Implementation Strategies for Creating Inclusive, All-Women HIV Care Environments: Perspectives From Trans and Cis Women

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Abstract

Introduction: Transgender (trans) women in the United States have disproportionately high rates of HIV acquisition, yet there remains a dearth of culturally appropriate and gender affirming HIV care services for them. Trans women often are aggregated with men who have sex with men based on biological essentialism and behaviorally defined characteristics, even though they have more in common with cisgender (cis) women, such as gender identity and psychosocial factors that influence HIV risk. As a result, trans women often are rendered invisible and underserved in the HIV response. We explore the feasibility of constructing inclusive, all-women HIV care environments as a way to redress the dearth of appropriate services for trans women living with HIV and to affirm their gender identity as women.

Methods: Thirty-eight women living with HIV and five providers participated in a qualitative focus group and interview study between April 2016 and January 2017, exploring the desirability and practicality of including trans women in HIV treatment and support services traditionally focused on cis women. Transcripts were coded and template analysis was employed to discern key themes.

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Results: Participants identified concrete strategies for implementation of inclusive, all-women HIV care related to representation and visibility of trans women, community input, education and training, aspects of the clinic environment, and flexibility and creativity. The impact of trauma and the need for safety and gender affirmation were emphasized throughout.

Conclusions: Trans and cis women found the idea of inclusive, all-women's HIV care environments attractive and feasible, notwithstanding cultural and structural challenges to creating them.

Despite disproportionately high rates of HIV infection among transgender (trans) women in the United States (Centers for Disease Control and Prevention, 2019), there remains a dearth of culturally appropriate and gender-affirming HIV care services for this population (Operario & Nemoto, 2010; Sevelius, Patouhas, Keatley, & Johnson, 2014). In HIV surveillance, prevention, and research efforts, trans women's data typically are aggregated with those of men who have sex with men, based on biological essentialism and behaviorally defined characteristics. This practice has impaired enumeration of trans communities and assessment of the impact of HIV, and it often has rendered trans women invisible and underserved in the HIV response (Baral et al., 2013).

Research has demonstrated trans women share more in common with cisgender (cis) women than they do with men who have sex with men with respect to the psychosocial factors influencing HIV risk. Chief among these factors are experiences of trauma, intimate partner and sexual violence, misogyny, sexual objectification, and unequal power dynamics within relationships, both personal and transactional (Machtinger, Haberer, Wilson, & Weiss, 2012; Operario & Nemoto, 2010; Sevelius et al., 2014). Among people living with HIV, both trans and cis women are less likely than men to receive antiretroviral therapy and fare worse than men in AIDS-related mortality and detectable viral load (Poteat et al., 2019). At the same time, trans women have unique experiences and needs from cis women that stem from social and economic marginalization due to trans-specific gender discrimination and transphobia (Brennan, et al., 2012; Bukowski, et al., 2018; Nuttbrock et al., 2014). This persistent marginalization can contribute to limited or no interactions with health care providers, lower levels of retention in HIV care, and worse antiretroviral therapy adherence than other groups of women and men, producing worse health outcomes for trans women (Bukowski, et al., 2018; Klein, Psihopaidas, Xavier, & Cohen, 2020; San Francisco Department of Public Health, 2019; Sevelius, Carrico, & Johnson, 2010).

One strategy for redressing the dearth of appropriate services for trans women living with HIV and for affirming their identity as women is to construct inclusive, all-women HIV care environments. We conducted a qualitative study to explore the desirability and practicality of this strategy—specifically, of including trans women in HIV treatment and support services traditionally focused on cis women. In this analysis, we present findings from the domain of our study dedicated to identifying concrete strategies for implementation of this model, and implications for practice and policy.

Methods

Between April 2016 and January 2017, we conducted a qualitative focus group and interview study, We Are All Women, in the San Francisco Bay Area.

Participants and Procedures

Focus group participants included cis and trans women living with HIV, aged 18 years or older, purposively sampled and recruited from local agencies where they received services. A total of 38 women—10 self-identified as trans, 25 as cis, and 3 as "other"—participated in the focus groups. They were diverse in age, race and ethnicity, educational background, and economic and housing status. A majority (71%) were Black/African/Afro-Caribbean, aged 41–55 years (55.6%), having more than a high school education (55.5%), receiving Social Security Insurance (55.6%), and currently living in rental housing (61.1%).

We conducted a total of six focus groups: two with only cis women, two with only trans women, and two with both cis and trans women. The focus groups were in-person, cross-sectional, semistructured facilitated discussions. Each included two facilitators and between 2 and 11 participants and lasted approximately 1 hour. Four groups were held in San Francisco and two in Oakland. Attendees received $40 for their participation.

In addition to the focus groups, we conducted in-depth interviews with five providers with expertise in direct medical services, clinic leadership, transgender advocacy, program management, and wrap-around services. These individuals were purposively selected based on the researchers' knowledge of providers at community-based organizations and clinics in four Bay Area counties (San Francisco, Alameda, Marin, and San Mateo) who specifically serve diverse populations of trans and/or cis women. Of the five providers interviewed, one identified as a trans woman, two as cis women, and two as cis men; two were Asian, two were White, and one was Latinx, and all were between 45 and 55 years old. Provider interviews were cross-sectional and semistructured, using an interview guide lightly tailored to the expertise of each participant. Interviews were conducted over the phone and lasted between 60 and 90 minutes. Interviewees received $100 for their participation. All interview and focus group sessions were recorded and transcribed by a professional transcription service.

Analysis

Transcripts from all focus groups and interviews were coded in Dedoose (2018), based on thematic codebooks developed by the research team. Template analysis methods (Brooks, McCluskey, Turley, & King 2015) were used to excerpt and summarize the qualitative data. The study protocol, including data collection and analysis methods, was reviewed and approved by the Institutional Review Board of the University of California, San Francisco.

Results and Discussion

The analysis of findings from the We Are All Women study related to the perceived benefits of and obstacles to inclusive, all-women HIV care environments have been published previously (Auerbach et al., 2020). In sum, that analysis revealed that both cis and trans

women living with HIV seek women's care spaces to experience a sense of community, to receive tailored care, and for safety from ongoing stigma and harm, including gender-based violence from men. They felt that an inclusive space would be gender affirming for all women and would foster better communication and understanding between cis and trans women, who share many needs and experiences as women. Participants also recognized that there are significant psychosocial and practical challenges to crafting an inclusive, all-women environment, related to the unique needs among trans women and an undercurrent of transphobia among cis women. That analysis further found that both the needs for and barriers to acceptable HIV care for many women (and trans women especially) exist within the context of trauma, both experienced and anticipated, and must therefore be viewed through that lens.

Despite challenges, study participants identified a number of implementation strategies that could be used to operationalize the model, which are reported here. First, we describe the overall findings from this aspect of the study in relation to the key themes that emerged from the data analysis: representation and visibility of trans women in all facets of the development of the care space, community input, education and training of providers and other clinic staff, aspects of the clinic environment, and flexibility and creativity. After this, to inform action steps and in recognition of the impact of trauma in the lives of both trans and cis women, we categorize specific implementation strategies mentioned by study participants within the trauma-informed primary care framework developed by Machtinger et al. (2015) (as described elsewhere in this article).

Theme 1: Trans Visibility and Representation

Data from both the focus groups and the provider interviews suggest that trans visibility and representation—in marketing materials, front office and medical staff positions, and patient data—would be powerful facilitators of an inclusive all-women's HIV clinic.

Hiring trans staff—Participants talked about how employing trans staff in a clinic creates a safe space for trans patients and demonstrates an expectation of respectful conduct. They felt that trans team members provide invaluable insight into programming for the trans patient population and ensuring competent care at every level. Multiple participants described how aspirational it can be for trans women to see other trans women being accepted and employed in mainstream occupations.

> Having somebody who is like you there, that can—you know, help you with whatever, you know, for like a transgender woman like me, I would like to have a transgender doctor who has been through what I'm going to try to get. [Participant 25, trans woman, all FG]

> We support trans leadership. So, even when it's not necessarily a trans led organization, they can still have transgender people being hired or promoted to decision making positions. And usually, those are how more effective changes happen, when a trans project is led by a trans person. [Provider 5, interview]

Providers also said that prioritizing the recruitment and development of trans people in key staff positions signifies a clinic's true values. Operationalizing this means

acknowledging the experiences of structural inequality, barriers to educational and employment opportunities, and unique challenges to navigating daily life. It also means being flexible about budget allocation, education and job experience requirements, and working hours.

> I think [achieving an integrated all-women clinic means] making a genuine commitment. And from a clinic director's perspective, that means money. It means making decisions about who to hire and where to invest the funds that you have, knowing that those decisions are going to affect different communities differently. So, if I have one case manager position open or one substance use counselor position open, making a decision to hire a transgender woman, really making an effort to hire a transgender woman to fill that position would be, you know, really where that commitment is expressed most concretely… You can really understand the values of an organization or the values of a grant proposal by just looking at the budget. [Provider 4, interview]

> [We can] create an environment where they have very flexible hours for trans women. Often times, we take time to get ready, for instance. So, in a traditional job, that might become an issue if you are late every day. But with us, it allows us to really look at where we put in our eight hours during the day, and we don't have as many questions about it because we are not doing direct services. So, yeah. It's a surprisingly important issue, I think, that a lot of organizations misunderstand or overlook, this question of time for trans people. It's actually extremely important for us, and particularly, it has a great deal to do with our relationship to work and also our ability to be at work and be successful at work, is this question of time. And it's hard sometimes to explain to people why it's so important, because it's absolutely those issues about getting ready, but it's also even just the sheer courage it takes to get out of bed and to walk out your front door as a trans person. That is daunting. [Provider 5, interview]

Marketing materials—Providers and trans focus group participants noted that designing visual marketing for an inclusive women's clinic that shows a diversity of gender presentations would accomplish a variety of goals: it would signal to trans women that this is an environment that does not just promise to accept them, but actively desires to serve them along with cis women; it would help to select for a patient population that is respectful of different experiences and presentations of being a woman; it would use the power of medical authority to socially reinforce that trans women are women; and it would enfranchise trans women with a tacit public acknowledgement that trans women have lives and needs that extend beyond their trans experience, that is, that are about them being women.

> So put [trans and cis] in a mix of your flyers, your posters around there, whatever it is in your clinic 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]

> But now I realize, I wonder if we sometimes make the flyer very trans specific. I think we have inclusive language on the flyer, but I'm not sure we have [anything

trans-specific]. So then I think if I'm trans and I don't see that specifically spelled out, I wouldn't think I'm included. I think that's my cis-orientation that I feel that's inclusive language. [Provider 3, interview]

Client data—The accuracy of client data is an easily overlooked but critical aspect of an inclusive, gender-affirming environment, and for ensuring optimal care for trans women in particular. Providers described the confusion that can ensue when a patient name and sex/gender identity appears differently over time in medical records, or between a medical record and what that patient specifies at the time of a visit. This can result from misunderstandings by front line staff about what is required by way of coding for diagnostic and insurance purposes. Those misunderstandings can be experienced as microaggressions by the client.

> My big thing now is this medical record piece. I think the system's issue with the medical record is huge, because it's going to be very hard to track microaggressions or purposeful issues when you are giving a frontline staff person information that's incorrect in the medical record. Because then people start saying stuff, microaggressions, this, that, and the other. I'm like, okay, it could be microaggressions, or they tried to read the chart and the chart's wrong, you know? [Provider 3, interview]

Theme 2: Community Input

Regular and ongoing input from community members was identified by study participants as essential for operationalizing an inclusive, all-women's HIV care environment. Providers, in particular, emphasized the importance of engaging the focus population, inclusive of trans women, in program planning and evaluation to avoid a "top-down patriarchal approach" and to ensure that the needs of all women are understood and addressed. They felt that it was important to seek regular feedback from the broader community, not just the patient population, for example, by hiring and seeking feedback from trans leadership and clinic staff.

> As a cisgender man and as a provider, there's going to be blind spots that I have even with the experiences that I've been able to, you know, build off of. So being able to have partners who can think about how do you… You know, like what do we wish providers would do? What has felt good and what has worked well? So, like really doing it together and looking at it from different perspectives to make sure it is sound and not just one person's thoughts or ideas. [Provider 1, interview]

> If we had a transgender social worker currently, if we had a transgender case manager currently, neither of which we have, we would be able to, most likely, get a much better sense of some of these hard questions around transgender specific programming versus integrated programming. And how we're doing with serving the transgender community, how we'd better serve the transgender community. It just seems pretty obvious that having that staffing would help us get to some of these key answers about how to best serve this community. [Provider 4, interview]

Theme 3: Education and Training

Education and training was a key theme among participants in considering implementation strategies for inclusive, all-women's HIV care. Whether developing a new stand-alone clinic or integrating trans women's care into an existing clinic serving cis women, staff and clinicians would need training on a broad set of competencies, as well as the policies and procedures designed specifically for this environment.

Competencies include an understanding of the barriers and facilitators experienced by cis and trans women to receiving HIV care, as well as receiving that care alongside one another. These competencies represent a cluster of skills and sensitivities about language, medical care, understanding the context of different women's lives, tending to psychosocial needs, knowledge of community resources, and awareness that health for trans people is not only about trans-focused services.

> [Part of trans competent care means] not mak[ing] these assumptions that just because somebody [is] not presenting themselves as the gender norm, that you assume they are trans and they need services. You know, make no assumptions. Ask what type of services they need instead of starting from a point of, who are you? And once I know who you are, doesn't mean that I know what you need. So, start with, "What do you need?" You know, and then you can work back to, "Who are you?" And build a core. [Provider 5, interview]

Similarly, participants mentioned the need for training and education among clients. As reported, trans women's fears of cis women's reactions to them are grounded in experience. Many cis women, including the ones most likely to be interested in an inclusive all-women clinic, are both willing and able to adjust their behavior when provided with basic education and clear communication about what is expected from them. Focus group discussions and provider interviews suggest that clients would benefit from a clear, visible, universal policy to which all clients and staff are held accountable.

> I feel like there has to be training for both sides [providers and patient populations]. I mean that's not the right word, but skill building, cultural competency as well. It's more for the cis aspect. I noticed from a lot of the focus groups from this study, there was a lot —I was surprised how much pushback and ignorance there was from the cis community, but then I also was like… hey, what's happening? Find out [what they need to know], and set up brochures, and start talking about it. [Provider 3, interview]

> I mean, that's—I don't go—I don't go around thinking that I know everything. And I always—and I—I sometimes mess up. There's so many, you know, letters now— and so many—so much—you know, I try to be proper. But I mess up sometimes. And so, I—I would think it would be helpful to have information. You know, in a room, in a setting that there's going to be cis and—and trans, and gay and straight. And you know, to edu — while you're sitting waiting the half hour for your primary care doctor. To be able to read up on some—some of the proper things that make all of us feel comfortable. [Participant 18, trans woman, trans FG]

Both providers and focus group participants thought that the client population should be appropriately represented in the development of curricula as well as the execution of the trainings themselves. More than one focus group participant had the idea of holding a facilitated dialogue—not unlike the focus group itself—where cis and trans women living with HIV could talk about their hopes, fears, and concerns about their care. One provider talked about the importance of putting a face on the community, and how when people are in a room together it stops being about "them" and starts being about "us." Another provider, while reflecting on how to train other clinicians, questioned the conventions of the doctor–client divide, and whether maintaining rigid interpersonal boundaries serves their patients. Data from our study show a desire from all sides for a more humanistic, narrative, and experiential approach to trainings than currently exists.

> I want to look for ways to help providers who really want to get better, go beyond that superficial level of just necessary, but not sufficient. Yes, pronouns, access to hormones, yes, that's a low-hanging fruit. That's the stuff that's super concrete and easy to grasp.

> But so much more of the work is about I think like what you and I are arriving on, you know, just like—it's just a hard life. It's how much somebody needs to be believed, how much of the healing that needs to happen is on such a human-to-human level. It makes me think about issues such as like the term professionalism, for example, like how that is conventionally thought to mean and how we're taught what that means as medical providers. And oftentimes that is such a bright line in the sand that you're taught that you can never cross and you don't reveal anything of yourself, that you don't form attachments with your clients. But that I think that—does that—the question, does that serve this population? Does it serve clients who are so intensely exposed to traumatic life experiences, that that's a common denominator regardless of whether somebody is Latina or African American or Caucasian? [Provider 1, interview]

Theme 4: Clinic Environment

Across focus groups and interviews, three elements of the optimal physical environment for an inclusive women's clinic came up repeatedly: single-occupancy bathrooms, a greeter at the door, and the availability of amenities that provide comfort and dignity, such as coffee and snacks and hygiene kits.

In the larger context during which this study took place, the subject of transgender persons' access to bathrooms of their choice took on national political significance in March of 2016 with the passage of a bill in North Carolina that banned people from using public bathrooms that did not correspond with the biological sex noted on their birth certificates. Although not the first time the issue had arisen, this particular incident fueled a renewed debate about gendered bathrooms in general and the civil rights of transgender people in particular (Davis, 2017).

It is not surprising then that the topic of bathrooms received a great deal of attention by both trans and cis women in all our study sessions. Associated comments made clear that

bathrooms can be a flashpoint for conflict and are representative of the potential dangers that cis and trans women perceive from each other.

> 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, all FG]

> I don't have anything against [trans women in women's bathrooms], but in certain ways as far as safety, I do. Just [to] have the access. Because what about the people who really aren't transgender that dress up and have those type of intentions of going to the bathroom like that? [Participant 6, cis woman, cis FG]

Although the details of the discussion of bathrooms varied across the sessions, everyone agreed that the problem would be solved by having single-occupancy, gender neutral (i.e., all-gender) bathrooms.

Having some sort of "greeter" in the space was also a popular idea among participants, although there was not consensus about what that role would actually entail. For example, ideas ranged from a chaplain-like figure to a person at the front desk who was friendly and knew clients' names. One participant asserted that what is important about the greeter is not the exact role that person has, but rather that they extend themselves to a client as she enters and establishes for both that client and everyone else in the reception area that the client is welcome exactly as she arrived that day.

> [A greeter would] give us women the type of umph, like, "Okay, they welcoming me." "Oh, I'm bad bitch." "Okay, I can sit with all the girls." And Kiki and Caca, they go, "What your secret girl? How you doin'?" Let's have a conversation. Like, okay, "I am [name], what's your name?" "Nice to meet you too." "Girl, I like those nails girl." Do it like that. A greeter at the door to make everyone feel comfortable. Without a greeter, it's going to be tension. [Participant 22, trans woman, all FG]

Theme 5: Flexibility and Creativity

Providers noted that delivery of services for trans women, in particular, requires a willingness to be flexible to patient needs.

> I had one client who was my client at [clinic] and then she switched over to [program with a drop-in system] after we started. You know, the number of times I actually saw her in an appointment-based system for a year was three or four. And [we] never got enough traction to go deep. And then at [drop-in], all of a sudden, the number of visits increased significantly so that she was dropping in every week, every two weeks, and that degree of continuity allowed us to chip away at things instead of like you do something and then like three months goes by and, you know, everything fell backwards. I think that for people who have particularly intersecting problems, if you can't get enough intervention exposure, if you can't get enough visits in there, you can't—you just don't get a finger hold on things and so the open access model I think structurally has helped. [Provider 1, interview]

Tele-health [for patients], I actually think, could totally revolutionize trans health for so many reasons, as well as some of these issues around trans safety and violence stuff. I think we could do some really innovative stuff there. [Provider 5, interview]

Limitations

There are a few limitations to this study that are worth noting. One relates to sample size and distribution by gender identity. Specifically, we had only two trans women in each of the two trans women-specific focus groups compared with the larger number of cis women in their respective groups (6 and 11). Population demographics are always an element of recruitment, and there are much fewer trans women than cis women in the general population. Moreover, trans women may be less comfortable and trusting of research environments, may experience more barriers to participation in research (e.g., transportation), and may be more concerned about privacy and the potential for appropriation or misuse of their stories. As a result, it was more difficult for us to recruit trans women. At the same time, it is important to note that we did achieve balance in the mixed groups, having an equal number of cis (3) and trans (3) women in one group and a nearly equal number in the other (3 trans and 2 cis). Additionally, we were only able to recruit and interview five providers in the timeframe of our study, but we attempted and achieved diversity among them with respect to the type of care they provide.

Another limitation is that our study took place only in the San Francisco-Oakland Bay Area, and perceptions and experiences of cis women, trans women, and women's health and HIV care providers may be different in other locations, given the relatively progressive nature of the Bay Area culture compared with other regions in the United States.

Notwithstanding these limitations, we believe this study is the first to provide data on attitudes, experiences, and recommendations related to gender-affirming HIV care directly from the voices of both cis and trans women in the United States.

Implications for Practice and/or Policy

The cis and trans women in our study—both patients and providers—were very interested in exploring the possibilities of inclusive all-women care spaces for women living with HIV. They identified challenges in doing so, particularly related to perceived danger and preexisting beliefs about sex and gender. At the same time, they acknowledged the commonalities felt as women, and expressed a desire for greater understanding and community that they felt could be engendered by a shared clinic. Study participants identified a number of requirements to be considered and addressed in an effort to make a truly inclusive and accepting space for both cis and trans women a practical reality.

Underlying these requirements is a recognition of the central role of trauma in the experiences of women living with HIV, particularly trans women. Although our analysis extracted themes and recommendations for implementation strategies as they arose in the data, the trauma-informed primary care framework developed by Machtinger et al. (2015) provides a useful way to categorize the specific strategies suggested by our study participants. This framework has four core components: *Environment* (calm, safe,

empowering for both patients and staff); *Screening* (inquiry about current and lifetime abuse, post-traumatic stress disorder (PTSD), depression, and substance use); *Response* (onsite and community-based programs that promote safety and healing); and *Foundation* (trauma-informed values, robust partnerships, clinic champions, support for providers and ongoing monitoring and evaluation). Table 1 summarizes the practical applications of our study findings, by key themes, in relation to this trauma-informed primary care framework.

Conclusions

In our study, trans and cis women living with HIV and their providers found the idea of inclusive, all-women's HIV care environments attractive, notwithstanding cultural and structural challenges to creating them. Participants identified a number of practical requirements and specific implementation strategies, aligned with the practices of a trauma-informed primary care model, to operationalize an inclusive, all-women HIV clinic. Of greatest importance are creating physical environments that are safe, welcoming, and respectful; promoting visibility and engagement of all women in the community, particularly trans women who have been marginalized in women's health arenas; creating employment opportunities for trans women so that clients see staff who are like themselves; and building competencies among both staff and clients that demonstrate understanding of the context and complexities of different women's lives.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

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Table 1

Practical Requirements and Implementation Strategies for Inclusive, All-Women's HIV Care Aligned With the Trauma-Informed Primary Care (TIPC) Framework

Practical Requirement	Implementation Strategies	Rationale	TIPC Framework Practice Realm
Trans visibility and representation			
Hiring trans staff	• Allocate funding to recruit and train trans women. • Modify job descriptions to outline desired skills and qualities rather than required education or experience. • Ensure visible representation of trans women on staff. • Develop training programs to promote hiring and training of trans women on staff. • Develop a flexible clinic flow, or establish hours that align with client patterns, such as later start and end times.	Hiring, training, and developing trans women on staff shows trans women that they are welcome, visible, and employable; shows cis women that there is a baseline expectation of respect and inclusion; and shows all patients that the clinic prioritizes lifting up members of the patient community.	Foundation
Marketing materials	Develop a visible marketing campaign (flyers, posters, bus stop ads, etc.) showing cis and trans women together, with a diversity of gender expressions, and simple, inclusive messaging such as "all women welcome" or "HIV care for all women."	This is gender affirming by signaling to both trans women and the general public that trans women are women, and that there are multiple ways to present as a woman.	Environment
Client data	Use one of two systems: • An electronic medical record system that allows for varying combinations of name, sex, and gender entries; OR • A supplementary computerized or paper-based system that flags clinic staff and providers to a patient's pronouns and preferred name when they differ from those on file. Train clinic staff on how to operationalize the system from a patient-centered approach.	Accurate and up-to-date medical records that are attentive to the complexities of name, sex, gender, and diagnoses/billing code entries particularly for trans women can facilitate appropriate treatment of patients by staff and providers.	Screening
Clinic environment			
Bathrooms	Make single-occupancy all-gender restrooms available.	Restrooms often are the locus of negative experiences among trans women, the source of anxiety about exposure and conflict, and an environment that triggers discomfort among both trans and cis women.	Environment
Greeter	Employ a greeter (rotating staff or volunteers) to welcome patients as they walk in the door. This person could be responsible for other client services in the reception area, such as assistance with forms, letting a manager know if issues arise between patients, or directing patients to educational materials and snacks.	A dedicated, welcoming person in the front office of the clinic sets a tone upon entry that each individual is welcome and cared about.	Environment
Comfort and dignity amenities	Provide amenities, such as coffee, tea, and snacks in the waiting area; a clean place for clients to wash up and shave; small complimentary hygiene and shaving kits; and occasional on-site community events, such as a clothing swap.	These provide a convivial environment and one conducive to gender affirming care.	Environment
Community input			
Key stakeholder engagement	• Build in iterative community feedback: a monitoring and evaluation component should be built into existing programs or new interventions. • Engage staff at all levels in feedback systems. • Engage a community advisory board to collaborate on programming.	It is important to obtain ongoing input not just from clients, but also from other community stakeholders who understand what clients need and want.	Foundation

Practical Requirement	Implementation Strategies	Rationale	TIPC Framework Practice Realm
Education			
Educational materials	• Host Critical Conversations events where HIV-positive trans and cis women discuss their care experiences and needs (with facilitators to guide and food for participants). Develop informative pamphlets that provide detailed information about gender diversity and respectful language, including FAQs, testimonials from cis and trans patients, and resources to learn more. Make these available in reception and exam rooms for patients to peruse during wait times.	Providing comprehensive information enhances agency and control over health care decisions among trans and cis women.	Environment
Trainings and competencies	• Recruit and provide training/training referral for providers with specialist competencies in transgender primary care throughout the life course. • Develop trainings for staff and providers that include community members (i.e., a panel, a facilitated discussion similar to focus groups) with the goal of framing the patients and providers as "us" rather than "them." • Ensure staff training involves attention to trauma, sensitivity to trans women's needs and vulnerabilities, understanding of the full context of cis and trans women's lives, and awareness of potential conflicts that may arise and how best to mitigate them. • Train providers and staff in the Clinic Code of Conduct.	Experience and expertise in social-emotional dynamics, gender affirmation, and trauma-informed care, and observance of a code of conduct are essential to providing appropriate and respectful services to cis and trans women.	Response
Flexibility and creativity	• Consider creative solutions to access issues, such as drop-in portions of the day, unconventional clinic hours, or tele-health, based on understanding patients' barriers and patterns. • Incorporate a commitment to flexibility as a core clinic value. • Explore creative ways to address reimbursement coding so that dynamic elements of trauma-informed care are captured (i.e., trust building, psychosocial support) and a financial case can be made for allotting more time to patients.	Acknowledging patients' barriers and patterns and adapting the clinic's operations and culture to address these will serve trans and cis women better.	Environment