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We Are All Women: Barriers and Facilitators to Inclusion of Transgender Women in HIV Treatment and Support Services Designed for Cisgender Women

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Abstract

Transgender women share more in common with cisgender women, with respect to sociocultural context and factors influencing HIV risk and outcomes, than they do with ''men who have sex with men'', a behavioral risk category in which they often are included. However, it is not yet clear whether both transgender and cisgender women would find integrated, all-women HIV programs and services desirable and beneficial. We Are All Women was a qualitative study conducted in the San Francisco Bay Area from April 2016 to January 2017, using a conceptual framework based on gender affirmation and trauma-informed care, to explore barriers and facilitators to inclusion of transgender women in HIV treatment and support services traditionally focused on cisgender women. Thirty-eight women (10 trans, 25 cis, and 3 ''other'' gender) participated in six semi-structured, facilitated focus groups. In addition, five HIV care providers participated in semistructured, in-depth interviews. Both trans and cis women identified the desire for gender affirmation, a feeling of safety (specifically space without men), and potential community building within a care and healing context as powerful facilitators of an inclusive all-women care environment. At the same time, they recognized that tensions do exist between idealized visions of such an environment, deep-seated sentiments and behaviors among some cis women toward trans women, and the practical realities of creating the optimal spaces for all women. Opportunities for dialog between trans and cis women to mitigate gender-associated phobias and misperceptions are a valuable first step in creating HIV care environments that serve all women.

Keywords: HIV, women's health, transgender women, cisgender women, HIV treatment

Introduction

Transgender (''trans'') women (people who have a feminine gender identity and/or expression but were assigned male at birth) experience disproportionately high rates of HIV.[1] A meta-analysis found HIV prevalence among trans women in the United States to be 14%, compared with an estimated 0.5% HIV prevalence for United States adults overall.[2] Despite the high prevalence of HIV among trans women, to date there is a dearth of evidence-based HIV prevention or treatment interventions designed specifically for this group. This disparity is driven by the continued aggregation of trans women with ''men who have sex with men (MSM)'' in HIV surveillance and prevention efforts, which has impaired enumeration and description of trans communities affected by HIV and often rendered trans women invisible. This strategy has not served trans women well, as programs designed for men do not address trans women's unique sociocultural context and drivers of HIV risk.

Accessing services for men, being treated as a man, and not having one's own unique issues addressed during health care is alienating and humiliating for trans women.[3,4] They, their

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advocates, and public health researchers have issued a strong call for the disaggregation of trans women from MSM,[1,5–7] as the importance of incorporating gender-affirming practices in addressing HIV among trans women is becoming increasingly recognized.[4,8] Trans women are women first and foremost and share more in common with cisgender (''cis'') women (people who have a feminine gender identity and/or expression that is congruent with the female sex they were assigned at birth) than they do with MSM with respect to psychosocial drivers of HIV risk. These drivers include experiences of trauma, intimate partner and sexual violence, misogyny, survival sex work, sexual objectification, and unequal power in relationships to negotiate safer sex.[4,9,10] Both trans and cis women living with HIV are less likely to receive antiretroviral therapy (ART), trans women are less likely to be retained in care,[11] and trans women on ART demonstrate worse adherence and report less confidence in their abilities to integrate treatment regimens into their daily lives than other groups.[12] Moreover, there is increasing evidence of disproportionate rates of AIDS-related mortality and detectable viral load among both trans and cis women, particularly women of color and low-income women.[13,14]

Addressing the sociocultural barriers to HIV care and adherence for all women living with HIV is vital to improving their health outcomes. Cis and trans women face a complex array of psychosocial challenges that complicate their access and adherence to HIV care, such as limited access to and avoidance of health care due to stigma and past negative experiences with providers, competing priorities, and trauma.[4,15] For trans women, social and economic marginalization due to sexism and transphobia (negative societal attitudes toward transgender persons) often result in poverty and unstable housing, familial alienation, limited formal education, limited social support, mental illness, trauma and victimization, substance abuse, and sex work.[15–22] These factors can result in late or no presentation to HIV medical care and poor health outcomes.[23]

In sum, although they have unique experiences and needs, trans women living with HIV have more in common with their cis women counterparts than they do with MSM; however, they historically have not had access to appropriate, women-focused services. In envisioning how best to address the needs of trans women as women and redress HIV and associated health disparities among them, a core question is whether both trans and cis women would find integrated, all-women HIV programs and services desirable and beneficial. The aim of this study was to explore barriers and facilitators to inclusion of trans women in HIV treatment and support services designed for and traditionally focused on cis women.

Methods

Sample selection, characteristics, and procedures

We Are All Women was a qualitative study utilizing focus groups and interviews with trans and cis women living with HIV and health care providers conducted between April 2016 and January 2017. The study design was informed by a conceptual framework that integrates models of gender affirmation[8] and trauma-informed care.[24,25] Cis and trans women were purposively sampled and recruited from local agencies that provide various types of assistance to trans and cis women living with HIV in the San Francisco Bay Area. We aimed to recruit participants who were diverse in geographic location, race/ethnicity, and current ART engagement, but no formal stratification along these lines occurred. Core eligibility criteria for focus group participants included being 18 years of age or older, identifying as a woman, and living with HIV. A total of 38 women—10 self-identified as trans, 25 as cis, and 3 as ''other''—participated in the focus groups.

Five health care providers with expertise in direct medical services, clinic leadership, transgender advocacy, program management, and provision of wrap-around services were recruited for in-depth interviews. They were drawn from the researchers' existing knowledge of HIV care and treatment providers at community based organizations (CBOs) and clinics in the Bay Area that specifically market their services to trans and/or cis women. Because the number of providers with significant experience working with trans women living with HIV was limited, we began by recruiting those most well known for their trans-specific services from within Bay Area counties (e.g., San Francisco, Alameda, Marin, San Mateo) to ensure geographic diversity.

As can be seen in Table 1, we obtained demographic and related information from focus group participants. Of these, the majority (71.1%) were black/African/Afro-Caribbean, 41–55 years old (55.6%); had more than a high school education (55.5%), were receiving Social Security Insurance (55.6%), could barely get by on the money they had (50.0%), and were currently in rental housing (61.1%) but had at some point been homeless or lived in a shelter (83.3%). Nearly all (94.4%) were currently in HIV care, and a majority were currently taking ART (88.9%) and had an undetectable viral load (72.2%).

Among the five providers who were interviewed, one identified as trans woman, two as cis women, and two as cis men; and two were Asian, two were white, and one was Latinx. All were between 45 and 55 years of age.

There were six focus groups: two comprised only cis women, two comprised only trans women, and two comprised both cis and trans women. The focus groups were cross-sectional, semistructured facilitated discussions. Each was held in person, consisted of 2 facilitators and between 2 and 11 participants, and lasted $\sim$1 h. Four groups were held in San Francisco and two in Oakland. Attendees received $40 for their participation. All focus groups were audiorecorded and transcribed. Provider interviews were cross-sectional and semistructured, following an interview guide lightly tailored to the expertise of each participant. Interviews were conducted over the phone and recorded and lasted between 60 and 90 min. Interviewees received $100 for their participation.

Analysis

Focus group and interview transcripts provided the data for analysis. The analysis team consisted of one lead and one supervising analyst, neither of whom were involved in primary data collection. The lead analyst reviewed all transcripts, developed codebooks representative of crosscutting themes, conducted primary coding of all transcripts, and uploaded transcripts and codes into *Dedoose*, a web-based analytical software application. Excerpts were extracted by code and summarized, following the methods for template analysis.[26] Themes were analyzed independently and in

Table 1. Characteristics of Focus Group Participants ($N=38$)

Characteristic	N *(%)*[a]
Gender identity	
Female	25 (65.8)
Trans female–transgender woman	10 (26.3)
Other	3 (7.9)
Sex assigned at birth	
Male	16 (42.1)
Female	22 (57.9)
Race/ethnicity[b]	
Black/African American/Afro-Carib	27 (71.1)
Latinx	4 (10.5)
Asian	3 (7.9)
Native American or Alaska Native	3 (7.9)
White	8 (21.1)
Multiracial/multiethnic	1 (2.6)
Age (years old)	
18–29	2 (5.3)
30–40	2 (5.3)
41–55	19 (50.0)
55+	15 (39.5)
Currently in HIV care	
Yes	36 (94.7)
No	1 (2.6)
Decline to answer	1 (2.6)
Currently taking antiretroviral medications/ART	
Yes	35 (92.1)
No	2 (5.3)
Decline to answer	1 (2.6)
Current viral load status	
Undetectable	30 (78.9)
Detectable	5 (13.2)
Do not know	2 (5.3)
Decline to answer	1 (5.6)
Citizenship[c]	
United States citizen	21 (55.3)
Missing	17 (44.7)
Highest level of education completed	
Less than high school	7 (18.4)
High school diploma/General Educational Development	11 (28.9)
Technical or vocational school	2 (5.3)
Some college, Associates, or technical degree	15 (39.5)
College degree or above	3 (7.9)
Recent sources of income and financial support[b]	
Employed full time	1 (2.6)
General assistance/welfare	4 (10.5)
Disability insurance	11 (28.9)
Supplemental security income	25 (65.8)
Spouse/partner	1 (2.6)
Other family members or friends	2 (5.3)
Other	1 (2.6)
Description of current financial situation	
Have enough money to live comfortably	14 (36.8)
Can barely get by on money I have	16 (42.1)
Cannot get by on money I have	8 (21.1)
Most recent living situation	
Own apartment or house	2 (5.3)
Rent apartment or house	24 (63.2)
Live with friends or family	3 (7.9)
Halfway house or treatment center	2 (5.3)
Homeless shelter	2 (5.3)
Hotel, boarding house, or single room occupancy	4 (10.5)
Decline to answer	1 (2.6)
Ever been homeless or lived in shelter	
Yes	29 (76.3)
No	8 (21.1)
Decline to answer	1 (2.6)

[a]Percentages may not always add up to 100 due to rounding.
[b]Respondents could indicate all responses that applied, so the total exceeds 38.
[c]The citizenship question was the only one with missing data. Only 21 of the 38 participants provided citizenship information. Of those, 100% were United States citizens.
ART, antiretroviral therapy; SSI, social security insurance.

relation to one another by the team and were used to organize preliminary findings. The study protocol, inclusive of data collection and analysis methods, was reviewed and approved by the Institutional Review Board of the University of California, San Francisco.

Results

Overall, findings from the focus groups and interviews suggest that both cis and trans women are drawn to women's care spaces out of desire for community, for care tailored specifically to meet women's specific needs, and for a place that feels safe from stigma and harm. Participants hypothesized that an inclusive, all-women care environment would disentangle trans women demographically from MSM, foster community and understanding among trans and cis women, and affirm trans women's gender identity through the parameters of their care environment. At the same time, participants in both the focus groups and interviews recognized conceptual and practical challenges of integrated, all-women's care. Overarching themes that emerged from the data were: needs (in common and unique to trans women), acceptability, community, gender affirmation, and knowledge/education. All of these themes were infused with issues related to trauma, a ubiquitous experience for both cis and trans women living with HIV.

Themes

Needs in common. The most salient needs-related themes articulated by cis and trans women alike were histories of trauma, the need for a safe space away from men, the need for a space to deal with the unique challenges of being a woman in the world, and needs associated with living with HIV:

> I feel like trans and non-trans women have in common experiences around trauma and violence, and we have in common stories we tell ourselves about our bodies, and we have in common that we have a number of priorities that we shift and we sometimes put ourselves further down the list, our own wellness. So on those kinds of wellness, resiliency, healing kind of things, I do feel like there's a place for bringing all women together. [Provider 3, interview]

> I would feel powerful and supportive being in a room with cisgendered women and trans women because some men - here, I'm going to put this out on the table.. . Sometimes some men could be assholes, you know, and I don't look like every-

> body's picture of what a woman looks like, or what their sister looks like, or what their aunt looks like, or what their cousin looks like. And, you know, you know, it might be - I think it would be a conflict sometimes because some men can be real assholes and - and say things and give you that dirty look and stuff and - you know? So, yeah, come to think of it, yeah. I really don't like being in a clinic with men. I really don't. [Participant 13, trans woman, trans FG]

A higher level of need. Data suggest that, despite myriad overlapping needs, those of trans women—clinical, structural, and psychosocial—are consistently higher than those of cis women, chiefly due to an even greater burden of trauma and violence borne by trans women living with HIV. Trauma and violence link to comorbidities, as well as to behavioral and situational factors that make engagement and retention in any kind of treatment extremely difficult for trans women.

> I think people look at substance use, opiate dependency, depression, anxiety, violence, incarceration, persistent obesity, persistent non-adherence to medications or, you know, persistently elevated viral loads, or even just looking at the social determinants—whatever the social determinants are, the barriers to care, even homelessness—I think people tend to look at these as, you know, people are described as complex patients or high need, high cost patients. And to me, I think, just like, people are missing that there is a unifying factor, which is trauma and which are the impacts of trauma.. . [Trans women] are predominantly getting sick and dying from trauma-related issues. And not to mention, you know, not to mention those women who are either not adherent to PrEP or not adherent to their own HIV medications and get sick and die from AIDS. That adherence and those deaths are also predominantly trauma-related. [Provider 4, interview]

Traumatic experiences of stigma, harassment, and discrimination are compounded over time. Further, the risk of experiencing harassment based on gender identity or presentation within a women's environment is acute for trans women, who fear rejection of gender membership and rejection from a community at exactly the moment they are seeking refuge and safety. The fear or actual experience of such rejection may lead trans women to opt out of HIV and primary health care entirely.

> Well, in my experience. .. It's the cis women who have more of a fear of trans women and/or have a higher judgement level of whether or not you can consider yourself a woman. And if your voice is too low, if you're not pretty enough, and all of these things that they don't want to be judged as females, you know, natural females, they want to push on somebody else because in any kind of environment, it makes them feel better or whatever. [Participant 15, trans woman, trans FG]

> Yeah, because it's not just about that single interaction. We have also found that, you know, a majority, over 50% of the community have experienced traumas, multiple traumas. And so, every single rejection or discrimination or stigma added to their, you know, their experience would actually amplify exponentially, you know, like, they'll decide to disengage. [Provider 5, interview]

> As you all know yourselves, some people will sit home and die rather than go seek medical care. I'm sure you all have heard stories like that before. Some people will not go get medical care because of being transgender. [Participant 13, trans woman, trans FG]

For cis women, the perceived risks of sharing care space with trans women had less to do with danger posed to their own wellbeing, and more to do with social discomfort and feeling different from trans women. One cis participant talked about not knowing much about trans women, not wanting to say the wrong thing, and feeling uncomfortable with that pressure. Several cis participants seemed particularly concerned about the biological differences between cis women and trans women, but were not able, or perhaps did not have the opportunity, to articulate what it was about those differences that concerned them.

> I don't go around talking about my vagina to everybody. Anyway, but the question was how would I feel sitting talking in a setting like this with a transgender. I would feel very uncomfortable for some reason. [Participant, cis woman, cis FG]

Providers felt that the combination of particularly high needs of trans women with increasingly constrained resources posed a challenge to inclusive, all-women's care. They spoke about the relative merits of dividing up limited HIV funding across demographic populations versus investing in elevating trauma-informed care or enhanced case management. In sum, while they supported the idea of an inclusive women's clinic, they felt that addressing more fundamental elements of the health care system and its practices to better address trans women's needs before constructing such a space might be required and be a better use of limited resources.

> I'm picturing almost this first layer of interacting with the system that is very women inclusive, trauma-informed, dealing with structural barriers, and then as you move up into the medical pieces you could go into more trans-specific, or cis-specific, so it met your needs, was very patient-centered in that way. But at the entry point [it's] about safety, and about healing, and about resilience. [Provider 3, interview]

Acceptability. The vast majority of participants—cis women, trans women, and providers—reported positive feelings ranging from general acceptance to passionate insistence about the concept of an inclusive all-women HIV care environment. Seventy-eight percent ($n = 25$) of focus group participants expressed willingness, support, or enthusiasm for the idea of receiving their HIV care in an inclusive, all-women's space, due to its potential for creating community, meeting shared needs, and providing a safe space. For trans women, much of the openness to sharing care space with cis women took the tone of neutral consent rather than desire, a ''don't hassle me and I won't hassle you'' attitude:

> And if there's a seat, I'll ask: Can I sit here? And have my seat and mind my own business. You know, I'm not into the head trip anymore. It don't matter if it's male, female, or a sex change in there, we all here for the same reason, boo boo. [Participant 13, trans woman, trans FG]

For some cis women, the ethics of inclusion were important:

> I would feel - comfortable with that [getting services in a clinic that serves all women]. But I feel uncomfortable with somebody being excluded from care. That would mean I would second-guess the place. Because they're human - and I look at them as just human healthcare. And everybody deserves it for whatever reason. So, what would make me

> different than that person? And that fairness and equality, if it wasn't allowed, would make me not as comfortable in a place like that. Because why isn't it allowed? [Participant 30, cis woman, cis FG]

This is not to say that there was no ambivalence about integrated cis and trans women care. At the same time as expressing willingness and support for the idea of inclusive women's care, both trans and cis women expressed concern about what that would look like in practice. Trans women reported being mainly concerned about harassment, receiving care that is not trans competent, and having triggering experiences. This fear was grounded in their own and other trans women's experiences of life-long stigma and discrimination:

> If I'm thinking of it as a clinic that just specifically served [us] as women, it would be too difficult of a scenario to - because some women have children, some women have, you know, little babies, and when a child is not very ashamed to ask, you know, is that a boy or a girl or, you know, all of these kinds of things where… Those kind of things that can set a trans woman off, you are subjecting your patients in that kind of environment to that by no fault of their own. [Participant 15, trans woman, trans FG]

Community. One of the main anticipated benefits of inclusive all-women care is its ability to build community among women and reduce isolation, particularly for women dealing with stigma and trauma. Focus group participants said that the opportunity to connect with and learn from one another as women could serve as a bridge across varied lived experiences. Providers felt that building community and reducing personal isolation are essential components of effective health programming for women and marginalized groups.

> Yes, we might be different skin tones. Different heights. Different weights. Different eye colors. But we are women. We should come together as one, and fight this. [Participant 22, trans woman, all FG]

> I think that you would be more open [to a clinic that serves all women], I think as a woman, 'cause you'd be more comfortable being around everyone who identifies as a woman. [Participant 23, cis woman, all FG]

> The interventions that I've seen that have had transformative impacts on women, transgender women and non-transgender women, are ones where a woman can go from not being out about her HIV status to anyone, or to most people, not being out about her history of trauma … Not having people in their family that they can be open to about their feelings, what's really going on inside their head, what's really happening in their lives. And what happens, the result of this isolation is that they are then facing abusive partners or substance use or tremendous anxiety or discrimination alone. And they're walled off from the opportunity to get supported by other people. … And so, the interventions that I've seen that have changed women's lives have allowed for a sisterhood to develop where people have gone from not having real friends to having a group of friends who will support them. [Provider 4, interview]

Gender affirmation. Gender affirmation was perceived as a powerful facilitator to inclusive all-women care among our study participants. For many, the inclusion of trans women in women-only spaces represented an active affirmation that trans women are women. Some focus group participants talked about not feeling comfortable with the trans label and liking the idea of an all-women environment because it aligns more precisely with their gender identity. Others referenced gender affirmation obliquely, that is, less as the presence of affirmation and more as the lack of nonaffirming experiences, such as being misgendered or seeing trans exclusion as normalized. Additionally, participants asserted that gender affirmation could not just be an ideal of inclusive women's care, it must be operationalized in practice, for example, by not having separate spaces for trans and non-trans women within a women's clinic.

> I hate the word transgender and I do not like being categorized. I am a woman and that's it, period. So, put that in a mix of your flyers, your posters around there; whatever it is in your clinic has to reflect that that's how you see all your patients.. . instead of a trans girl here and a cis girl there, it's.. .if you put them together, then you're a women-serving clinic. [Participant 15, trans woman, trans FG]

> If it's an HIV clinic…it's hit or miss if it's just women in the full expressions of cis and trans.. . First of all, the pros of it is, you're not going to be mis-gendered. You're not going to be called by your legal name - your boy name or your previous name or anything like that. [Participant 15, trans woman, trans FG]

> Don't separate the space because if you're training about inclusiveness and then you're having clinics for trans patients and then for nontrans patients, you're already making that separation. I feel like if you have a women's clinic, they need trans women. You know what I mean? This whole thing like, ''Oh, no. We need to have - '' I mean, I get it. Trust me. To have a separate space because of the needs or whatever. I think that that doesn't help the situation. You need to have everybody together. People need to just used to it. I feel like the only way to do that is to bring people together. [Provider 2, interview]

However, as noted above, the positive potential for gender affirmation that such an environment holds is offset by an equal, potential danger for trans women. The draw of an explicitly inclusive all-women clinic creates an expectation of gender affirmation that, if violated, inflicts trauma inside a presumed safe space. In other words, any experience of harassment of a trans woman by a cis woman within a specifically women's space may be felt as community rejection and, more pointedly, as gender un-affirming.

Knowledge/education. The concern noted above about how trans women might be treated by cis women in an all-women's environment played out in the focus group discussions themselves, where some cis women displayed a lack of knowledge, had incorrect assumptions, or used harmful language about trans women. But, as exemplified in the following exchange between a cis participant, a trans participant and two group facilitators, often a knowledge and education exchange occurred as a result of open dialog.

> Participant 26(c): Well, I've been in situations where I was in a detox with a transgender.
> Facilitator 2: Mm-hmm.
> Participant 26(c): It was – definitely could tell it was a male. He was a very big guy.

Facilitator 2: Mm-hmm.
Participant 26(c): But he identified as a woman. You know? And so, I – I felt safe. I never felt bad. I'm secure in myself, so.
Facilitator 2: Mm- hmm.
Participant 26 (c): I didn't – you know – I didn't feel no threat –
Facilitator 2: Mm-hmm.
Participant 25(t): -Going to the bathroom with ''him.''
Facilitator 1: Sorry, can I – can I break in? 'Cause – 'cause we're talking about a transgender woman. So, we're going to say ''she'' and ''her,'' and ''hers.''
Participant 26(c): Oh, okay. I'm sorry. Did I say it wrong?
Facilitator 1: Yes.
Participant 26(c): Oh, okay. Sorry.
Facilitator 1: Mm-hmm.
Participant 26(c): I wasn't thinking. Okay.
Facilitator 1: Okay. Perfect.
Participant 25(t): Well. Or ''they'' or ''them.''
Facilitator 1: Mm-hmm.
Participant 26(c): And – I didn't feel uncomfortable. 'Cause we – we selpt in the same area. You know, 'cause it was a women on one side, and the men on the other side. But since they identified with woman, with being a woman, they were on our side.

There were many similar interactions across our focus groups. These suggest that some of the behavior that causes harm to trans women stems from a lack of fundamental understanding that many cis women are receptive to education, and that the educational threshold to behavior change may be quite low.

Discussion

The idea of an inclusive all-women care environment is both promising and fraught to different degrees for cis and trans women. On the one hand, it holds the potential to create a safe space for cis and trans women together in a way that both satisfies their criteria for safety and builds community, social enrichment, and personal empowerment while reducing isolation and stigma. On the other hand, the opportunities for compounded trauma are high. Cis women who are specifically seeking a women's space because of trauma related to men may have their trauma triggered by voices or appearances that they read as a man in a woman's space. For example, some cis women in focus groups talked about hearing a ''dude's voice'' in a bathroom [Participant 9, cis FG1] or seeing a someone in a women's space whom they could ''visually tell he was a guy'' [Participant 27, cis FG2], and they referenced these experiences as being out of place and uncomfortable. Some may even feel emboldened by the ''women only'' context and perhaps by a sense of privilege that comes with being a cis woman, to confront that person or demand their removal.

Trans women who are specifically seeking a women's space because of trauma related to men, misgendering, gender policing or questioning, or harassment from strangers based on their presentation or appearance will almost certainly have their trauma compounded should they encounter disaffirming reactions from cis women. For example, trans women in focus groups talked about rejection and harassment from cis women if their voice is too low or they do not look the way cis women think women should look. They referenced how common it is for cis women to complain to staff when they think there is a man in a women's space, or a non-cis woman:

I have seen - not at General, but at other facilities -even like going to the dentist at UOP, that when a transgender go in or whatever, I have seen some women fly out of there and go to the front desk and say that there's a man in there; you know? Either because you don't want to sit down or either when you come out the stall, they clock the T. [Participant 13, trans woman, trans FG]

General discomfort anticipated by cis women did not attach to any specified harm that they feared, nor led them to think they might opt out of health care because of their discomfort. By contrast, providers were concerned that the fear of being traumatized in a medical environment lacking specialized trauma-informed competencies might lead trans women to ''sit at home and die.''

While some focus group exchanges showed a transphobic undercurrent, most of the cis women's narratives around inclusion reflected ambivalence and a concern that everyone would get their needs met. The knowledge exchanges mentioned above suggest that these may easily be addressed with a relatively minor amount of education and dialog. However, it is important to acknowledge that before these dialogs, many of the study's cisgender participants—even several of those who self-report as accepting of trans women—used language, displayed discomfort, and imagined themselves behaving in ways that might have inflicted real harm on trans women.

Our study found that both cis and trans women perceive value in creating inclusive, all-women HIV care environments that provide a safe space away from men, affirm women's gender identity, and provide competent, trauma-informed care services. At the same time, tensions do exist between idealized visions of such an environment, deep-seated sentiments and behaviors among some cis women toward trans women, and the practical realities of creating the optimal spaces for all women. Opportunities for dialog between trans and cis women to mitigate gender-associated phobias and misperceptions are a valuable first step in creating HIV care environments that serve all women.

Finally, in addition to discussing the idea of an all-inclusive, gender-affirming, women's care environment, study participants offered a number of practical ideas about how to implement it. Suggestions included: modifying the physical environment to include such things as single-occupancy gender-neutral bathrooms; engaging the target population (trans and cis women) in program planning and evaluation; and elevating trans women's visibility and representation in marketing materials, front office and medical staff positions, and patient data. These implementation ideas will be further explored in a subsequent article.

Author Contributions

J.D.A. and L.M. wrote the article. S.W. and J.S. provided valuable feedback on the contents of the article. All authors reviewed and approved the article.

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