2S people and needs

At present, few organizations include training for staff, volunteers, and board members about trans people and relevant issues in service provision and organizational leadership, including in onboarding. The lack of efforts in this area are a significant contributor to a key challenge identified by many participants—that a lack of knowledge among cis staff and volunteers about TNB2S people and needs creates barriers to inclusion and integration.

This broad deficit in knowledge includes:

- poor knowledge of the biomedical realities for TNB2S people, including risks for STI transmission
- poor working knowledge of TNB2S people's sexual experiences. This is also connected with a lack of knowledge in how to provide competent support and care for TNB2S people across the HIV prevention, engagement, and care cascade
- a lack of understanding of the obstacles that TNB2S people face in accessing HIV-sector organizations and health care—whether for HIV-related care, transition-related care, or general health care.

The project team also noted that this deficit in knowledge contributes to a lack of informed decision-making about TNB2S people and our needs.

> I was asked to do training on sexual health in a trans group that meets in the evening. Most of these were 16- to 17-year-olds who are so "switched on," which was intimidating. I was there, as a cis guy who didn't know about changes [that trans people's] bodies go through. There needs to be a better onboarding process, and a way to challenge workplace cultures and their biases. (F2J01707)

TNB2S staff are not embedded into organizations' support structures

Current and former TNB2S staff also reported experiencing barriers to having supportive and inclusive work environments. These barriers largely stemmed from a lack of specific labour-related supports, such as supports for management on how to give guidance to staff who are exploring transition or who are transitioning.

Some participants pointed out a lack of clear organizational policies or practices to address transphobic attitudes or comments from colleagues, volunteers, or clients. As a consequence, the root issues that are giving rise to transphobic behaviours are not always being addressed. Furthermore, few organizations have an extended health care plan that provides counselling or other forms of emotional support; this may be a particular gap in need for TNB2S people whose mental or emotional health is being impacted by transphobic experiences in the workplace.

> Workplace cultures don't always allow trans folks to exist or experience their personal issues in their workplaces. How can we ask folks to come with their lived experiences, and then say they are too difficult, or too much to work with? (F2J01707)

Participants reported gaps in administrative and human resources processes to prevent disclosing a person's legal name when it is different from the name they use in daily life. For example, such disclosures could occur in financial contexts, such as handling certain types of payments (e.g., honorariums and contractor fees). The project team noted that while this challenge was brought up primarily in the context of deadnaming people, it may also contravene organizations' privacy and confidentiality policies and obligations.

One non-binary staff member commented: "There is no commitment to reaching out to the [trans] community, beyond just hiring you because you are trans. You're left to figure things out on your own. I don't feel very supported. It has to do with how funding is gendered" (TFBR1507). This speaks once again to the breadth of impacts of funding silos (see section 10.1.1). The importance of agencies reaching out to trans communities and maintaining positive relationships was also underscored by another concern that participants raised: If an agency has a poor reputation in trans communities, this can be detrimental to the personal reputations of trans staff who are working there, especially if the organization as a whole is not addressing the root issues of its poor reputation. As one participant stated:

> [Working at an agency with a poor reputation in trans communities] can ruin [a trans staff person's] reputation, because the person is put in a difficult position of wanting to be doing good work, but also navigating certain

> politics of the reputation of that agency, their [own personal] place in [the trans] community, and also historical mistrust in the trans community [toward that organization]. (F2J01707)

With TNB2S staff often feeling isolated and having little organizational support for some of the unique challenges and demands that are put upon them, the project team was not surprised to hear from participants that the HIV sector seems to have lower retention rates for TNB2S staff. We also noted that—unlike staff who are in roles connected with a PPN—trans staff do not have existing structures to help them connect across organizations or to raise issues that span multiple organizations.

Finally, TNB2S staff also pointed out a lack of practices and policies to create accessible space, programs, and services. These participants discussed a range of access needs—once again reflecting the need for an intersectional approach to trans inclusion and integration—and specifically mentioned:

- physical access for people using wheelchairs
- gender-inclusive bathrooms, including ones that are wheelchair-accessible
- linguistic accessibility, including access to interpreters.

> Accessibility is not just about including trans people and being anti-racist. It has to do with how many steps it takes to reach the service. Is the elevator in the back alley? … There are people who have HIV who have accessibility needs. How can we accommodate that? It was demoralizing to have to tell a clinic that I needed an accessible entrance. The accessible entrance was cluttered. There were spiders. It was very unwelcoming. (RAN1207)

10.1.6 Sectoral and organizational culture

Many participants spoke about aspects of sectoral and organizational culture that impede trans inclusion and integration. Below, we discuss the key topics raised.

Significantly, the population-specific focus groups also discussed several pertinent barriers related to sectoral and organizational culture (see chapter 7). In particular, the Indigenous focus group noted that western approaches that were grounded in a binary gender system can create barriers to engagement (see section 7.4.3, The imposition of western binary-gender systems). Again, it is important to consider this project's broader sectoral and organizational findings together with its population-specific findings.

Historically entrenched discrimination

> In terms of trust, awareness, and online outreach, there's a staggering amount of room to grow within the [cis] gay/queer men's community when it comes to being affirming, welcoming, or even aware of gay/queer trans men. Assumptions about kinds of sex, positioning, risk factors, fetishization, and rampant transphobia within the community might be great places to start engaging with communities and demonstrating active allyship as well. (TFJA2207)

As transphobia and other forms of discrimination exist in society and large, it is not surprising that they also exist in the HIV sector. Many participants noted that:

- historically the HIV sector has been focused on white, cisgender, gay men in particular
- the fact that the sector "hasn't been inclusive, and for so long" (F2BE1707) is itself a barrier to trans inclusion and integration.

One non-binary staff member commented:

> Organizations think they are inclusive. They think they don't need antiracism and antioppression training. Maybe they have done it 10 years ago, but it is not updated. The gaps are there, as antiracism and antioppression and antitransphobia training has evolved. ASOs have a hard time catching up to what makes us feel inclusive and safe. (TFBR1507)

These forms of discrimination can also be internalized, intermingling with other forms of discrimination as a cluster of exclusions. This cluster of exclusions can be dense, compounding and complicating the challenges that trans people face in accessing the HIV sector and, more broadly, cis gay men's communities. As a manager in the sector stated, "There's so much to unpack in relation to HIV stigma, homophobia, racism, internalized homophobia … and adding trans[phobia] into the equation …" (ED04). Similarly, one HIV-positive trans person who has worked in the sector responded to a question about what they saw as the biggest challenges to trans inclusion and integration by stating, "The internalized transphobia and transmisogyny, and homophobia, and misogyny of gay men providing those services. … Specifically, misogyny in general. This is one of the biggest things that gets in the way" (H4).

Some participants expressed that sometimes antitrans sentiment is expressed more intensively and in unique ways in cis gay men's communities and the HIV sector. This includes rejection in social spaces, rejection as potential sex partners, and negative comments about genitals and bodies that are not cis male. For example, several participants related experiences of discrimination in bars:

> [Cis] gay guys would say, "You should not be here. You should be in a bar for yourself," which is horrible. (H3)

> You see a guy across the bar, and he's hot, and you and your friends are talking about him. And then someone comes up and says, "Oh, that guy? He's trans, or he's positive, or he's whatever," and next thing you know, the person who was hot five seconds ago, people are saying, "Oh, no, not him" [sneering tone of voice]. It's such crap! (ED04—cis, gay man)

Perhaps less obviously, antitrans sentiment also includes using campy language in condescending ways:

> I think that trans women and trans femmes get used as props or jokes … [by] cis fags in the context of trying to relate, trying to find ways of connecting [through camp]. … This can be an easy way of alienating folks in the service of trying to build solidarity … or even just seeming cool with a trans woman … or with a known queen or fem. "GURRL!" (H4)

Additionally, participants perceived the history of discrimination in cis gay men's communities and the HIV sector as being reflected in many of the decisions still being made by HIV-sector organizations today, including in the ways that ciscentrism and white privilege manifest in organizations. One concrete example that was provided was how HIV-sector organizations frequently turn to the same well-known, white trans men for input or other kinds of involvement (see also section 10.1.4, Limited diversity of TNB2S people, particularly Indigenous and racialized people).

Fear of making mistakes

Frontline staff and management alike noted that a fear of making mistakes in relation to trans people is a significant barrier to trans inclusion and integration. One HIV-sector manager noted that "so many people are frozen stiff by insecurity, by fear of saying or doing the wrong thing" (ED04). A Two-Spirit person said:

> The idea of being more than two genders is complicated for people to understand, especially in sexual health promotion for non-binary, trans, and Two-Spirit people. They are afraid to offend, so [they] don't even try. Thanks, I see why you don't want to offend, but I need you to try. (IED0809)

The fear of making mistakes was not unique to cisgender people working in the HIV sector. A trans person who is a frontline worker commented:

> As a trans person, I never feel comfortable how to address or initiate [a conversation about trans sexual health] even when a client wants to ask. I am afraid of misinforming them as there is not enough research [about trans sexual health]. … If I am struggling around it, then an ally and cis gendered person may also struggle. (TFBL0715)

10.1.7 Competitiveness between agencies obstructs collaboration

In interviews, two of the HIV-sector managers mentioned that issues regarding turf and trust get in the way of collaborating, including in relation to serving trans people. For example, one manager commented:

> A lot of organizations are really territorial. We [act as if we] own our community, we're the keepers of that door. It's something that I so hate. If we don't have the capacity to [take on a particular initiative], why are we keeping the door shut? We need to collaborate if we do not have the capacity and resources to do work. We, as leaders, close doors. This is unacceptable and sometimes as leaders in the sector, we do not need to speak for all. … But if leadership is lacking, and I don't see a vision or why I should buy into it, then I become a gatekeeper because I don't trust what you're doing. But at the same time, if I don't see it as being safe to collaborate, I need to protect community. (ED03)

In the deliberative dialogue, participants made similar observations in written notes about what needs to stop for trans inclusion and integration to occur: "Deal with the competitiveness that's not useful and creates barriers to collaboration!" and "Let go of the idea that the HIV sector only talks/works with itself."

10.2 Barriers in programming and service delivery

Below, we focus on several barriers in programming and service delivery, concluding with an example of the challenges that arose during a trans-focused project in the HIV sector.

1. This section is divided into seven parts:
2. Trans programming by other local organizations may not mean that trans people's sexual health needs have been met.
3. The word "gay" in the names of programs and organizations.
4. Exclusion of trans people from programs and services.
5. Barriers in social media engagement and online outreach.
6. Barriers in prevention work.
7. Challenges in smaller cities and rural areas.
8. Challenges in trans-focused projects and initiatives: A case in point.

10.2.1 Trans programming by other local organizations may not mean that trans people's sexual health needs have been met

Participants in one of the staff focus groups expressed that sometimes a local ASO might absolve itself of meeting trans people's needs when any form of trans programming is offered by another organization (e.g., a community health centre or a CMHA branch) elsewhere in the region. Moreover, the project team noted that these ASOs are likely not considering that trans people's sexual health needs are probably not being addressed by these other organizations. Although programming at other community-based organizations may be of interest to trans people and address social support needs, this programming may not address sexual health, HIV prevention, and trans-specific syndemic factors.

10.2.2 The word "gay" in the names of programs and organizations

A range of participants spoke about the word "gay" in programs' and organizations' names as being a barrier to inclusion for parts of trans communities for whom services and supports would

be highly relevant. To date, these kinds of names have been intended to make cisgender gay men feel welcomed and seen. However, these names can inadvertently signal exclusion for:

- trans men who are gay or have sex with men
- trans men who identify as queer or bisexual
- trans women
- non-binary people
- some Two-Spirit people and other trans people who are connected with gay, bisexual, and queer men's communities and sexual cultures.

An HIV-sector manager noted that organizations can use appropriate consultation to develop transinclusive names and branding for programs and services for men—cis and trans—who are GBQMSM.

> I think that one of the problems is cissexism and funder mandates that make orgs … have names like "Health Initiative for Men" and "GMSH." I look at them and don't think it is for me—the genderspecific titles. It goes back to funders and [organizational] origins but it is not very trans inclusive. (02EL0817)

10.2.3 Exclusion of trans people from programs and services

Several trans participants, as well as trans and cisgender staff, discussed experiences of trans people being excluded from relevant programs and services. This included both queer trans men being excluded from gay men's programming and trans women being excluded from women's programming. Two stories outlining these experiences are below.

> I went to an ASO for a counselling group on anxiety. I was the only trans person. Or almost. They ran another group around body issues, but the facilitator felt it wasn't a good fit because it was mostly cis guys attending. I felt it was discrimination [but] I didn't complain because the anxiety group was good. But it was a group on body issues, and if it wasn't for trans people, they should have made it explicit. … During the intake, [I'd shared that] I was trans. (01KH2707)

> Trans women in my life have directly been turned away from accessing services when they've contacted [ASO programs], and they [have been] told that they're "not real women." They have been told that if they were involved in the [women's] programming, they would make cis women there very uncomfortable because a lot of cisgender women have experienced sexual violence from men. I bristle at that response on behalf of my friends because they're not men. It's just women in the room. Somebody needs to get over that. They need to get over that these are women. Not men. To exclude cannot be an option anymore. And to tell a woman to go to the Gay Men's Sexual Health Alliance? If that's [a trans woman's] autonomous decision, I support that decision! But if they're coming to GMSH because they are being turned away from services for women … (CORI2920)

10.2.4 Barriers in social media engagement and online outreach

Participants discussed two kinds of barriers in online engagement. The first occurs in responses to social media posts by HIV-sector organizations; the second occurs in online outreach.

In one focus group, participants noted that transphobic comments are commonly made on social media posts by HIV-sector organizations, and that these organizations are not always quick to remove these comments on their posts. This can convey the message to trans people that an organization either does not see a problem with a transphobic statement or that the organization actively condones the transphobic statement. In turn, this can diminish trans people's willingness to engage with the organization and, moreover, can be detrimental to the organization's reputation.

In online outreach, the online profiles that staff use may lack information for trans people to gauge the background of these staff and, more specifically, whether the staff have sufficient trans health expertise. As a result, TNB2S may not feel comfortable reaching out to such staff.

> On dating apps like Grindr, I see more presence of sexual health initiatives and agencies doing outreach there. I see some outreach to trans and non-binary folks who might be there. I am wondering if those folks are knowledgeable of trans health or Two-Spirit experiences. Are those people representative of folks accessing the outreach? Are these workers trained enough and how are they doing beyond a 101 training—what comes after? (IED0809)

10.2.5 Barriers in prevention work

Participants identified several barriers to effective prevention work with TNB2S people. We have grouped these barriers into three categories: staffing, information and resources, and PrEP.

Staffing

We heard from at least one participant that he will not talk about HIVrelated risks or STIrelated risks with staff who do not see him as a man.

Participants spoke about the need for clarity regarding who on a staff team would have knowledge about trans sexual health and HIV and STI prevention and treatment. Another barrier is experiencing transphobia from staff: We heard from at least one participant that he will not talk about HIVrelated risks or STIrelated risks with staff who do not see him as a man.

Information and resources

Participants discussed the difficulty of accessing information that has had TNB2S people involved in its creation and is accurate, up to date, and trusted by TNB2S communities.

Additionally, given the dearth of prevention and sexual health information resources for TNB2S communities, we were unsurprised to hear that there were some critical gaps. One gap was for trans teenagers, with resources needed about trans bodies and sexual health that could be brought into high schools, especially in rural communities. Additionally, some older participants noted a critical gap in sexual health resources and supports focusing on TNB2S people who are older (60+) and for people who have transitioned later in life. The project team thought these gaps might be related to assumptions that trans people are young adults—in their 20s or 30s—as well as ageism resulting in a general neglect of older people, and ageist assumptions that older people do not have sex.

PrEP

Barriers specifically related to PrEP include a lack of information about PrEP absorption and protection in light of how PrEP interacts with trans people's genital tissues, especially for trans people who have had genital surgery, or for trans people who use their front hole for receptive sex while also taking testosterone.

As indicated in the following quote, an additional barrier to accessing PrEP stems from health care providers' assumptions that trans peoples' sexual behaviours do not carry HIV transmission risk:

> In terms of PrEP, it feels like no one thinks to offer it to anyone but cis gay men. My doctor didn't think or offer it to me until I started to pass as someone who is assumed male, even though I have had sex with people who are "high risk" for years—queer men and trans women. Trans men and non-binary people are not often considered among people who might need access to things like PrEP. (010L0819)

10.2.6 Challenges in smaller cities and rural areas

Participants identified several challenges that trans people living in smaller cities and rural areas face in accessing services and supports from HIV-sector organizations.

Generally, there are far fewer supports available for trans people in smaller cities and rural areas. We also heard that some smaller rural regions can have very strong religious influences, which can result in reduced levels of support for trans youth and adults from their families and broader networks.

Meanwhile, however, ASOs are often the only or primary LGBTQ-inclusive spaces in smaller cities and rural communities, and so are the de facto recipients of referrals for trans people—whether or not these ASOs have the ability to meet trans peoples' needs. Indeed, participants pointed out multiple challenges that such ASOs face in meeting trans peoples' needs. For example, GMSH Alliance-linked staff who work in smaller rural communities noted that geographical location can influence the availability of funding for transspecific work. Some participants also noted that it can be more difficult to recruit trans people who are qualified for roles at these ASOs.

> Even in my transspecific program, filling these two staff positions can be difficult. In [a smaller city like this] it can be hard to find trans people who have the educational requirements, like a social work degree. … Where I work, there are not many visibly trans folks working in the not-for-profit or social service sectors. I only know a few folks in my area doing this work, and I am the only trans person providing psychotherapy in my area. It can be so hard balancing being trans and professionally trans. (CTIN1707)

We also heard about the need for local trans people to travel sometimes significant distances to access trans-affirming supports, including trans-affirming health care providers. In turn, this required extra effort by HIV-sector staff to find appropriate referrals for these individuals. One trans man who had had genital surgery expressed fear of moving outside of a large city as he feared not being able to access sexual health care should he acquire an STI.

Finally, participants commented that trans people in smaller and rural areas need to be engaged by approaches that are different to the edgier or more sexually explicit HIV and sexual health campaigns that may be appreciated in larger cities; instead, local ASOs need to lead initiatives that are attuned and sensitive to the broader communities in the area. Some participants with experience working in rural and First Nations contexts noted that in some small communities, simply talking about sex and sexuality can be a significant taboo.

10.2.7 Barriers in trans-focused projects and initiatives: A case in point

In one focus group, some participants discussed a trans-focused project in the HIV sector that they had been involved in. Although they generally had a good experience and were very happy that the project had happened, they also described challenges that had emerged, some of which have not been mentioned thus far in this chapter. To conclude our discussion of barriers in programming and service delivery, we describe these challenges.

Challenges related to diversity and inclusion

Although the project lead had made deliberate efforts to include trans people with disabilities and BIPOC trans people, the organization did not seem to understand how to make the kinds of accommodations needed. This included how to provide honorariums to people on the Ontario Disability Support Program (ODSP) in a way that would not negatively impact their ODSP benefits. Some participants also noted that insufficient time had been allowed to foster trust building between the project's advisory committee and the organization, and that the project needed a slower process, both to build trust and to provide disability-related accommodations.

> There are histories there of discrimination and exclusion of trans people, particularly around disability. I sometimes feel we rush into projects without acknowledging this, and this makes me carry distrust in[to] this project. In this case, I felt this come up for me around consulting around disability for [this initiative]. I felt

> pressure and as if we did not have enough time to go into a broad topic like disability. I did not feel like I had support to go into this. … It was a big responsibility on us. It made it feel like we did not do enough to really touch on that. (CTER1807)

Overestimating availability of trans-specific resources

Participants discussed a set of challenges that highlighted the relative wealth of resources for cis gay men's sexual health in comparison to resources for TNB2S people's sexual health. The organization that was supporting this trans-focused initiative was familiar with the level of information, resources, and research available in relation to cis gay men's sexual health, including being able to find a broad range of expert advisers in the field. This led to a significant overestimation of the pre-existing resources that would be available to this initiative and the amount of time and effort it would take to develop them.

Budgets and transparency

Finally, participants pointed out that the project's budget and broader resourcing appeared to be much lower than another initiative that had some similarities but was directed primarily at cis gay men. The participants therefore noted that these discrepancies could result in trans people not being compensated appropriately for work that is similar to that being done by and for cis gay men; they indicated a desire for overall transparency about wages and fees. One participant noted, "As trans folks, we usually ask for less funding as we don't expect much" (CTRO2007). Another participant, who had worked as a contractor on the project, stated: "If we want to create change, this needs to stop. We cannot continue this way, being underpaid. I work in this industry, I know what rates are, and I don't understand why we aren't being paid as much" (CTYA1907).

10.3 Barriers for TNB2S people who might consider HIV-sector resources, programs, and services

Having discussed barriers that are internal to the HIV sector and its programming and service delivery, we will now shift focus to trans people who might engage with the sector and its offerings. Specifically, we will discuss barriers that impede TNB2S people's willingness and ability to access services and supports from HIV-sector organizations. In this section, we have grouped the barriers into three categories:

1. Stigma and stereotyping.
2. Agency reputations among TNB2S networks.
3. Impacts of poverty on accessing HIV-sector services.

Once again, it is worth noting that the population-specific focus groups also discussed some pertinent barriers to accessing HIV-sector resources, programs, and services (see chapter 7). In particular, the trans francophone and trans migrant focus groups identified various linguistic and cultural accessibility challenges—for example, the lack of French-language sexual health information for TNB2S people (see section 7.5.3, Large gaps in services and community spaces for francophones in Ontario).

10.3.1 Stigma and stereotyping

We heard that stigma and stereotyping can affect TNB2S people's willingness to access HIV-sector services. This stigma and stereotyping can take different forms, including stigma related to being trans, stigma in relation to drug use and accessing harm reduction supports and services, and stigma and stereotyping in relation to sex work.

Participants also observed that HIV stigma and stereotyping can deter trans people from associating with an HIV-sector organization or engaging online with an ASO. This is certainly not unique to trans communities; the participants who brought this up noted that this is a common issue, especially in other communities with less anonymity (e.g., smaller regions and in the context of some ethnocultural communities).

> When it comes to stigma, in harm reduction services, people look at you differently when you ask for [harm reduction supplies]. (SWME0812)

10.3.2 Agency reputations among TNB2S networks

> When I look at it from [an] Indigenous Two-Spirit perspective, a lot of Two-Spirit people won't access services from [large mainstream ASOs]. When I was attending [that ASO], I literally felt like I was the only Indigenous person who was accessing the services from there. I wish I met more peers like me who were accessing those services there, but that is not so, even to this day. (H2)

Community-level knowledge mobilization (how key information is shared via word of mouth and social media) affects whether trans people are willing to engage with HIV-sector organizations. If trans people have poor experiences with an HIV-sector organization—including not seeing themselves reflected there—word of their experiences will spread, and trans people will be less likely to be willing to get services at the organization. One person framed this as "You'll have one person come in and not feel included, and that word will spread in community. [The agency] will have lost a whole bunch of contacts" (IAT0809).

Furthermore, participants noted that a trans person already has to have connections into trans communities in order to learn about the HIV-sector organizations that are considered more welcoming to trans people, or to learn of resources such the Rainbow Health Ontario Service Provider Directory or the HIV 411 directory.

> [Our organization's engagement] is now working, but I think where I have tried to connect with trans guys online or spoken with them—because of the history of the region, there is an attitude of distrust towards our agency. Trans folks we engaged with usually access services outside of [city in the Greater Toronto Area] and go to [downtown] Toronto. This could be due to discretion needs, but it could be a feeling of [there being] nothing comfortable enough here. (F2J01707)

10.3.3 Impacts of poverty on accessing HIV-sector services

Unsurprisingly, poverty impacts TNB2S people's ability to access HIV-sector services in a wide range of ways. For example, we heard that trans people, especially trans people who grew up poor, may not know how to access financial supports, benefits, or means to offset costs for PEP, PrEP, and other forms of HIV-related prevention or care. Moreover, one participant pointed out that there are barriers to even knowing about the existence of certain supports to begin with:

> Unless you know the terminology, you don't know what it means. Like, terms like "compassionate care." If I don't have finances or grew up poor, I may not know those terms. … People say, "Just Google [it], but I need to put [in] something, like the [search] terms. Google will not be able to read my mind. (RAN1207)

Another participant noted that after their local HIV-sector organization had to move out of the downtown area due to increasing rental costs, some of their friends have not been able to afford to visit the organization. Although the organization does provide bus tickets to reduce such barriers, this person's friends have been unable to travel to the organization to get the bus tickets in the first place.

This same participant also described some of their own past experiences with poverty. Their vulnerability during this time highlights that stigma and discrimination from other ASO service users can occur outside of the walls of an ASO. ASOs can play a role in intervening in this stigma, and ensuring that poor TBN2S people are able to access the HIV-sector supports and services that they need:

> I was a homeless drug user for a few years [while] accessing services at my ASO. I found the street population I was living with and spending time with knew nothing about trans and non-binary identity. I

> feel like including more trans-specific resources and trans allyship resources in harm reduction kits, for example, or including it in [ASO programming] … might be a useful way to help give people information and also combat stigma. I can't count the number of times people came to me in the park asking if I [had] a dick or [was] a chick. I don't want that to keep happening for trans people. (01LA3007)

Poverty can also create barriers for trans people in accessing HIV and sexual health information online and participating in virtual interventions. Several participants shared that they know a number of trans people who do not have easy access to computers and the internet, due to their very limited incomes. One participant stated that due to experiences with transphobia, some trans people also avoid certain settings where computers are available for public use, such as libraries. This participant noted that being able to access computers in safer environments, such as at HIV-sector organizations, makes a real difference in the lives of trans people who are experiencing poverty.

Finally, several participants mentioned that legal name changes, and the subsequent costs of changing ID, can be prohibitive for some trans people. Moreover, not having changed one's legal name can result in being misgendered or deadnamed in ASOs and other settings, including in interactions with health care providers (see section 10.4.3).

10.4 Barriers in health care

Although we did not ask participants about barriers in health care, TNB2S participants nonetheless frequently commented on the barriers that they had encountered and the resulting impact of their poor experiences in health care.

We have organized this section into six subsections:

1. Health care organizations are not committed to addressing trans people's needs.
2. Barriers to finding trans-competent primary care.
3. Problems with health records can lead to mistreatment.
4. Barriers in HIV and STI testing and treatment.
5. Myths about approval for transition-related surgeries.
6. Impact of poor experiences in health care.

> Sometimes we just want whatever is hurting us to be addressed, and maybe I don't want to talk about Two-Spirit identity and sexual orientation with intake nurses. I had possible kidney stones, where an ambulance picked me up and I was wearing a blouse and long hair, makeup. The paramedic asked me to close my shirt. I just wanted the pain to stop and there was nothing to look at on my chest. In the ER, nurses asked me to close my shirt because it was inappropriate, apparently? I did, but asked them to stop the pain. Hours later, the doctor came up and asked me, "Anatomically … are you …" and I said, "Male." He thanked me and walked out. How come that had not been a question before? Why was it delivered that way? It was not the time to jump in and teach these folks. So many folks don't or can't advocate for themselves, so we just go back to being in the [closet]. (IED0809)

10.4.1 Health care organizations are not committed to addressing trans people's needs

Many participants spoke about the lack of commitment from health care organizations to addressing trans people's needs. As one participant observed, the health care system is ciscentric by design:

> Our health care system is not designed for us. There is some effort by some organizations to make it very trans inclusive, but mainstream health care is focused on addressing cis needs rather than trans needs. So, it is not a safe environment for trans folks. (SWME0812)

An HIV-positive person also commented: "The majority of health care settings and health care providers are not up to par [for serving trans people] and they don't even know where to look to get up to par. Most the time

they are not really interested" (H1). Additionally, a participant said, "We are constantly put in situations where we [2STNB people] have to educate health providers. We have to teach them the history and how to care for us, instead of [the organizations] putting the time and energy in to training frontline workers" (ILI0809).

The problems that this lack of commitment creates are often compounded by racism and other forms of discrimination. In particular, Indigenous and Black participants spoke of how they are already facing systemic racism and inequities in the health care system (see section 7.4.3, Historical and structural anti-Indigenous racism, and section 7.6.3, Racism and ciscentrism in health care), which can result in traumatic experiences in care.

10.4.2 Barriers to finding trans-competent primary care

Both ASO staff and TNB2S community members spoke about the difficulty of finding trans-competent primary care providers, especially providers who are knowledgeable about HIV care. Notably, while many participants spoke about the lack of knowledge about trans people among HIV-sector workers (see section 10.1.5, Cis staff and volunteers lack knowledge about TNB2S people and needs) and health care providers, only one participant brought up the lack of content relating to trans people's existence, health, and wellbeing in health care provider training programs.

These challenges pertain not just to a scarcity of knowledgeable primary care providers, but also to the problem of knowing which primary care providers are competent to serve TNB2S people. Some ASO staff spend quite a bit of time developing and maintaining referral networks; both trans people and ASO staff use Rainbow Health Ontario's resources; and trans people use word of mouth—including through trans-specific groups on social media—to find providers.

> Until recently, we could facilitate access to [hormone care] from our MSM clinic but our doctor is no longer able to maintain that service. We can support existing clients, but not folks newly coming in. We don't know where to send those new people, because we don't know which doctors can offer competent care. (F2AN3006)

10.4.3 Problems with health records can lead to mistreatment

> I went to hospital to get my eyes checked. I gave them my health card. She looked at the health card and looked at me and said in a loud voice that everybody behind her could hear. See, people need to lower their voice in cases like that, for confidentiality. And this woman said in a loud voice, "Why does your health card say 'male'?" I said, "I am transgender." She said, "You are what?" I said, "I am transgender" and she said, "What is that?" I then said, "Oh lord, I have 36DD implants and a large penis, and it has nothing to do with getting my eyes checked, so give me my damn card." Everyone behind me clapped. (H3)

Some trans participants reported experiences of mistreatment due to the name and sex marker that was listed in their electronic medical records and on their OHIP cards. This led to mistreatment from health care staff, including misgendering, publicly breaching trans people's privacy in waiting rooms, and otherwise behaving in disrespectful ways. As one participant expressed:

> [Health care staff] need to have education around the name. For example, my name is [name], and my ID says another name. It [would cost] me a lot of money to change everything over. … [Health care staff] are not educated enough to know that even though I said I am trans, not to call me by the name on the file. If I said my name, please don't use my dead name. (SWTA1208)

10.4.4 Barriers in HIV and STI testing and treatment

TNB2S participants also described poor experiences in HIV and STI testing. The most common concern was providers making inaccurate assumptions about trans people's sexual behaviour, sexual partners, genital surgery status, and use of genitals during sex, rather than asking good questions

to assess risk. We also heard that providers may not be exploring contraceptive needs.

We also heard that providers lack knowledge of biomedical realities for trans people, including risks for STI transmission. Participants also shared concerns that these providers lack knowledge of how to provide care along the HIV care cascade, given trans people's biomedical and social realities. These concerns spanned:

- HIV risk assessment, prevention, and treatment uptake, including supports and strategies for risk reduction
- specific considerations for trans people who have had genital surgeries, are taking hormones, and/or have contraindications for HIV medications.

One trans man who had had genital surgery described an experience where he had been refused an STI test in an emergency department, despite having had a risk event, as the provider did not know how to swab his genitals. Participants also shared their experiences of being stigmatized by health care providers due to having multiple sexual partners, whether through participating in hookup culture or engaging in sex work.

> I have gone in for STI testing with a doctor who knows I'm trans and that I'm queer, and received a meandering lecture about how "lesbians have very little risk when it comes to STIs," which was invalidating on all levels, since I'm not a woman, not a lesbian, and not exclusively having sex with (cis) women, and also the assumption about the types of sex that I was having. (TFJA2207)

10.4.5 Myths about approval for transition-related surgeries

Participants in the francophone focus group noted that in trans communities there are widespread yet no longer accurate beliefs that trans people will not be approved for transition-related surgeries if they have:

- any mental health diagnoses (other than gender dysphoria)
- an addiction or are using any substances
- are HIV positive.

These beliefs can cause trans people to avoid HIV testing, treatment, and care, and also avoid seeking supports for mental health or addiction concerns.

In reflecting on these widely held community beliefs, the project team noted that transition-related surgery regulations and restrictions have changed over time, significantly increasing access to transition-related surgeries, and yet many trans people—as well as some health care providers serving trans people—are not aware of these changes. Moreover, most health care providers do not yet have the skills to work effectively with trans people. We also know that stigma, discrimination, and violence—among other factors—are linked with the high rates of anxiety, depression, and suicidal ideation that trans people experience (Bauer et al., 2015; Veale et al., 2017). We therefore wondered if the lack of awareness of ongoing trans advocacy "wins" and the lack of opportunities for better health care, combined with negative mental health outcomes and an accompanying negative worldview as a result of stigma, might describe elements of the syndemic factors that drive HIV in trans populations.

> Les personnes trans et non binaires qui veulent faire une transition médicale n'oublie jamais ces buts. Elles vont faire attention pour ne pas risquer ça. Rainbow Addiction Services est rarement utilisé, par exemple. Mais si tu es trans et tu veux une chirurgie, tu ne vas pas y aller. Tu vas survivre en communauté pour pouvoir te faire approuver et avoir accès aux chirurgies ou aux hormones. Il y a des liens là avec le VIH, mais aussi être trans va tout compliquer. Tu vas prioriser différents aspects de ta santé en fonction de ta transition. Mais là, on te dit d'arrêter de prendre de la drogue pour avoir accès à des soins trans. C'est inhumain et impossible comme demande des gens avec des problèmes de dépendances. (FRTH1108)

Trans and non-binary people who want to make a medical transition never forget these goals. They will be careful not to risk this. Rainbow Addiction Services is rarely used, for example. But if you're trans and you want surgery, you're not going to go. You're going to survive in the community so that you can get approved and have access to surgeries or hormones. There are links there with HIV, but also being trans will complicate everything. You're going to prioritize different aspects of your health based on your transition. But now you're being told to stop doing drugs to get access to trans care. It's inhumane and impossible as a request of people with addiction issues. (FRTH1108)

10.4.6 Impact of poor experiences in health care

Some participants shared stories about having to fight and self-advocate when they had had dehumanizing experiences; others shared stories of times where they did not have the energy to self-advocate.

As well as discussing the health care barriers that they had encountered, participants spoke about the impact of their poor health care experiences, particularly the emotional impact. Due to widespread experiences of stigma and discrimination, "most trans people walk in with fear and [the] assumption [that] these places are going to be transphobic unless otherwise proven" (02RA2807). Some participants shared stories about having to fight and self-advocate when they had had dehumanizing experiences; others shared stories of times where they did not have the energy to self-advocate. The project team saw a strong sense of exhaustion and frustration from a number of participants stemming from the cumulative impacts of poor experiences in health care, and apprehension about future interactions.

Finally, some trans people shared their experiences of travelling significant distances to access welcoming health care. A participant in the sex worker focus group stated:

> I access my health care in an institution that is inclusive of the trans and non-binary community; however, I don't live close to it. However, I feel more comfortable accessing my health care there. I'd rather spend 40 minutes travelling to it, rather than accessing my health care from other institutions. I don't feel as comfortable [with other health care institutions] that are, say, 10 minutes away from me, because of fear [of] stigma and discrimination that's attached not only to accessing those kinds of services [for harm reduction] but also for fear of discrimination against trans and non-binary communities. (SWME0812)

10.5 Conclusion

The previous chapter identified the strengths that can be leveraged in the HIV sector and in related sectors. This chapter outlined the breadth of obstacles and challenges to trans inclusion that are currently in place, beginning with foundational barriers, such as silos related to funding models, staffing and workforce barriers, and sectoral and organizational culture. These foundational barriers in turn contribute to a range of barriers in program and service delivery.

Although the sheer range and number of barriers that exist is sobering, these obstacles, in combination with existing strengths, need to be considered in identifying the steps to take to advance inclusion and integration for trans people in the HIV sector. The project team has developed carefully considered recommendations, outlined in the following chapter, to address the challenges and opportunities identified by participants in the focus groups, interviews, and deliberative dialogue.

11. Embedding trans inclusion and integration: Recommendations

This chapter outlines our 29 recommendations for GMSH, HIV-sector organizations, and Indigenous organizations.

As this report was commissioned by GMSH, we will first discuss the 22 recommendations for GMSH that make up the bulk of our recommendations. All of these recommendations pertain to the HIV sector, with the exception of recommendation 20, which is relevant to the HIV sector but also has broader relevance. We will then outline six organization-level recommendations: six recommendations for HIV-sector organizations and one recommendation for Indigenous organizations.

All 29 recommendations have built on participant input from the consultations. GMSH and the Trans Interweaving Project Advisory Committee, including current and former HIV-sector management and frontline staff, also shaped and refined the recommendations.

11.1 The recommendations: Purpose and principles

These 29 concrete recommendations are designed to:

- support the vision—expressed in this report as inclusion indicators—for trans inclusion and integration within GMSH and the broader HIV sector
- leverage existing strengths in trans inclusion and integration
- address barriers to trans inclusion and integration.

Drawing on the three principles underpinning trans inclusion and integration work (see section 8.1), we stress that implementing all recommendations should be grounded in an approach that:

- embeds intersectionality in trans inclusion and integration work
- includes trans people being more involved and engaged in more meaningful ways
- focuses on the strengths, empowerment, and celebration of TNB2S people.

In turn, the recommendations will support bringing these principles to life in the work of GMSH and other organizations across the HIV sector. Applying these principles will also address the gaps and barriers that many participants identified in serving and supporting the full diversity of TNB2S communities who are connected with gay men's communities and sexual cultures. Addressing this diversity will in turn increase equity and improve HIV and sexual health outcomes across Ontario's TNB2S communities.

11.2 Recommendations for GMSH

The 22 recommendations in this section span:

- work that GMSH will lead (and work that is clearly within its mandate)
- work where GMSH can initiate conversations with other organizations and play a collaborative role in advancing the associated recommendations.

Timeframe and themes

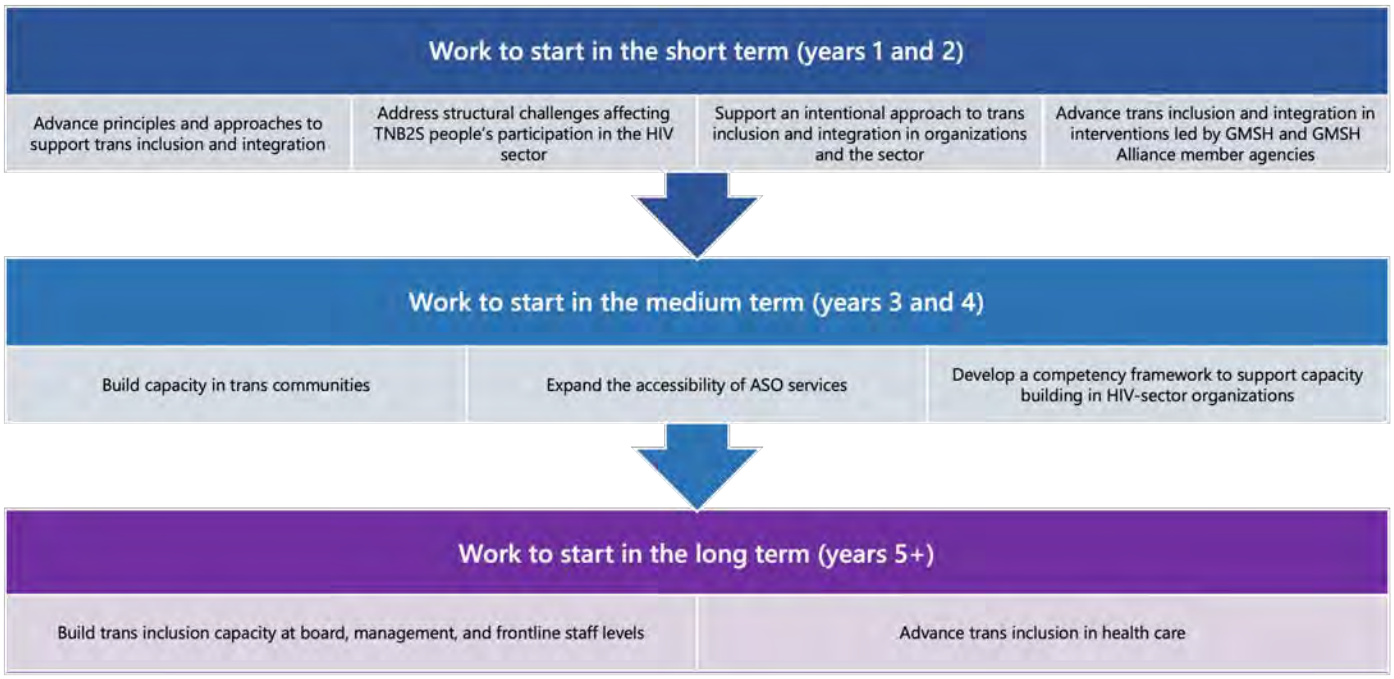
We have grouped these recommendations into work that will start in the:

- **short term (years 1 and 2**). These recommendations lay the groundwork for other recommendations or are time-sensitive due to other HIV-sector initiatives (such as the Ontario Accord being refreshed). Note that although some of these recommendations will start in the short term, they may take a substantial period to fully implement.

- **medium term (years 3 and 4).** This work is typically either nonfoundational work or it builds on work to be started in the short term.
- **long term (years 5+).** This work typically builds on the work conducted from years 1 to 4). For instance, developing a trans inclusion competency framework for the HIV sector (which outlines the knowledge, skills, and attitudes needed to effectively serve, support, and engage TNB2S people) is a precondition to developing a robust set of initiatives to build these capacities at the board, management, and staff levels.

Within each timeframe, we have also grouped the recommendations under themes. The scope of the recommendations—as organized by timeframes and themes—is summarized in Figure 111:

Figure 11-1: Scope of recommendations for GMSH



Overall, GMSH's role in implementing the 22 recommendations involves not only doing work toward the immediate deliverables, but also taking on a lot of the work—in appropriate partnerships—to support the HIV sector in advancing trans inclusion and integration. In this section, we note some of this work that GMSH has already committed to doing. Recognizing that the kind of change that is needed will require sustained work over time, both the project team and GMSH hope that this approach will facilitate and catalyze lasting change in the sector.

11.2.1 Work to start in the short term (years 1 and 2)

Advance principles and approaches to support trans inclusion and integration

The following two recommendations will help to establish the principles and approaches identified in chapter 8 (see sections 8.1 and 8.2).

Recommendation 1: Develop a resource to support GMSH and the HIV sector in consistently advancing intersectionality.

To increase equity and reduce disparities, we recommend developing a brief, practical resource to support GMSH and GMSH Alliance member agencies in consistently advancing an intersectional approach in their work. This intersectional approach is crucial for engaging across the full diversity of not only TNB2S communities but men (cis and trans) who are GBQMSM. This resource is envisioned as:

- including sections relating to each of GMSH's core areas of work
- outlining factors to consider when developing, implementing, monitoring, or evaluating initiatives.

GMSH will inform the development of this resource by holding conversations with relevant stakeholders. These conversations will identify what would be most important and useful, in light of applying an intersectional approach, to TNB2S people using HIV-sector services, as well as HIV-sector management and staff.

Recommendation 2: Increase the involvement and meaningful engagement of TNB2S people in the HIV sector.

Two key activities must be taken to advance the greater involvement and meaningful engagement of trans people in the HIV sector. This work is foundational for trans inclusion and integration.

1. **Name TNB2S people in the Ontario Accord GIPA/MEPA statement.**

   The Ontario Accord GIPA/MEPA statement is currently being reviewed by OAN. We recommend that GMSH advocate for HIV-positive TNB2S people to be named in the next iteration of the statement.

   GMSH will support this activity by working with OAN to advocate that TNB2S people are involved and considered in the review of the Ontario Accord.

2. **Develop processes and tools to support GMSH and HIV-sector organizations in engaging TNB2S communities in decision-making processes.**

   These processes and tools would outline effective approaches and key considerations for engaging TNB2S people and communities in HIV-sector work, with an emphasis on decision-making in the HIV sector. Processes and tools would span one-off consultations, ongoing advisory committees, and specific projects, and would address both trans-specific and trans-inclusive initiatives. The first steps in developing these tools and resources would be to reach out to other organizations in the HIV sector and beyond to learn about and adopt or adapt existing good or promising practices.

   GMSH will lead the development of these tools and resources, and share them with the HIV sector.

   Address structural challenges affecting TNB2S people's participation in the HIV sector

   Recommendations 3 and 4 address two foundational barriers to trans inclusion and integration in the HIV sector: the siloed landscape (see section 10.1.1) and a broad lack of organizational support (see section 10.1.4).

Recommendation 3: Advocate with HIV-sector funders to address issues facing TNB2S people.

This work entails:

- helping funders to learn more about issues facing trans communities, with a view to funders supporting trans inclusion across the HIV prevention, engagement, and care cascade
- encouraging funders to address structural challenges, such as funding silos, that create barriers to trans inclusion and integration.

Recommendation 4: Embed trans inclusion and integration work in the Ministry of Health Annual Reference Guide.

The Ontario Ministry of Health (MOH) produces an annual reference guide that it shares with each of its funded programs in advance of program plan submissions for the upcoming fiscal year. The PPNs contribute content to the reference guide regarding their strategic priorities. This guide:

- gives a general overview of the MOH response to HIV and hepatitis C in Ontario
- outlines MOH expectations for program activities, to ensure alignment with MOH strategic directions and goals.

To foster continued accountability for embedding trans inclusion and integration in Ontario's HIV sector, GMSH will include activities related to this report's recommendations in each forthcoming reference guide, starting with the 2022 to 2023 fiscal year.

Support an intentional approach to trans inclusion and integration in organizations and the sector

Creating a clear and consistent approach for trans inclusion across the HIV sector is a foundational step for achieving trans inclusion and integration. Recommendation 5 addresses several inclusion indicators outlined in section 8.2, which focuses on an intentional approach to trans inclusion and integration in the HIV sector, as well as barriers stemming from a broad lack of organizational support in the sector (see section 10.1.4) and exclusion of trans people from programs and services (see section 10.2.3).

Creating a clear and consistent approach for trans inclusion across the HIV sector is a foundational step for achieving trans inclusion and integration.

Recommendation 5: Clearly embed and define trans inclusion in the scope of work and communities served across the GMSH Alliance.

This recommendation will help GMSH to foster a consistent approach to serving TNB2S people across the GMSH Alliance. It will also support each GMSH Alliance member agency with language and messaging for trans communities about what they can expect at that agency.

This recommendation entails five key activities:

1. **In integrated planning between GMSH and GMSH Alliance member agencies, continue to make trans inclusion and integration a strategic priority.**

   GMSH included a strategic priority to advance trans inclusion and integration for GMSH Alliance member agencies for the 2021 to 2022 fiscal year. Going forward, GMSH will maintain this as a priority until the long-term recommendations in this report are implemented, and inclusion and integration has been embedded in the operational work of GMSH Alliance.

2. **Redefine the scope of communities served by PPNs, to clearly define how trans people are included in their work.**

   GMSH can support this activity by leading engagement with PPNs and funders. GMSH will also co-create the process with PPNs, with input from TNB2S people in Ontario.

3. **In memoranda of understanding (MOUs) with GMSH Alliance member agencies, GMSH will be intentional about including text that outlines that TNB2S people and communities are part of the communities that Alliance member agencies work with, serve, and engage.**

   GMSH will advance this activity in the process of updating the MOUs. This work will begin in the 2022 to 2023 fiscal year.

4. **Develop a tool to help filter opportunities and requests for trans-focused work in GMSH's context.**

   A tool such as a decision tree will foster clarity and consistency and reduce the risk of mission creep. GMSH will lead the development of the tool in collaboration with GMSH Alliance member agency executive directors and frontline staff, with input from TNB2S people in Ontario.

5. **Develop and jointly roll out a communication and implementation strategy.**

   This communication and implementation strategy will foster understanding of and support for the changes to the scope of the communities that GMSH will serve. GMSH will co-create and co-implement the strategy with GMSH Alliance member agency executive directors, with input from TNB2S people in Ontario. If changes happen to clarify how trans people are addressed in one or more other PPNs, these PPNs could also be involved in the co-creation of this communications and implementation strategy.

Advance trans inclusion and integration in interventions led by GMSH and GMSH Alliance member agencies

Recommendations 6 through 9 will advance several inclusion indicators outlined in section 8.3, with a focus on including and integrating TNB2S people within interventions. Recommendations 6, 7, and 9 will also advance various inclusion indicators identified by priority populations, as well as one or more of the three principles underpinning trans inclusion and integration (see section 8.1). Finally, recommendation 8 addresses stigma and stereotyping, as described in section 10.3.1.

Recommendation 6: Develop English and French style guides to foster trans inclusion and integration in communications, social media engagement, and campaigns.

Developing French and English style guides to promote trans inclusion in communication, social media, and campaigns will:

- lend consistency to approaches by GMSH and GMSH Alliance member agencies
- provide technical support to HIV-sector organizations, among others
- promote meaningful representation of the diversity of TNB2S people.

Each style guide will include:

- explanations of how certain terms or approaches may differ by region, age group, or target population
- guidance on ensuring that a diverse range of trans people, experiences, and narratives (e.g., from Indigenous and racialized trans people, as well as trans people with disabilities, and both TNB2S anglophones and francophones) are brought forward in meaningful and nontokenizing ways.

The French style guide will recognize that francophones in Ontario speak many dialects of French and that dialects need to be addressed in creating accessible resources.

GMSH will develop the style guides in partnership with trans anglophones and francophones. This work will begin in the 2022 to 2023 fiscal year.

Recommendation 7: Create guidance to equip GMSH Alliance member agencies to effectively reach and engage with TNB2S people and communities.

GMSH can support the HIV sector by working with TNB2S people and groups to create guidance on engaging with TNB2s people and communities. Updating and expanding on GMSH's existing training and resources, this guide will address specific areas already identified by this project's participants, including:

- in-person and online outreach
- disseminating information and resources
- means to effectively promote interventions and opportunities to TNB2S people and communities.

Specific attention is needed to equip GMSH Alliance member agencies to engage with Indigenous 2STNB people. Ensuring that guidance is relevant to engaging TNB2S older adults, including Indigenous Elders, is particularly important. Drawing from the input of Indigenous participants (see section 7.4.1), guidance may also be helpful for respectfully engaging with Indigenous organizations and exploring whether, when, and how to participate in Two-Spirit and Indigenous events in accordance with protocol, recognizing that protocol varies from nation to nation.

In implementing the Indigenous aspects of this recommendation, GMSH will be informed by the seven guidance steps outlined in Reconciliation in Action, a guide to support HIV-sector organizations in the work of reconciliation (The Reconciliation in Action Working Group et al., 2020). For example, GMSH will cultivate partnerships with interested Indigenous groups, organizations, and individuals—and moreover, do so with the intent to work collaboratively over the long term, thus avoiding ways of relating that are shorter term and more transactional (see section 7.4.3, Ongoing exclusion and tokenism). Organizations to approach include Oahas, Canadian Aboriginal AIDS Network, Two Spirits in Motion, 2Spirited People of the 1st Nations, and NYSHN. In accordance with Reconciliation in Action, GMSH's initial steps might be to complete a preliminary self-assessment and self-education; Indigenous partners should be engaged in this process. A subsequent step might be to explore what guidance, resources, or toolkits would support the engagement of Indigenous 2STNB people.

Recommendation 8: Build capacity among cisgender people who use HIV-sector services to interact effectively and respectfully with trans people.

A broad range of participants spoke about the need for cisgender service users to learn how to interact effectively and respectfully with trans people in a broad range of contexts, including during sex.

Participants suggested a range of learning content in this regard, including:

- building skills in recognizing and responding to behaviours that are transphobic, stigmatizing, or otherwise disrespectful to trans people (e.g., by drawing on stereotypes)
- unlearning and unpacking ciscentrism, misogyny, transmisogyny, internalized homophobia, racism, and other beliefs that negatively impact trans people
- sex, consent, and trans people.

Participants also suggested that HIV-sector organizations:

- include content in sexual health workshops and other relevant contexts that creates safe and respectful spaces for cis people to learn with trans people about trans people's bodies and sexuality
- foster understanding of transition and trans people's experiences among cis participants in harm reduction programs and other forms of outreach with streetinvolved people, to reduce harassment of homeless and street-involved trans people.

GMSH will:

- collaborate with GMSH Alliance member agencies, trans people, and trans-focused organizations to identify priorities for this capacity building
- work with HIV-sector organizations to develop learning materials and other resources that can be used by multiple organizations.

Recommendation 9: Create trans-inclusive and trans-focused campaigns, resources, digital content, and interventions in both English and French.

Participants identified a breadth of resources, digital content, and interventions that would benefit TNB2S people's sexual and reproductive health. Implementing this recommendation will tap into and build on this input.

The three principles underpinning trans inclusion and integration activities—intersectionality, meaningful engagement of trans people, and approaches that are strengths-based, celebratory, and empowering—are critical to implementing this recommendation. For example, the principle of intersectionality speaks to the importance of providing French-language versions of all deliverables produced for this recommendation. Moreover, the principle of meaningful trans engagement will require TNB2S people to be involved in developing and implementing all of the deliverables. Trans francophones should also be part of these processes, beyond providing translation. Through involvement such as developing content ideas, as well as reviewing and editing material, francophones can ensure that materials are appropriate for the target populations; this will also help to avoid later and potentially costly edits.

This recommendation aligns very closely to GMSH's core work. To realize this recommendation, GMSH will:

1. Develop documents to guide planning for each of GMSH's five strategic priority areas (sexual health information, PrEP and PEP, testing, harm reduction, and online outreach). These documents will outline how initiatives in these areas, whether led by GMSH or by individual ASOs, could be more trans-inclusive or trans-focused. Content from this project's consultations could be used as part of the foundations for this material.
2. Explore options for campaigns, initiatives, digital content, and resources, based on suggestions provided by participants in the Trans Interweaving Project consultations (see below for a summary of these suggestions).
3. Prioritize content in partnership with trans communities and HIV-sector organizations.
4. Lead the development of campaigns, resources, information, and interventions, in collaboration with trans people and communities, other PPNs, and where relevant, other agencies both inside and outside of the HIV sector. Trans people will be hired for roles and participate in advisory processes for this work.
5. Support access to trans-competent translation of resources. This will include making large-scale initiatives available in French, and providing translations of posters, flyers, and more ephemeral materials. GMSH will maintain a budget for French translation and engage French translators who are skilled in the nuances of trans-inclusive French.

Suggestions from participants

Below, we summarize participants' key suggestions for campaigns, resources, information, and initiatives.

General resources

- Materials to help reduce individual-level poverty for trans people, including how to:
  - access various income supports
  - request waivers of fees relating to changing one's name and gender markers, other transition-related costs, as well as costs for PrEP or HIV-related care.
- A guide for trans people who are contractors and consultants in the HIV sector, outlining means to navigate the gig economy, standard ranges of compensation in the HIV sector, and how to navigate and negotiate compensation.
- In all knowledge products about biomedical and social interventions related to HIV, create one or more sections or integrate additional information on the implications for trans people, communities, and/or bodies.

Sexual health campaigns, resources, information, and initiatives

- Affirming, sexpositive sexual health resources for trans people. Such resources would advise on topics such as:
  - navigating sex and gender dysphoria, and disclosure
  - negotiating sexual activities.

- Campaigns and initiatives that:
    - adopt a body-positive and sex-positive approach
    - celebrate the diversity of trans bodies
    - promote bodily autonomy
    - resist the narrative that all trans people hate their bodies, while also recognizing the dysphoria that many trans people experience.
- Resources for cis men who are attracted to trans people. Such cis men would be consulted in the development process. The resources would address cis men's knowledge needs about trans people, trans bodies, and healthy sexuality in the context of their attractions to trans people.
- Resources specifically for cis clients of trans and non-binary sex workers.
- Resources on how francophones and other linguistic minorities navigate gay men's social spaces and sexual cultures.

Other campaigns

- Building allyship in gay men's communities, particularly in relation to addressing misogyny, internalized homophobia, transphobia, and racism.
- Addressing transmisogyny and street harassment.
- Supporting the visibility and identity of non-binary people assigned male at birth.

PrEP and PEP

Materials to:

- build access to and awareness of PrEP and PEP for trans people, including how costs can be reduced or covered, and how international students and other newcomers can access these medications
- foster awareness among HIV-positive trans people's partners about PrEP and PEP.

Harm reduction

Materials to:

- recognize that patterns in substance use are different for trans people than cis GBQMSM
- explore how to advance harm reduction initiatives that are designed for or inclusive of trans people
- reduce stigma and discrimination from street-involved cis people toward street-involved TNB2S people.

11.2.2 Work to start in the medium term (years 3 and 4)

Build capacity in trans communities

The following suite of four capacity-building recommendations will address the root conditions to advance inclusion indicators or reduce barriers identified by participants, in areas such as:

- having the HIV-sector workforce reflect the full diversity of trans people
- having more trans-focused work led by trans people
- being able to effectively spread the word about good work happening in trans communities and helping to ensure that accurate information is disseminated and inaccurate information is corrected
- developing initiatives that are responsive to the needs and priorities of trans communities.

Recommendation 10: Create a pathway for TNB2S people into employment and leadership roles in the HIV sector.

With staff turnover and other staffing challenges creating workforce barriers in the HIV sector (see section 10.1.5), GMSH can work with other organizations in the HIV Resources Ontario network, as well as GMSH Alliance member agencies, to co-create recruitment, retention, and professional development initiatives for TNB2S people.

Spanning a range of employment opportunities in the HIV sector, these initiatives could:

- help TNB2S people gain employment in frontline and nonclinical roles in the HIV sector
- help TNB2S people prepare for management roles
- prepare TNB2S people to join HIV-sector boards.

Particular attention is needed to ensure that initiatives to support TNB2S people to move into entrylevel and frontline roles are accessible to and inclusive of TNB2S populations who have greater barriers to formal education, such as Indigenous 2STNB people. Furthermore, to ensure equitable access to opportunities for leadership and management development across the breadth and diversity of trans populations, initiatives will need to take an intersectional approach and, in particular, proactively attract and support Indigenous and racialized trans people.

Implementing this recommendation also creates an opportunity to trial new approaches in engaging TNB2S people in HIV-sector employment. Learnings could then be applied more broadly across the HIV sector, which may help to increase retention and reduce turnover, both for employees from priority populations as well as more broadly.

Recommendation 11: Develop and pilot skills development interventions for TNB2S people.

Participants suggested a wide range of skills that TNB2S people could apply in trans community organizing and/or within the HIV sector. These skills included facilitation, communication, conflict resolution, project management, grant writing, media (including social media), as well as skills with a social justice focus, such as unlearning racism, classism, ableism, and other forms of privilege.

GMSH can work with other PPNs, GMSH Alliance member agencies, and TNB2S people to determine how best to develop, pilot, and deliver these skills development interventions. The interventions might be inspired by or modelled after the Positive Living Development Institute.

Recommendation 12: Create a trans community knowledge mobilization initiative.

This initiative will support and upskill TNB2S people to share health information within TNB2S communities. This information will focus on HIV and sexual health (including trans-inclusive interventions), as well as other health topics of interest to trans communities (e.g., how to access transition-related care).

The initiative will aim to:

- leverage trends in trans communities of trusting information from trans communities and often mistrusting information from other sources
- help cultivate the sharing of more accurate information.

The initiative could draw inspiration from programs such as Totally Outright, a leadership program that equips young queer, trans, and Two-Spirit people to be health leaders in their communities.

Among its components, the initiative will have a training phase. Building on issues and suggestions raised by participants, preliminary ideas for modules include:

- sexual pleasure, choice, and consent
- HIV and STIs, sexual health care
- self-esteem, mental health and well-being, and stigma
- listening skills
- anti-racism and anti-oppression on the ground in communities and in organizations
- sex, dating, and relationships as a trans person: What does fabulous look like?
- drug use and harm reduction
- public speaking and confidence building
- trans resources, trans health and sexual health services, and critically assessing trans health information
- communicating effectively online to support the sharing of accurate information
- navigating health care—including HIV testing and care—as a trans person
- jobs, careers, and staying connected with the trans health and sexual health fields.

The training phase could be complemented by an ongoing engagement approach, such as a "trans champions network," which could include:

- special sessions to discuss newly released information or resources
- "virtual visits" that build exposure to and knowledge of organizations that are already serving trans people in relation to sexual health and other areas of interest
- regular sessions to discuss further questions about sexual health and effectively sharing information within peer networks.

GMSH will support this work by securing funding and other resources in partnership with HIV-sector organizations and potentially in partnership with TNB2S groups across the province, and then collaboratively developing the initiative with these partners.

Recommendation 13: Develop mechanisms to support trans people in creating programming and interventions that trans populations need and want.

GMSH will explore with GMSH Alliance member agencies, PPNs, and TNB2S people and organizations how best to implement this recommendation. Options for implementation may include:

- working with trans people in a particular region to identify ideas for locally relevant programming and interventions, and then collaborating on funding proposals
- GMSH (or other organizations) setting aside a small pot of funding for time-limited, small-scale projects for trans communities
- working across multiple GMSH Alliance organizations for trans staff (and cisgender allies) to collaboratively develop or refine programming specifically with and for TNB2S people.

Expand the accessibility of ASO services

This recommendation advances several inclusion indicators from the francophone focus group (see section 7.5.1) and also addresses barriers identified by this same group (see section 7.5.3). The approaches can also be used to expand the accessibility of ASO services to people from other equity-seeking groups within trans communities.

Recommendation 14: Develop means to serve trans people who experience additional barriers to accessing their local ASO.

Trans people can experience additional and compounding barriers to accessing their local ASO, including trans people who are linguistic and/or cultural minorities and trans people with disabilities.

Yet, there may be means to surmount such barriers through multi-agency and possibly cross-sector collaboration, use of online technologies, and/or other approaches. For instance, it may be possible to establish arrangements for TNB2S people to access services in different regions (e.g., a Spanish-speaking trans person living in the Niagara region might be able to access services virtually through an agency in Toronto; a trans francophone in Windsor might be able to access services virtually in Sudbury or Ottawa). There may also be opportunities to run virtual groups for segments of trans communities where there may not be enough people in one region for a group to be viable (e.g., a region outside of the Greater Toronto Area), such as a multi-regional group for BIPOC trans people or trans people with disabilities.

GMSH will convene conversations to explore these and other such means, and will then support relevant agencies to develop the new approaches.

Develop a competency framework to support capacity building in HIV-sector organizations

This recommendation will:

- advance the inclusion indicator that "knowledge and skills regarding TNB2S people and TNB2S experiences would be embedded in organizations at all levels" (see section 8.2.3)
- reduce barriers regarding a lack of organizational support for trans inclusion (see section 10.1.4), and cis staff and volunteers' knowledge gaps about TNB2S people and needs (see section 10.1.5, Cis staff and volunteers lack knowledge about TNB2S people and needs).

Identifying and addressing these knowledge gaps will also advance the sector's ability to address a broad range of other inclusion indicators and barriers, such as improving aspects of sectoral and organizational culture that impede trans inclusion and integration (see section 10.1.6).

Recommendation 15: Develop a competency framework for upskilling HIV-sector personnel in trans inclusion and integration.

A competency framework will outline what management, boards, staff, and volunteers need to know and do to support trans people to access and participate in the work of GMSH and GMSH Alliance member agencies. This competency framework will then be used as a framework for creating role-specific knowledge and skills development activities that address the key skills and knowledge needed by management, boards, staff, and volunteers (see recommendation 16).

Preliminary areas to explore for competencies include:

- leadership to spearhead and support trans inclusion and integration
- privacy and confidentiality
- trans-inclusive language
- sex, sexuality, and sexual health for trans people
- how to address transphobic and other exclusionary behaviours
- how to address stigma related to sex work and to drug use.

GMSH could work with a consultant with expertise in adult learning and developing competency frameworks, while involving all relevant stakeholders (e.g., management, board, and staff from GMSH Alliance member agencies; relevant HIV Resources Ontario organizations; and trans people who use HIV-sector services). It may also be useful for GMSH to engage transled consulting groups that have content expertise in the areas where competencies are to be developed.

11.2.3 Work to start in the long term (years 5+)

Build trans inclusion capacity at board, management, and frontline staff levels

Building trans inclusion capacity at all levels of an organization, including at management and board level, will:

- address the broad lack of knowledge and skills in the sector regarding TNB2S people and our needs
- help staff develop confidence in engaging with TNB2S people and reduce staff fears about making mistakes with trans people that can impede trans inclusion and integration (see section 10.1.6, Fear of making mistakes)
- reduce the burden of trans people needing to educate staff and health care providers.

A nuanced and intersectional approach to capacity building may also help to:

- address the "whitewashing" of BIPOC trans peoples' experiences in the sector
- reduce the racism that BIPOC trans people experience in the sector
- expand sectoral understanding beyond the limits of western concepts of transness, gender identity, and sexual orientation.

Recommendation 16: Develop knowledge and skills development initiatives in alignment with the competency framework.

GMSH will explore partnership opportunities to develop and implement knowledge and skills development initiatives that will:

- align with the competency framework to advance trans inclusion and integration in the HIV sector
- support sustainable capacity building for management, boards, staff, and volunteers across the HIV sector.

The first initiatives should focus on enabling management, boards, staff, and volunteers to reach a foundational level of knowledge and skills that are relevant to their roles. Future initiatives would need to go into more depth in more advanced areas. In creating the knowledge and skills development initiatives, we recommend taking an approach that recognizes that competencies are developed over time, and staff, volunteers, and management will need support in acquiring and applying new knowledge and skills. Such support might include coaching and mentoring.

Recommendation 17: Establish and support a community of practice focused on trans inclusion and integration in the HIV sector.

The community of practice will:

- support all staff in the HIV sector who have a specific role or key interest in advancing trans inclusion and integration
- provide a means for staff to further develop knowledge, skills, and confidence in advancing trans inclusion and integration
- offer a means for staff to get timely access to support for challenging situations
- be a vehicle for trans staff working in HIV-sector organizations to connect with each another.

The community of practice could also take on small projects that are of mutual interest to participants, such as collaboratively developing trans-inclusive workshops or revising existing workshops to make them trans inclusive.

GMSH can lead the development of the community of practice, provide ongoing staffing support, and provide a small budget for projects.

Recommendation 18: Cultivate peer-to-peer mentoring and knowledge exchange among HIV-sector executive directors.

This recommendation leverages a key strength noted by HIV-sector leaders: that some people in HIV-sector management roles already have substantial experience in supporting trans staff and volunteers and leading initiatives to advance trans inclusion and integration (see section 9.1). Peer-to-peer mentoring and knowledge exchange among executive directors and managers of HIV-sector organizations and PPNs can support, inform, and increase leadership that fosters trans inclusion and integration.

GMSH can work with HIV-sector executive directors to identify structures and approaches that would be most useful to realizing this peer-to-peer mentoring, and will then collaboratively implement these options.

Recommendation 19: Develop resources to support HIV-sector management in fostering trans inclusion and integration in their workplaces.

This set of resources, which will be rolled out across the HIV sector, will:

- support HIV-sector management in hiring and supporting the growth and development of TNB2S staff, peer workers, volunteers, and contractors
- help foster supportive and trans-inclusive organizational cultures and environments
- create mechanisms to monitor and evaluate the inclusion and integration of trans people and other populations where there may be gaps in engagement.

Content to address, most of which is related to human resources, includes:

- recruiting and hiring practices that foster trans-inclusive experiences

- policies and practices to support TNB2S staff who are pursuing a social, legal, and/or medical transition
- supervision and development approaches to support trans people in taking on increasingly senior responsibilities
- means to support trans staff in addressing challenges that arise in working with their own communities (e.g., ethically managing multiple relationships, navigating personal and organizational reputations when an organization has a poor reputation in trans communities)
- processes and supports to address trans-exclusionary behaviours from staff, volunteers, and clients, including through unpacking and/or unlearning mindsets and beliefs that are contrary to trans inclusion and integration
- supports to prevent and address factors contributing to turnover, that uniquely affect TNB2S staff
- procedures to eliminate or otherwise address payment challenges for trans people whose legal name does not match the name they use in daily life.

As noted above, the resources will include mechanisms to monitor and evaluate organizational progress on trans inclusion and integration. This will include mechanisms to:

- evaluate progress on culture change in relation to trans inclusion and integration, including mechanisms to understand and address gaps between current and desired norms, policies, and behaviours
- monitor whether goals in relation to intersectionality, trans inclusion, trans integration, and TNB2S participation are being achieved
- monitor and evaluate whether TNB2S people and other underserved populations are participating in programs and services, and whether there are inequities in patterns of participation.

As this recommendation falls largely within the area of responsibility of other organizations that are part of HIV Resources Ontario, GMSH can implement this recommendation in partnership with relevant HIV Resources Ontario organizations. There may also be trans-led consulting groups that have expertise in elements of this recommendation.

Advance trans inclusion in health care

Given the challenges reported in accessing respectful and clinically competent sexual and reproductive health care as well as other relevant health services, GMSH will take up three recommendations to advance trans inclusion in health care. Although delivering mental health and addiction services is outside of GMSH's mandate, two of the three recommendations below relate to important advocacy and awareness-raising work that GMSH can pursue.

Recommendation 20: Create online training modules and associated job aids to improve clinical practice in sexual and reproductive health care for trans people.

Many health care providers have not had access to learning opportunities about providing sexual and reproductive health care for trans people. Clinical training content is needed in relation to:

- HIV and STI testing
- using affirming language
- asking questions about body parts and sexual practices
- asking trans people about what they are already doing to take care of their sexual health
- raising possibilities for additional steps to take.

Training content should also address how to make warm referrals to other trans-affirming providers and how to connect patients with specialists for post-surgical care.

As access to training is only one element of supporting practice change, it would also be beneficial to:

- provide ongoing support and consultation for people who have completed trainings. This would create opportunities for clinicians to ask questions after they have completed training.
- provide training and follow-up supports for managers and supervisors of frontline clinicians, in order for them to support their staff.

GMSH will consider establishing a collaborative initiative to create the online learning modules. Potential partners could include Rainbow Health Ontario (given their existing role in providing online and in-person training for health care providers, as well as regular clinical mentorship calls), ASOs that are already providing education to public health nurses about how to work with trans people in sexual health contexts, and clinicians who would be the end users of such training.

Recommendation 21: Advocate and raise awareness to encourage increased access to mental health and substance use supports and services that are trans inclusive.

A broad range of participants spoke about the need for trans-inclusive supports and services related to mental health and substance use for TNB2S people across the continuum of care, spanning health promotion, prevention, harm reduction, treatment, and care. Given that a large proportion of trans people experience high rates of violence, including sexualized and intimate partner violence (see section 3.5), programs and services related to mental health and substance use need to have the capacity to serve and support TNB2S people who have experienced complex trauma.

GMSH will:

- advocate and raise awareness of the need for trans people to have access to mental health and substance use supports
- raise awareness of existing professional development opportunities to upskill providers of mental health and substance use services in working with TNB2S people (e.g., professional development opportunities through Rainbow Health Ontario and Trans Care BC).

Note: HIV-sector organizations that are providing access to mental health and/or substance use supports can contribute to this recommendation by ensuring that these supports are available to and relevant for trans people.

Recommendation 22: Advocate for organizational and systems commitment to trans inclusion in the health care sector.

We heard from many participants about the lack of commitment from health care organizations to addressing trans peoples' needs (see section 10.4.1); consequently, trans people are often put in the position of having to educate their providers. The resulting poor experiences and barriers to care are often further compounded by racism and other forms of discrimination.

GMSH will explore what work is currently under way to foster commitment from health sector organizations and health systems to address trans inclusion, and how GMSH can contribute to or complement this work at a provincial level.

11.3 Recommendations for HIV-sector organizations

This section presents six recommendations for HIV-sector organizations to consider. To better embed trans people in their programs and organizations, management and staff teams within individual ASOs in the sector can play vital roles in implementing change. To this end, we encourage management and staff teams to explore other parts of this report on:

- what inclusion and integration can look like for priority populations (see sections 7.4.1, 7.5.1, 7.6.1, 7.7.1, and 7.8.1)
- what trans inclusion and integration in the sector can more broadly look like (see chapter 8)
- inclusion indicators on websites (see section 6.2).

These parts of the report all point toward desired future states. We encourage management and staff teams to determine the areas where they are already strong, and what actions might be most feasible and strategic for their organizations to take on next.

GMSH will support organizational-level work across the sector through many of the recommendations where GMSH will play a leadership role.

Recommendation 1: Provide transparency and clarity in how trans people are served and engaged.

To achieve this recommendation, organizational leaders will likely need to engage their boards and staff to foster a commitment to serving and engaging trans people. This commitment to serving trans people should align with the guidance that will be developed through recommendation 5, which is among the 22 recommendations that GMSH will be leading: "Clearly embed and define trans inclusion in the scope of work and communities served across the GMSH Alliance" (see section 11.2.1). The commitment to engaging trans people can span from one-off consultations, to supporting and retaining TNB2S volunteers and staff, to engaging trans people in boards and committee work. Note that to foster retention of TNB2S staff in particular, organizations should consider how trans people can be welcomed into staff teams and supported as new employees. Existing resources, as well as the resources to be developed under recommendation 19 (see section 11.2.3), can assist in this regard.

Organizations should then make visible and clear their commitment to serving and engaging trans people, and the scope of this commitment—for instance, in relation to access to programming, and in supporting trans staff and volunteers. This commitment can be communicated both internally (e.g., in staff and board orientation materials, reinforced in staff and board meetings) and externally (e.g., via organizations' websites and other key communications vehicles).

Recommendation 2: Embed TNB2S people and needs in strategic and organizational materials.

A concrete step toward embedding, serving, and supporting TNB2S people in an organization is to account for TNB2S people and our needs in an organization's strategic and operational plans, priorities, and approaches. An organization's commitment to serving TNB2S people, and what can be expected by a trans person who is reaching out to the organization, can be conveyed via websites, social media, online outreach, and more.

Recommendation 3: Partner with groups and agencies within and outside the HIV sector to expand organizational capacity to meet trans people's needs.

No single organization will be able to meet all the needs of all trans populations. Partnership and collaboration can therefore offer a more strategic and feasible approach to trans inclusion and integration, allowing several groups and agencies to find synergies and opportunities to have a greater impact than they could each have separately.

Participants offered suggestions for partnership activities that HIV-sector organizations may wish to consider, which are listed below. These suggestions span partnerships with trans groups and organizations, as well as partnerships with other agencies. Alternatively, HIV-sector organizations may wish to consult with local individuals, groups, and organizations—including those from trans communities—to identify partnership actions that better fit their local context.

Suggestions from participants

According to participants, partnerships with trans groups and organizations could entail:

- offering local trans groups the use of meeting spaces at no charge
- supporting fledgling trans groups and organizations by assisting with grant proposals, serving as an agency of record, and providing some incubation assistance.

Partnerships with other agencies could entail:

- organizing trans-focused office hours at one location, with staff being present from multiple agencies that serve trans people, thus offering increased visibility, breadth of choice, and access. As not all trans people are "out" or are visibly trans, the participating agencies should ensure that all people are welcomed in these office hours, while maintaining a focus on trans populations
- collaborating on programs or initiatives, while also seeking guidance and leadership from TNB2S people.

Recommendation 4: Create and offer developmental opportunities for trans people.

Offering developmental opportunities will increase skills and career prospects for trans people, who in turn will bring their perspectives and talents to HIV-sector organizations. Moreover, increased trans involvement in organizations can foster a more diverse workforce and a more inclusive organizational culture.

Developmental opportunities could include volunteer opportunities, placements for TNB2S students in health and social work disciplines, as well as stretch opportunities for trans people already on staff that will allow them to develop new skills. Developmental opportunities may have an added benefit of supporting the retention of trans staff.

Recommendation 5: Include TNB2S people and needs in funding proposals.

Trans inclusion and integration should be supported by funders, and a concrete and impactful way that organizations can advance trans inclusion and integration is to include TNB2S people and our needs in funding proposals. For example, organizations could include fees or honorariums for trans people in project roles (including advisory roles), costs for translation of trans-inclusive materials into French, and project costs for dedicated trans-specific supports.

Recommendation 6: Foster linguistic accessibility.

HIV-sector leaders can foster the linguistic accessibility of their organizations by:

- establishing norms for indicating the current linguistic capacity of programs and services on organizational websites and promotional materials. Websites and promotional materials could also specify how to request linguistic accommodations
- including the linguistic abilities of workers in signature blocks, on website profiles, and business cards (for an example, see section 7.5.1, Increasing linguistic accessibility within organizations)
- including considerations for linguistic minorities as part of broader intersectional approaches, such as in antioppression and antiracism work.

11.4 Recommendation for Indigenous organizations

Recommendation 1: Include Indigenous 2STNB people in a holistic manner in cultural activities, programs, and services.

Participants in the Two-Spirit focus group noted that for Indigenous 2STNB people to be able to access traditional medicines, cultural programming, and ceremony, it is necessary for Indigenous community programs and services to go beyond the gender binary imposed by colonialism. Indigenous participants recommended that for Indigenous people who transition to another gender, a person's history and relationship to ceremony should be able to continue if they wish for this. Indigenous organizations could address this need by working with Indigenous 2STNB community members to understand what cultural practices or ceremonies 2STNB people would like to participate in, and work with Two-Spirit and trans-affirming Elders to identify the best ways to move this forward.

Glossary of key terms and abbreviations

Some of the entries in this glossary have been adapted from the glossary for the third edition of the Primed guide (Gay Men's Sexual Health Alliance, 2020). We are grateful for the efforts of the team who created this resource.

In the definitions below, we have **bolded** any terms that are defined elsewhere in this glossary.

2SGBQ+ men: We use this term in this guide specifically to refer to cisgender and trans men whose identities may include, but are not limited to being, Two-Spirit, gay, bisexual, and queer.

2STNB: Two-Spirit, trans, and non-binary. In this report, we use the 2STNB abbreviation, often prefaced by "Indigenous," to refer to Indigenous Two-Spirit, trans, and non-binary communities and people (including the Indigenous 2STNB participants in this project).

ACCHO: African and Caribbean Council on HIV/AIDS in Ontario. ACCHO is a PPN.

Active offer: Making an invitation to members of the public to use one of Canada's two official languages when they are engaging with a service. An example of an active offer is a frontline worker using a bilingual greeting such as "Hello! Bonjour!" when interacting with first-time users of a service. In this report, we use "active offer" in reference to offering Frenchlanguage services and resources.

AFAB: Assigned female at birth.

AMAB: Assigned male at birth.

ASOs: HIV/AIDS service organizations. We use this term to refer to organizations that are mandated to provide HIV-related services, typically as part of their mission or through core funding. In Ontario, most ASOs are region-specific or population-specific (e.g., ethnoracial, gender, language, etc.).

BIPOC: Black, Indigenous, people of colour.

CAAT: Committee for Accessible AIDS Treatment.

CAMH: Centre for Addiction and Mental Health.

Ciscentric, ciscentrism: Centring cisgender as the "normal" or most important gender, usually to the exclusion of trans people.

Cisgender, cis: Describes a person who identifies as the sex they were assigned at birth. Cisgender can be shortened as cis.

CMHA: Canadian Mental Health Association.

Community-level knowledge mobilization: How key information is shared via word of mouth and social media.

Dead name, deadnaming: A dead name is a trans person's birth name or other former name, which is no longer used. Deadnaming is the use of this name without the person's consent.

Front hole: Some trans men and transmasculine people use this term to refer to their internal genitals.

FTM: Female to male.

GBQ: Gay, bisexual, queer.

GBQMSM: We use this term to refer to men who are gay, bisexual, queer, or men who have sex with men.[12] See also MSM.

[12] In this report, we also use several other umbrella terms that span a range of sexual and/or gender minorities. This glossary lists the key umbrella terms used in this report. Other umbrella terms that we have used include LGBT (lesbian, gay, bisexual, transgender) and LGBTQ+ (including, but not limited to, lesbian, gay, bisexual, transgender, queer).

GIPA/MEPA: Greater involvement of people living with HIV/AIDS/Meaningful engagement of people living with HIV/AIDS. This powerful statement was adopted by many groups in Ontario following the Ontario Accord. It is one way for HIV-positive people to assert agency by saying "nothing for us or about us, without us."

GMSH: Gay Men's Sexual Health Alliance. GMSH is an Ontario-wide network of ASOs (GMSH Alliance member agencies) who are working in various aspects of the HIV/sexual health response as it relates to 2SGBQ+ men. This work includes participation from allies in various HIV-sector organizations, including public health units (particularly in Toronto and Ottawa), sexual health clinics, HIV outpatient clinics, and other health and social services. GMSH is a PPN.

GMSH Alliance member agencies: The ASOs that collectively comprise the network of agencies that make up GMSH. Their mandate is to provide programs to assist 2SGBQ+ men to prevent the transmission of HIV, and to improve the sexual and overall health of both HIV-positive and HIV-negative men.

GMSH Alliance-linked staff: The staff who work at GMSH Alliance member agencies.

HIV Resources Ontario: A network of 12 capacity-building organizations whose mandate includes offering free training, assistance, and information dissemination to community-based ASOs across Ontario. One of the organizations in this network is GMSH.

IDU: Injection drug user.

Intersectionality, intersectional: We use intersectionality to capture the understanding that systems of oppression and power intersect and overlap in multidimensional ways. An intersectional approach can be used to avoid or oppose exclusionary analyses—for example, analyses of HIV prevention that primarily consider the needs of white cisgender men.

MEPA: See GIPA/MEPA.

MOH: Ontario Ministry of Health.

MSM: Men who have sex with men. An epidemiological category created to group HIV and STI risk profiles by combining sociosexual networks and sexual practices. The category was also created in resistance to labelling all men having sex with men with a nonconsensual western monosexual identity label ("gay"). Unfortunately, this category is not always useful, and can in fact be discriminatory, especially when misapplied to trans people, who may or may not fit within the biomedical, behavioural, identity, or sociosexual network assumptions associated with the term.

MTF: Male to female.

NIHB: Non-Insured Health Benefits. This program provides health benefits for certain First Nations and Inuit people.

Non-binary: This term spans a range of people who do not identify exclusively as a "man" or "woman." This includes people who identify as not having a gender and people whose gender identity spans more than one gender.

NYSHN: Native Youth Sexual Health Network.

Oahas: Ontario Aboriginal HIV/AIDS Strategy.

OAN: Ontario AIDS Network.

ODB: Ontario Drug Benefit program. This program provides extended drug benefits to some people with low incomes.

ODSP: Ontario Disability Support Program. This program provides income and other supports to certain Ontarians living with disabilities.

OFNHAEC: Ontario First Nations AIDS/HIV Education Circle.

OHIP: Ontario Health Insurance Plan.

OHTN: Ontario HIV Treatment Network.

Ontario Accord: A statement of solidarity regarding the greater involvement of people living with HIV/AIDS. HIV-sector organizations across Ontario have signed on to this statement.

PEP/PrEP: Post-Exposure Prophylaxis/Pre-Exposure Prophylaxis. PEP and PrEP are anti-retroviral medications that are used to prevent HIV infection. These medications need to be prescribed. PEP is taken before being exposed to HIV and PrEP is taken after potentially being exposed to HIV.

PLDI: Positive Leadership Development Institute.

Poz: HIV positive.

PrEP: See PEP/PrEP above.

PPN: Priority Population Network. In Ontario, PPNs help community-based organizations to focus their efforts on populations that are considered most at risk of HIV/AIDS (Ontario HIV Treatment Network, n.d.-b). Three PPNs (ACCHO, GMSH, and WHAI) are funded by the Ontario AIDS Bureau to achieve the provincial HIV/AIDS strategy to 2026.

RAMQ: Régie de l'assurance maladie du Québec. This health insurance board manages Quebec's provincial health and drug insurance plans.

STI: Sexually transmitted infection. STIs are infections that can be transmitted via sexual activity. In this report, we intentionally separate STIs from HIV to recognize that: (a) HIV is not only acquired through sex, (b) HIV cannot be passed on through sex from someone with an undetectable viral load, and (c) STIs are an important aspect of our sexual health regardless of our HIV status.

Syndemic: The concept of syndemics, or synergistic epidemics, acknowledges that epidemics exist in the context of pre-existing social contexts, complex social problems, and health conditions. Disadvantaged populations are most often impacted by syndemic factors resulting in significantly poorer health outcomes.

TasP: Treatment as Prevention. TasP refers to using HIV interventions to prevent HIV transmission. For example, people who use anti-retroviral treatments can maintain an undetectable viral load, which prevents them from transmitting HIV to others.

TNB2S: Trans, non-binary, and Two-Spirit.

Trans: This term spans a broad range of people whose gender identity is different from the sex that they were assigned at birth. Not all Two-Spirit or non-binary people identify as trans or align themselves with this term. Sometimes used as a shortened form for transgender.

Trans man, trans men: A trans man is a man who was assigned female at birth. In this report, we also sometimes refer to trans men as trans guys, another commonly used term.

Trans woman, trans women: A trans woman is a woman who was assigned male at birth.

Transfeminine: This term spans a range of people assigned male at birth whose gender involves or leans toward a female or feminine identity.

Transmasculine: This term spans a range of people assigned female at birth whose gender involves or leans toward a male or masculine identity.

Transmisogyny: This term describes the marginalization of AMAB and other transfeminine people due not only to transphobia, but sexism as well. Transmisogyny "is steeped in the assumption that femaleness and femininity are inferior to, and exist primarily for the benefit of, maleness and masculinity" (Serano, n.d., para. 2).

Trillium: Ontario Trillium Drug Program. This provincial public program helps Ontarians pay for high-cost prescription drugs.

Two-Spirit: A term coined in 1990 to describe centuries-old practices and identities held by Indigenous peoples on Turtle Island. Among its many meanings, this term is often used to describe someone Indigenous to Turtle Island whose sexual, gender, and/or spiritual identity has both a masculine and a feminine spirit.

WHAI: Women and HIV/AIDS Initiative. WHAI is a PPN.

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