

“I do the she and her”: A qualitative exploration of HIV care providers' considerations of trans women in gender-specific HIV care

Ashley Lacombe-Duncan¹ , Kathryn R Berringer^{1,2}, Jennifer Green³, Amy Jacobs⁴ and Amy Hamdi⁵

Abstract

Objectives: Women of all genders, including cisgender (cis) and transgender (trans) women, experience social and structural drivers of HIV inequities and pervasive barriers to HIV care. Yet, little is known about how HIV care providers address gender diversity in health care. Through a critical feminist lens informed by intersectionality theory, medical anthropology, and critical sociology, we explored (1) how do HIV care providers describe women living with HIV's care needs and barriers; (2) what are their perspectives on optimal HIV care for women; and (3) to what extent do these conceptualizations include/exclude trans women.

Methods: Utilizing a community-based exploratory qualitative study design, we conducted 60–90 minute semi-structured individual interviews from March 2019–April 2020 with eight HIV care providers ($n=4$ social service providers; $n=4$ physicians) practicing across seven counties representative of rural, suburban, and urban Michigan, United States. Data were analyzed utilizing a reflexive thematic approach.

Results: Three overarching themes emerged: (1) Emphasis on (different) clinical needs: key considerations in cis and trans women's HIV care; (2) Recognition of the structural: barriers to HIV care affecting women of all genders; and (3) Proposed solutions: piecing together individual, social, and organizational interventions to increase access to HIV care that may benefit women living with HIV of all genders but are disproportionately framed as being for cis women. While HIV care providers recognized both cis and trans women living with HIV's clinical care needs and structural barriers to care, they rarely envisioned optimal HIV care inclusive of gender affirmation and structural interventions.

Conclusions: Findings suggest that HIV care providers can avoid reducing gender to biology and making assumptions about reproductive care needs, endocrinological care needs, caregiving responsibilities, and other life circumstances; provide gender-affirming medical care; and address structural barriers to HIV care to enhance intersectional and structurally focused gender-affirming—that is, trans-inclusive—women-centered HIV care.

Keywords

HIV primary care, intersectionality, stigma, transgender, women living with HIV

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Introduction

Social and structural drivers that perpetuate gender-based inequalities in access to resources and health, such as violence, increase HIV vulnerability among women of diverse gender identities, including both cisgender (cis) and transgender (trans) women. Cis women are those whose gender identity corresponds with their sex at birth and trans women are those whose gender identity does not correspond as such.^{1,2} In 2016, cis women accounted for approximately one-quarter of all people living with HIV in

¹School of Social Work, University of Michigan, Ann Arbor, MI, USA

²Department of Anthropology, University of Michigan, Ann Arbor, MI, USA

³Unified: HIV Health and Beyond, Ypsilanti, MI, USA

⁴Michigan HIV/AIDS Treatment Program, Michigan Medicine, Ann Arbor, MI, USA

⁵Michigan HIV/AIDS Council (MHAC), Lansing, MI, USA

Corresponding author:

Ashley Lacombe-Duncan, School of Social Work, University of Michigan, 1080 South University Avenue, Ann Arbor, MI 48109-1106, USA.
Email: lacombed@umich.edu



the United States (US).³ Trans women, and especially those of color, whose lives are shaped by intersecting racism, misogyny, and anti-trans stigmas,^{4,5} are among the most disproportionately affected by the HIV epidemic in the United States.^{6–9} For example, while the US Trans Survey (USTS) reported an overall HIV prevalence of 1.4% among all respondents ($n=27,715$), nearly one in five (19%) Black trans women were living with HIV.⁹

There are also gender and racial inequities among cis and trans women regarding access to HIV care. For example, a large US population-based study showed that Black trans women were less likely to be retained in HIV care than Black cis women.¹⁰ Population-specific HIV prevention and care services have been lauded as enhancing HIV care engagement, particularly among sub-populations of people living with HIV perceived to have specific care needs.¹¹ Relatedly, culturally tailored and so-called “culturally competent” HIV prevention and care has been promoted to increase engagement of HIV care for sub-populations of people living with HIV who experience intersecting oppressions, such as Latina women and young Black gay and bisexual men, among others.^{12–14}

Women-centered HIV care is one example of population-specific HIV care with theoretical and empirical support.^{15,16} At its core, women-centered HIV care addresses clinical (e.g. HIV and women's health care priorities), social (e.g. social isolation and stigma), and structural concerns (e.g. violence, poverty) of women, through the promotion of peer support and women living with HIV's leadership.¹⁵ However, much of the women-centered HIV care literature has not accounted for diversity and is particularly exclusive of care considerations of trans women.¹⁵ Many researchers historically grouped trans women along with gay and bisexual cis men, labeled as “men who have sex with men,” both conflating sexuality and gender and erasing trans women's specific experiences as women. With trans activism, research emerged that specifically focuses on the needs and experiences of trans women living with HIV.^{17–21}

More recently, an emergent body of women-focused HIV research has intentionally included trans women.^{1,2,22–24} One study argued that gender-inclusive women-centered care environments might foster community among cis and trans women while providing essential affirmation of women's genders.² At the same time, there was some concern among study participants, particularly among trans women, of the potential to overlook differences in trans women's realities, as well as concern among service providers with the practicalities of carrying out inclusive care.² Indeed, trans women have specific needs for gender affirmation, which can affect HIV care engagement.²⁵ Gender affirmation, a process whereby a person receives recognition and support for their gender identity and expression,²⁶ can be enhanced through social (e.g. use of a new gender pronoun), psychological (e.g. self-love/

affirmation), legal (e.g. updating identity documents), and/or medical processes (e.g. feminizing hormone therapy (FHT); gender-affirming surgeries).²⁷ Moreover, many studies indicate that intersecting anti-trans and HIV stigma, including stigma perpetuated both interpersonally by providers and structurally, poses a barrier to HIV prevention and care for trans women, whereas gender-affirming interpersonal relationships between trans women living with HIV and their providers, as well as physicians' knowledge of both HIV and trans health issues, are of critical importance for engaging women in ongoing care.^{17,28} Therefore, a model of intersectional, structurally focused care is also relevant to trans women's experiences in health care that is gender-affirming.

While gender-affirming—that is, trans-inclusive—women-centered HIV care has the potential to recognize and affirm trans women's identities as women, as well as the potential to expand notions of culturally tailored or culturally competent, population-specific health care to be more intersectional and structurally focused, scant research has examined how HIV care providers may address gender diversity and conceptualize such care. In applying a critical feminist lens informed by theories of intersectionality, critical sociology, and medical anthropology, we offer a first step toward understanding barriers and opportunities for intersectional and structurally focused gender-affirming, women-centered HIV care by examining: (1) how do HIV care providers describe the care needs and barriers of women living with HIV; (2) what are their perspectives on optimal HIV care for women; and (3) to what extent do these conceptualizations include/exclude trans women.

Methods

Study design and setting

This community-based exploratory qualitative study engaged community activists and HIV care providers from Michigan in all aspects of the study, from conceptualization, protocol development, and participant recruitment to interpretation of study findings. Michigan is a Midwestern US state with a population of just under 10 million people²⁹ and an overall HIV prevalence of 18,970 persons.³⁰ New diagnoses are primarily concentrated in the city of Detroit, at a rate of 33.7 per 100,000 population, over 3.5 times the rate of the next highest jurisdiction.³¹ In 2013, Detroit became the largest city in the US' history to enter bankruptcy, fuelling widespread unemployment.³² The Detroit metropolitan area is also among the most racially segregated regions of the US, with resultant health, social, and economic racial inequities.³³ Similarly, the state of Michigan is among the most racially segregated in the country and a great deal has been written about the associated urban/rural divide, with 75% of the state's population residing on 6.4% of the state's urban land area, and 25%

spread out over the state's rural land area.³⁴ Despite racial segregation between these urban and rural areas, rates of poverty and other indicators of social inequities are quite similar between urban and rural areas.³⁴ Cis women comprise approximately 21% of all people living with HIV in Michigan, with 70% of those cis women living with HIV identifying as Black.³¹ Data on trans people are not disaggregated by gender (e.g. trans women, trans men, nonbinary persons); however, about 77% of trans people living with HIV identify as Black.³¹

Theoretical framework

This study is underpinned by intersectionality theory and critical scholarship in medical anthropology and sociology. Intersectionality is a critical social theory emerging from Black feminism that allows for an understanding of how multiple intersecting systems of privilege and oppression operate at the macro level of society to influence the everyday lives of individuals at a micro level.^{35–38} For example, much research has described the ways how patriarchal systems of power fuel misogyny and resultant HIV inequities among cis women.^{39,40}

Trans women also exist within a patriarchal and misogynistic society, in addition to having lives shaped by cis-normativity—the “sociocultural assumptions and expectations that all people are cissexual and/or have a cisgender body” (Bauer et al.,⁴¹ p. 356), which socially sanctions anti-trans stigma within multiple institutions, including health care. While intersectionality takes a structural lens, much of the literature on cultural competency in HIV care has focused on interpersonal interactions between patients and their care providers and has diluted anthropological and sociological understandings of culture.⁴²

As such, critical scholarship in medical anthropology and sociology that argues against orientations to culture and cultural competency in medicine that adopt a “trait list approach,” synonymizing culture with ethnicity and treating cultural groups as static or monolithic^{42,43} further informs our study. We take up these scholars' suggestion of redefining “culture” in structural terms, attending to how economic, physical, and socioeconomic forces drive inequities and disparities.⁴³

Participant recruitment and characteristics

HIV care provider participants were recruited using purposive and snowball sampling, whereby the first author and principal investigator (ALD), a doctoral-level trained researcher employed in a large public university, first sent study information emails to HIV care providers at HIV hospital-based and community-based settings. Each interviewee was invited to provide contact information for up to three other providers, external to their care setting. Considering patterns of racial and geographic segregation

across the state, attention was paid to purposively recruiting participants from diverse geographic settings (e.g. urban, rural, and suburban settings), as well as those holding diverse professional roles (e.g. social work, medicine). A total of 19 providers were emailed, one of whom declined to be interviewed, and 10 of whom did not respond to the initial email nor a subsequent follow-up email.

Participants included eight HIV care providers, including four social service providers (e.g. case managers, behavioral health workers, social workers) and four physicians, each of whom was an infectious disease specialist. Participants practiced in seven distinct counties of Michigan, including those both densely populated (e.g. Wayne County, 2,974.4 persons per square mile)⁴⁴ and sparsely populated (e.g. Marquette County, 37.1 persons per square mile 2019).⁴⁵ Three-quarters of the participants ($n = 6$) were women.

Data collection

Between March 2019 and April 2020, participants completed 60 to 90 minute semi-structured individual interviews with the principal investigator (PI) (ALD), facilitated using an interview guide developed for this study in collaboration with community partners. Prior to beginning the interview, participants were informed of the PI's research interests and their background in community-engaged HIV research with lesbian, gay, bisexual, transgender, and queer (LGBTQ+) populations. They were also informed that these interests stemmed from the PI's social work practice background. In some interviews, the PI and interviewee also discussed the PI's own identities as a White cis queer woman. The interview guide explored providers' current role and responsibilities (e.g. “What is a typical day like for you?”) and providing HIV care to women (e.g. “Please walk me through a typical experience with a woman living with HIV from the time she enters your setting to the time she leaves”) (see Supplementary File: Participant Interview Guide). The interview guide prompted HIV care providers to reflect on multi-level barriers. It also focused on women living with HIV's intersections of gender, race, and class and how providers tailored HIV care provision across these intersections (e.g. “One of the things I am very interested in is how HIV primary care providers take into consideration different kinds of identities, such as trans identity, when delivering HIV primary care”) consistent with an intersectional theoretical approach.^{35–37,46} Finally, providers were asked about recommendations to improve care for women living with HIV (e.g. “What do you think is the best way to structure health care to address HIV and other health and social needs for women living with HIV?”).

Before data collection, the interview guide was reviewed by an HIV activist and HIV care provider and adjustments were made. Minor adjustments to the

interview guide (e.g. accessibility of language) were also made iteratively throughout the data collection process. All interviews were conducted by phone with solely the interviewee and interviewer present. The consent form and honorarium were transferred by email. All participants provided written informed consent to participate. The study was considered exempt from institutional review board (IRB) oversight by the University of Michigan IRB (HUM00160823). Interviews were audio-recorded with participant permission and transcribed verbatim. Participants each received a \$40 pre-paid Visa gift card as honorarium for their participation.

Data analysis

We utilized a reflexive thematic approach to data analysis to explore themes.^{47–49} Through a highly flexible yet systematic and rigorous approach, thematic analysis provides a rich, detailed, and complex account of data.⁵⁰ Thematic analysis is a cluster of versatile qualitative research approaches that can be used across epistemological orientations and address a range of research questions.^{48,50} Reflexive thematic analysis, specifically, involves a “situated interpretative reflexive process” (p. 333–334) whereby coding occurs organically and openly and does not involve the development of an a priori coding framework or pre-conceptualized themes.⁴⁹ An underlying assumption of reflexive thematic analysis is that analysis can never be complete, and any decision to stop coding and move to theme generation or to stop theme generation and move on to writing is an interpretative judgment made by the researcher.⁴⁹ Thus, rather than seeking data saturation, we sought information power, assessing the adequacy of our sample size based on the relevant information the sample held to meet our research objectives.⁵¹ Reflexive thematic analysis is consistent with an intersectionality theoretical approach rooted in a social constructionist viewpoint whereby one objective “truth” does not exist and the researcher is positioned as rooted in the everyday and not distanced from it.³⁷

Two of the authors (ALD and KRB) followed Braun & Clarke's⁴⁷ steps to reflexive thematic analysis, which included (1) reading and re-reading transcripts for familiarization with the data; (2) undertaking an iterative process of coding whereby we each independently coded one interview, followed by a meeting to discuss our independent coding and to create and define sub-codes, for each of the eight transcripts. All coding was done by commenting on original transcript files in Microsoft Word. At these meetings, ALD also shared reflections from her field notes that were made immediately following each interview. Moreover, both ALD and KRB reflected on their positionalities as White cis women who identify as trans allies and their experiences working and researching within HIV care settings in the United States and Canada.

KRB is a doctoral candidate with extensive training in sociocultural and medical anthropology and qualitative research methods, including, in particular, ethnography. All transcripts were analyzed after data collection. These meetings also constituted the process of steps (3) searching for themes, (4) reviewing themes, and (5) defining and naming themes. Finally, the results were written-up by the first author (ALD), with specific contributions from the second author (KRB), and shared with the broader team, including HIV community activists and HIV care providers, who share some experiences with the participants. Strategies utilized to promote rigor included peer debriefing between members of the research team and negative case analysis whereby we intentionally sought and highlighted discrepant findings.^{52–55}

Results

Three overarching themes emerged: (1) Emphasis on (different) clinical needs: key considerations in cis and trans women's HIV care; (2) Recognition of the structural: barriers to HIV care affecting women of all genders; and (3) Proposed solutions: piecing together individual, social, and organizational interventions to increase access to HIV care that may benefit women living with HIV of all genders but are disproportionately framed for cis women. While HIV care providers predominantly recognized both cis and trans women living with HIV's clinical care needs and structural barriers to care, when asked to consider imagined possibilities of ideal HIV care for women, they rarely envisioned care inclusive of gender affirmation and structural interventions thus opening a conversation about potentials of gender-affirming, women-centered HIV care. Exemplary quotes are presented in Tables 1–3.

Emphasis on (different) clinical needs: key considerations in cis and trans women's HIV care

When prompted to discuss women's HIV care needs, participants, and most often physicians, raised pregnancy and reproductive health more broadly as key considerations in women living with HIV's care (see Table 1). Given these participants' focus on biological reproduction and specifically concerns with carrying and/or avoiding pregnancy, it appeared they were speaking in relation to cis women living with HIV. Concerning care for trans women, most providers, irrespective of provider type, spoke of the importance of gender-affirming medical care, and particularly FHT, for trans women living with HIV. Contrary to how physicians positioned prescribing and monitoring of ART during pregnancy as “unique” but integral to their provision of HIV care to women, most physician participants were hesitant to

Table 1. Exemplary quotes for theme 1: emphasis on (different) clinical needs: key considerations in cis and trans women's HIV care.

Quote
Pregnancy-related concerns among cis women: "There are unique challenges now for women, because of some of these issues that we're seeing with neural tube defects with dolutegravir, so all of the first-line agents that are recommended are integrase inhibitors." (P1, Physician)
Pregnancy-related concerns among cis women: "My young women, I always talk to them about it if they are thinking about having a baby because I want to make sure that they are on the right antiretroviral and that we don't put them on any antiretrovirals that would harm the baby." (P6, Physician)
Pregnancy-related concerns among cis women: ". . . I as their HIV care provider, I try to leave that open and support whatever they want. I can still ask them what their reproductive plans are and I can support that, but I would say the majority of the patients their reproductive plans are not to have more babies, but there are a handful of women who do wanna become pregnant." (P2, Physician)
Feminizing hormone therapy-related concerns among trans women: "We do not manage the hormones directly . . . We do this through gynecology. There's a particular physician who does manage hormones in obstetrics/gynecology, and then also there's some in the endocrinology [department] who also will manage hormones." (P1, Physician)
Feminizing hormone therapy-related concerns among trans women: "I am willing to prescribe oral progestogen to patients, but a lot of them would prefer injectables and we don't. I don't feel comfortable with the injectable option. If they want injectables then I send them to endocrinology." (P2, Physician)
Feminizing hormone therapy-related concerns among trans women: "I'm a little nervous about it [providing feminizing hormone therapy], but my two nurse practitioners are willing to learn now how to do it. We do have an endocrinologist in our [health care] system who is very supportive of it, and she provides the therapy and our trans women are very comfortable going to her." (P6, Physician)
Feminizing hormone therapy-related concerns among trans women: "I'm not sure that he [HIV physician] is prescribing those hormones, so she must have a primary care doctor. Yeah. He's not prescribing those hormones for her, so she must have a primary care doctor that is doing that for her." (P13, Social Service Provider)

provide gender-affirming medical care themselves, expressing a lack of knowledge and preferring to refer trans women living with HIV to others for this care. Despite not prescribing FHT themselves, P5 (Physician) noted, "There's a lot of [drug] choices we have now and with the integration inhibitors that [don't interact] with the hormones like the older drugs were." As P12 (Social Service Provider) noted, concerns about drug-drug interactions are not unique to FHT and ART; in fact, what "is always a concern is how their hormones will interact with any medication they [cis and trans women living with HIV] are on, from their mental health, their hormones, and things like that."

Recognition of the structural barriers to HIV care affecting women of all genders

Gender-based violence, gaps in access to life-sustaining social determinants of health (SDoH) (e.g. income, housing, health care), stigma and discrimination in health care, and gendered caregiving expectations were discussed by all participants as barriers to HIV care affecting women of all genders (see Table 2). However, these barriers often co-occurred and were magnified among women inhabiting intersecting stigmatized social identities, such as women living in poverty, women of color, trans women,

women who are sex workers, and women at the intersection of these experiences (e.g. trans women of color; women of color living in poverty), a recognition that was more often—though not exclusively—identified by social service providers.

Anti-trans stigma and HIV stigma were discussed as barriers to health care access for trans and cis women living with HIV, respectively. Beyond gender-affirming medical care, providers recognized the importance of holistic health care that is gender-affirming and therefore trans-inclusive (e.g. where trans women are treated with respect) for fostering well-being and access to care among trans women living with HIV, as well as the absence of access to such an environment for trans women. Consequently, trans women living with HIV at times needed to travel long distances to access such care. Whereas social service providers more often foregrounded anti-trans stigma as an overarching barrier to accessing services for trans women, both social service providers and physicians discussed HIV stigma as specifically affecting cis women in reproductive health care. For example, P3 (Social Service Provider) described an experience of a client perceiving stigma from her obstetrician, whereas P13 (Social Service Provider) talked about outright denial of care for a pregnant woman living with HIV "because—and she told her, because she was HIV positive, that she didn't want to put her family at home at

Table 2. Exemplary quotes for theme 2: recognition of the structural: barriers to HIV care affecting women of all genders.

Quote
Gender-based violence: "I have another patient [who] is in a physically abusive relationship, but she is financially dependent on that man and for his—for her children. She takes a beating from him so that there's food for her kids." (P6, Physician)
Gender-based violence: "We've had many, many—many of our women have been through trauma surrounding violence, but it would be domestic violence of violence around substance use or sex work as well. A lot of our female clients have been previous sex workers and have experienced a multitude of violence and trauma through that." (P12, Social Service Provider)
Limited access to life-sustaining social determinants of health: "I've had a patient who was fired for being trans. She's a trans woman and told me the story and definitely felt it was based on her gender . . . I think that definitely is a barrier too 'cause now she is uninsured, now she is unemployed. Now, there is a barrier coming in for appointments, paying her rent, paying her bills . . ." (P3, Social Service Provider)
Limited access to life-sustaining social determinants of health: "The added barrier for trans women, it might almost be the equal opposite in the sense that they're trying to—they may have limited natural support, and then they're trying to meet all their own needs, while trying to find and maintain work, that that can become a huge barrier, just because of the stigma and the way society reacts." (P7, Social Service Provider)
Limited access to life-sustaining social determinants of health: "She [patient/client] was doing great and then she comes in, and she'd stopped taking her meds because her basement got flooded and her power was shut off because she didn't pay her whole bill." (P6, Physician)
Limited access to life-sustaining social determinants of health: "We do have patients that have lower SES [socioeconomic status], and women of color or trans women of color, and those folks tend to no show appointments or miss appointments either because of transportation or insurance instability, unstable housing . . ." (P3, Social Service Provider)
Stigma/discrimination: "We've had an issue [with another trans woman client] where they keep changing her gender on—with social security, and then that has made it so she can't get—on the Medicaid system." (P13, Social Service Provider)
Stigma/discrimination: "It's been a struggle with some of the detox facilities, residential care facilities, transitional housing facilities, homeless shelters—that they are not as trans-confident or friendly as they could be . . . I think we still see a lot of problems related to just, honestly, basic decent respect of pronouns and things like that." (P12, Social Service Provider)
Stigma/discrimination: "Not to say that there's not [trans-friendly providers], but there is limited access. Some of our folks drive quite a ways to get what they need." (P7, Social Service Provider)
Stigma/discrimination: "Well, I had a patient who was pregnant, and when she went to OB appointments her HIV was brought up all the time. It bothered her, and I'm not sure if that's just standard practice, but she felt it was not a major concern especially since today with prenatal detections we can eliminate that with c-section and not using breast milk." (P3, Social Service Provider)
Gendered caregiving expectations: ". . . If they have young kids or if they have—mostly children, they tend to put those children at the front of everything, they tend to neglect a lot of themselves and visits and this and that. If they have issues at home to take care of, some of them take care of their families, some take care of their kids, many of them are single, they tend to put off their own care because they have to take care of so many other things." (P5, Physician)
Gendered caregiving expectations: "You're focusing on women and trans women or cis women and trans women. The added barrier when considering that intergenerational poverty were women also are often the ones taking on the role of taking care of younger generations, older generations, sometimes both. That's something that I see a lot, women taking on the burden—not the burden, but taking on the responsibilities of caring for multiple individuals that are facing the same barriers in the community and their own needs often take a backseat." (P7, Social Service Provider)
Gendered caregiving expectations: "I have a patient coming in today, she has a granddaughter that she takes care of because her daughter is not around. Then, she has her son who [has mental health challenges] . . . Then, when she's home, she not only has to take care of this grown-up man who's her son, but she has a young grandchild that she has to take care of. You can see multiple reasons why it is very easy for her to forget to take her medication." (P6, Physician)
Gendered caregiving expectations: "She [woman living with HIV] takes care of everyone else but her. She takes care of her niece, her grandparents, her sister, her daughter, but she doesn't take this pill once a day to take care of herself, so and she say it's because she was stressed out, overwhelmed and depressed, so." (P2, Physician)

SES: socioeconomic status; OB: obstetrician.

risk because she was doing this procedure [i.e. prenatal care and delivery] on someone that was HIV positive." Notably, reproductive care—including fertility preservation and assisted reproductive technologies—was never discussed

concerning trans women, nor was HIV stigma affecting trans women living with HIV.

Another structural barrier raised was gendered caregiving expectations among cis women living with HIV.

Table 3. Exemplary quotes for theme 3: proposed solutions: piecing together individual, social, and organizational interventions to increase access to HIV care that may benefit women living with HIV of all genders but are disproportionately framed for cis women.

Quote

Individual-level interventions, “personal” work to enact person-centered care: “I think, for me, it’s not about going to classes and learning how—people say, “Oh, we should do a cultural diversity class.” I think that’s a—well, what I learn or how I treat patients is I learn from my patients” (P6, Physician)

Individual-level interventions, “personal” work to enact person-centered care: “I’m white. I’m not Black. I have tried to, like, in college and in medical school I lived in the city in a low-income Black neighborhood and tried to participate in the neighborhood that I lived in . . . I tried to build relationships that are genuine and real friendship with individuals of African-American descent that, I mean, in the city outside of work . . . I think that having real relationships with people that are of the same background as the patients that I see, I think is helpful to have some sensitivity of their life experiences.” (P2, Physician)

Social-level interventions, women-specific support groups: “It would be nice—I guess the support piece of it, to be able to bring women together more to talk to each other” (P13, Social Service Provider)

Social-level interventions, women-specific support groups: “I would say is I think it would be nice to have maybe programs that are specific to women just ‘cause again, the face of HIV is very much white gay male . . . I think support groups or having something in place for women living with HIV to come together would be amazing. That way there is a sense of comradery and community as well.” (P3, Social Service Provider)

Organizational-level interventions, hiring staff who are reflective of communities and partnering with affirming providers: “Currently our patient navigators are not [people living with HIV], but they are people that have an identity within the community serve[d]. They’re not positive, but on a face value, I guess they look like the people they’re serving . . . We are very cognizant of our organization about—because we understand how representation and feeling seen can be a barrier. We are very cognizant of having people that look like the people we are serving, that are part of the same community, to try to decrease that barrier . . . We have people [staff] that are gender non-conforming so using neutral pronouns.” (P7, Social Service Provider)

Organizational-level interventions, hiring staff who are reflective of communities and partnering with affirming providers: “Really, for us, finding that primary care doctor who is LGBT-friendly and knowledgeable and trans-competent has been great for our clients. I think once you can get clients into primary care, their hormones are being taken care of, if they wish to be on hormones, because it’s that basic need. Then they can really start thinking about getting their HIV under control, taking the medications, and that sort of thing. It’s like that hierarchy of needs, again, ‘cause once we can build that relationship and get them stable in a lot of these other areas, then we can also help them be stable in their HIV care.” (P12, Social Service Provider)

Organizational-level interventions, hiring staff who are reflective of communities and partnering with affirming providers: “A lot of times, especially with the trans community, a lot of it is the word of mouth, honestly. Then people doing outreach, building those relationships, continuing to cultivate those relationships and listening to the people that are going” (P7, Social Service Provider)

Organizational-level interventions, community advisory boards: “We also do a community advisory board, but it’s also a social support group although it’s not really the mission of the group but the objective is that that’s what it’s become. But I think it’s been helpful to get to know them and also provide a place for them to support each other. I would love to do more with those community advisory groups and ‘cause I think it’s been really helpful for the patients to come together to talk about their shared experience.” (P2, Physician)

Organizational-level interventions, community advisory boards: “We even do different things getting outside of the women, for instance, we have actually a women support group where we have women coming in and they meet together. Then they discuss different issues that go on, because we have a general support group like a community—what is it called? CAG, Community Activity Group or whatever. It’s basically patients who come together to talk about different issues about their treatment, about things that they would like to see in there. Then we meet together.” (P5, Physician)

Organizational-level interventions, comprehensive care: “I mean, if I had a dream clinic, that would provide optimal care for women with HIV, I think that would look like, number one, having the ability to have a gynecologist onsite in our clinic to provide a lot of the women’s healthcare issues, whether it’s Pap Smear, breast exam, mammogram, all of those types of things Then, oh, the other issue that would be great, again, having a gynecologist in clinic, is pregnancy prevention. Providing Depo-Provera for patients that need it, IUDs, things like that” (P1, Physician)

Organizational-level interventions, comprehensive care: “Also, in a perfect world, there would be childcare provided for mothers to access care. Places where people could go for all-in-one care, and then things like that to help them, especially if they have kids that are not-in-school age, to be able to provide that care for women to be able to get into health.” (P12, Social Service Provider)

Organizational-level interventions, comprehensive care: “One thing is, of course, transportation is a big thing for women. The other is childcare. Sometimes not even childcare but care for whoever they’re caring for at home.” (P6, Physician)

(Continued)

Table 3. (Continued)

Quote

Multi-level interventions, provider training: "I've had different trainings and met different people, so I think it's just been an ongoing [issue] through my work learning process. [Trainings,] they're not always very well attended." (P13, Social Service Provider)

Multi-level interventions, provider training: "Our social workers provide LGBTQ training for our front desk and other staff in the office, so that when patients come in, they feel like it's a welcoming environment and they don't feel like there's stigma there." (P1, Physician)

CAG: Community Activity Group; LGBTQ: lesbian, gay, bisexual, transgender, and queer.

Inherent participant narratives were assumptions about how these gendered expectations placed upon cis women regarding caregiving might impede the uptake of HIV care. Only one participant described this as a barrier experienced by trans women given their potential caregiving roles within trans communities.

Proposed solutions: piecing together individual, social, and organizational interventions to increase access to HIV care that may benefit women living with HIV of all genders but are disproportionately framed for cis women

A patchwork of interventions to increase women's access to HIV care and overall quality of life were highlighted—both tangible/ongoing and aspirational—that applied to women living with HIV of all genders, though framed mostly about the needs of cis women living with HIV (see Table 3). These strategies included those at the individual-level ("personal" work to enact person-centered care), social-level (women-specific support groups), and organizational-level (hiring staff who are reflective of communities and partnering with affirming providers to increase access to care; community advisory boards (CABs); comprehensive care inclusive of reproductive health care and with available transportation and childcare). In addition, provider training to reduce stigma, a multi-level intervention, was recommended. Less attention was paid to considerations of improving social and material conditions for women living with HIV and to dismantling intersecting systems of oppression that contribute to ongoing barriers to accessing HIV care experienced by women.

At the individual-level, both physicians and social service providers alike discussed their own "personal" work and strategies to grow toward and enact person-centered care, both external to and within their clinic environments. At the social-level, many participants suggested women-centered group support as ideal, though the extent to which these groups were envisioned as inclusive to trans women was unclear.

Considering the broader context of care, several ways in which participants could—or had—attempted to shift their organizational and practice contexts to be more welcoming for women living with HIV and to address their

care needs better were raised. While some had attempted to increase diversity, representativeness, and trans health knowledge of staff internal to their organizations, the need to partner with affirming providers to enhance access to comprehensive care for cis and trans women was resounding. For example, P5, a Physician, spoke of turning to their trans knowledgeable nurse practitioner, while P12, a Social Service Provider, described partnering with an LGBT-friendly primary care provider to support trans clients to access FHT.

While participants described partnering to build supportive networks for gender-affirming medical care for trans women, they spoke of identifying non-stigmatizing OB/GYN practitioners to support cis women living with HIV. As P1, a Physician, noted,

Then [Dr. X] stopped seeing patients. Then there was another OB/GYN who came into our institution, again who's interested in HIV, [Dr. Y], and we were referring all of our patients to him. Then he stopped seeing patients. It's hard.

P1's quote exemplifies a common challenge noted, which was the ever-shifting availability of affirming providers and an ongoing need to build supportive networks to meet the care needs of women living with HIV. Challenges were also pervasive in timely access to mental health and substance use support services, which affected all women, with the added element of lack of trans competency affecting trans women. While most themes appeared in similar ways across the geographic regions of participants, those in rural/suburban counties more strongly emphasized the challenges associated with finding and maintaining partnerships with trans-affirming and HIV knowledgeable providers. Participants noted reliance on trans community members to identify affirming providers. Community Advisory Boards (CABs) were also seen as a potential mechanism to ensure that the needs of their clients were being met. These CABs were described as meeting multiple functions, often providing a supportive space for people living with HIV to connect while also uplifting community voices to inform programming.

When describing ideal care for women, providers' descriptions of comprehensive care seldom included gender-affirming medical care, despite most having recognized the importance of such care for trans women.

Providers' discussions of "optimal" or comprehensive service for women often revolved around gynecological or reproductive care for cis women.

Recommendations for addressing gaps in SDoH within comprehensive care predominantly focused on childcare and transportation, despite those barriers noted as related to intersecting issues of poverty and insecure housing. Finally, participants talked about provider training on topics such as anti-trans and HIV stigma, debating the transformative benefits of such workshops when not required but optional.

Discussion

Taken together, these findings suggest that despite recognition of structural barriers to care for women and often acknowledgment of the particular barriers trans women face, HIV providers' efforts to tailor HIV care to women tend to focus on the clinical needs of cis women. To our knowledge, this is among the first studies to document perspectives of HIV care providers that can inform the provision of gender-affirming—that is, trans-inclusive—women-centered HIV care. This study joins one other published study that examines the inclusion of trans women in HIV treatment and support services designed for cis women from the perspectives of women living with HIV themselves.² To inform suggestions for intersectional and structurally focused gender-affirming, women-centered HIV care, we contextualize our findings and make suggestions for HIV care providers in three key areas: (1) avoiding reducing gender to biology and making assumptions about reproductive care needs, endocrinological care needs, caregiving responsibilities, and other life circumstances; (2) promoting the provision of gender-affirming medical care; and (3) addressing structural barriers to HIV care. Furthermore, we emphasize the importance of women living with HIV's leadership in structural change, organizational leadership, and health care and social service delivery, particularly women living with HIV across diverse intersections of gender, race, class, and more.

Despite an assumed separation between cis and trans women's health care, both cis and trans women were, in many ways, reduced by providers to their biological, reproductive, and endocrinological identities. By asking HIV care providers about both cis and trans women living with HIV's needs in the same study, we were able to identify these, among other, commonalities uniquely. This biologically focused approach to woman-centered care may ignore the social and structural needs of both cis and trans women and miss essential components of both women-centered and gender-affirming care as conceptualized.^{15,56,57} Although based on a small sample, these exploratory findings showing limited conceptualization from providers are also evident in how researchers have considered

comprehensive care for women. For example, one study⁵⁸ examined gaps in care among women living with HIV, with quality of care indicators including, among HIV care indicators, Pap test, Pap test discussions, reproductive goal discussions, and breast cancer screening.⁵⁸ Despite including trans women in the study, there was no recognition that trans women may not require Pap test or Pap test discussions, nor any consideration of gender-affirming medical care as part of comprehensive care for women.⁵⁸

Still, even as providers do tend to focus on cis women's reproductive health (especially pregnancy prevention) there may be an unmet need for comprehensive reproductive health care among both cis and trans women living with HIV, especially that which addresses socio-structural barriers to family-making for both cis women living with HIV¹ and trans women.⁵⁹ Thus, one crucial component of gender-affirming HIV care is to avoid assumptions about what women may need, or not need, based on their gender identity. In another example, post-menopausal cis women living with HIV and cis women with various health conditions may also take estrogen-based hormone therapies,⁶⁰ and have similar concerns about drug-drug interactions between such therapies and ART.⁶¹

Undoubtedly, medical gender affirmation and particularly access to FHT are critical to providing gender-affirming, women-centered HIV care, as evidenced by both our participants and prior research.²⁵ In response to the wave of recent Republican-led challenges to gender-affirming medical care for adolescents in state legislatures in the United States, medical experts and medical associations have overwhelmingly asserted the medical necessity of gender-affirming medical care.^{62–64} Unique to our findings, it is notable that participants discussed less comfort with prescribing and monitoring FHT for trans women, while such concerns were not raised for any medications—including hormone replacement therapy—for cis women, though drug-drug interactions are possible when managing a myriad of comorbidities experienced by both cis and trans women living with HIV.⁶⁵ HIV care providers could learn about FHT through accessing local resources (e.g. collaborating with local endocrinologists or OB/GYN leading care) and national supports (e.g. National LGBTQIA+ Health Education Center).⁶⁶ Moreover, given the disproportionate prevalence of HIV among trans women,^{6–9} gender-affirming medical care should be a core component of infectious disease—and particularly HIV—specialty medical training, as it has been argued with respect to primary care.⁶⁷

Gender-affirming care should not be construed only as biomedical interventions such as FHT. A core component of being a gender-affirming provider is to actively work toward creating an inclusive health care environment.^{56,57} Rather than focusing on identifying affirming providers, as many of the participants discussed, increasing the number of providers inclusive of trans women

and cis and trans women living with HIV and mitigating exposure to anti-trans and HIV stigma through structural interventions is needed. One strategy may be mandatory anti-trans and/or HIV-related stigma reduction training, both of which has been found to be effective with both practicing providers and providers-in-training.^{68–74} However, broad structural change is also needed to stem the tide of discrimination, such as human rights protections and removal of non-disclosure of HIV criminalization laws.^{75,76} HIV care providers can advocate for changes to regressive policies that impede access to HIV care for women. This is also consistent with an intersectional and structural approach that envisions a world in which women living with HIV are not subject to multiple intersecting systems of oppression as well as one in which research and clinical work conducted from an intersectional perspective are integrated with a critical praxis and social justice aims.^{35–38}

Such protective laws may address not only stigma and discrimination in health care but also broader SDoH impeding women's access to HIV care. As demonstrated in our findings, gender-based violence, gaps in access to life-sustaining SDoH (e.g. income, housing, health care), stigma and discrimination in health care, and gendered caregiving expectations were discussed as barriers to HIV care affecting women of all genders. However, some of these barriers, particularly lack of access to SDoH, are magnified for trans women, particularly those of color.⁷⁷ Integrated care, including psychosocial support services, is needed to increase access to HIV care among women. In addition to integrating social services within HIV care (e.g. case management to assist with housing, income support, etc.). One example of an innovative program is integrated HIV prevention and employment interventions.⁷⁸ However, more studies are needed that gather empirical evidence of comprehensive gender-affirming, women-centered programming that addresses SDoH gaps.

Finally, many of the provider participants interviewed resonated with scholarship on the importance of hiring cis and trans peers and CABs, echoing important suggestions from other studies as well.²² Studies have demonstrated the benefits of peer support with respect to HIV care and psychosocial outcomes among women. For example, Maiorana et al.⁷⁹ found that trans women of color providing HIV services to other trans women of color resulted in the development of caring relationships, promoted personal empowerment, and portrayed role models for participants and the community. Others have also highlighted the substantial advocacy of trans women of color in Detroit and surrounding areas and the benefits of such advocacy.⁷⁷ Thus, these findings indicate that HIV care providers could work alongside community groups already engaged in such work and promote opportunities internally to their organizations for the leadership of women living with HIV.⁷⁷

These findings and practice recommendations must be interpreted cautiously in light of our study limitations. As with all qualitative studies, the findings may not be generalizable beyond HIV care providers in particular communities in Michigan. Those providers who opted into the study may have had a baseline interest in the care needs of cis and trans women living with HIV, suggesting that the understanding of trans inclusion external to these providers may be even less. The study's small sample size, primarily due to disruption by the COVID-19 pandemic and shifting priorities of HIV care providers (and researchers) during this time, also limits its generalizability. These study findings represent a particular snapshot in time just prior to the coronavirus (COVID-19) outbreak. Much has been written about the shifting landscape of HIV care throughout the COVID-19 pandemic, and some of these shifts may well have addressed some structural barriers (e.g. virtual appointments may reduce transportation barriers). However, studies have also suggested that trans women with HIV may be particularly vulnerable to COVID-19-related harms.⁸⁰ Consequently, community organizations serving people living with HIV affected by intersecting oppressions, including trans women, have had to address ever-increasing needs (e.g. social isolation) under difficult circumstances (e.g. lockdowns).⁸¹ Future research could explore the ways in which women's HIV care needs—and in particular trans women's care needs—have or have not been addressed during the COVID-19 pandemic. Findings were also broadly consistent across geographic locations, which may have looked different had we had more participants from more disparate geographies.

With all of this taken into account, our study included a diverse sample of four physicians and four social service providers from across different geographic locales deeply embedded in the provision of HIV care, thus providing important context for our research questions and contributing to the information power of our study.⁵¹ In addition to the specificity of our sample, other study aspects that allowed us to achieve information power despite the small sample size were the specificity of our study aims, our use of an established theory, the high quality and comprehensiveness of the interviews, and our analysis strategy, which involved in-depth analysis of narratives of a few, selected, participants.⁵¹

Conclusions

Our findings showed that while cis and trans women have overlapping social and structural barriers to care—as well as overlapping clinical care needs—they are positioned by providers as trans- or cis-focused. Moreover, by discussing HIV care needs among women living with HIV from an inclusive perspective (i.e. asking about both cis and trans women's needs), we found that trans women's clinical

needs are rarely envisioned as an essential part of women's HIV care. To truly show *recognition*⁸² of trans women, gender-affirming medical care must be considered part of HIV care. Ultimately, the movement toward intersectional and structurally focused gender-affirming HIV care has the potential to ameliorate the health, social conditions, and structural realities of all women living with HIV.

Author contribution(s)

Ashley Lacombe-Duncan: Conceptualization; Formal analysis; Funding acquisition; Methodology; Project administration; Resources; Software; Supervision; Writing – original draft; Writing – review & editing.

Kathryn R. Berringer: Formal analysis; Writing – original draft; Writing – review & editing.

Jennifer Green: Conceptualization; Methodology; Writing – review & editing.

Amy Jacobs: Conceptualization; Methodology; Writing – review & editing.

Amy Hamdi: Conceptualization; Methodology; Writing – review & editing.

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ORCID iD

Ashley Lacombe-Duncan  <https://orcid.org/0000-0002-9023-8877>

Supplemental material

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References

- Adimora AA, Ramirez C, Poteat T, et al. HIV and women in the USA: what we know and where to go from here. *Lancet* 2021; 397: 1107–1115.
- Auerbach JD, Moran L, Watson C, et al. We are all women: barriers and facilitators to inclusion of transgender women in HIV treatment and support services designed for cisgender women. *AIDS Patient Care STDS* 2020; 34: 392–398.
- Centers for Disease Control and Prevention. Statistics overview: HIV surveillance report, 2018, <https://www.cdc.gov/hiv/statistics/overview/index.html>
- Trudy. Explanation of misogynoir. In: *Gradient Lair*, 2014, <https://www.gradientlair.com/post/84107309247/define-misogynoir-anti-black-misogyny-moya-bailey-coined>
- Preston AM. The anatomy of transmisogynoir. *Harper's BAZAAR*, 9 September 2020, <https://www.harpersbazaar.com/culture/features/a33614214/ashlee-marie-preston-transmisogynoir-essay/>
- Sevelius JM, Keatley J and Gutierrez-Mock L. HIV/AIDS programming in the United States: considerations affecting transgender women and girls. *Womens Health Issues* 2011; 21(Suppl. 6): S278–S282.
- Becasen JS, Denard CL, Mullins MM, et al. Estimating the prevalence of HIV and sexual behaviors among the US transgender population: a systematic review and meta-analysis, 2006–2017. *Am J Public Health* 2019; 109(1): e1–e8.
- Herbst JH, Jacobs ED, Finlayson TJ, et al. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. *AIDS Behav* 2008; 12(1): 1–17.
- James SE, Herman JL, Rankin S, et al. *The report of the 2015 U.S. transgender survey*. Washington, DC: National Center for Transgender Equality, 2016, <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>
- Klein PW, Psihopaidas D, Xavier J, et al. HIV-related outcome disparities between transgender women living with HIV and cisgender people living with HIV served by the Health Resources and Services Administration's Ryan White HIV/AIDS Program: a retrospective study. *PLoS Med* 2020; 17(5): e1003125.
- Rotheram-Borus MJ, Swendeman D, Flannery D, et al. Common factors in effective HIV prevention programs. *AIDS Behav* 2009; 13(3): 399–408.
- Peragallo Montano N, Cianelli R, Villegas N, et al. Evaluating a culturally tailored HIV risk reduction intervention among Hispanic women delivered in a real-world setting by community agency personnel. *Am J Health Promot* 2019; 33(4): 566–575.
- Desrosiers A, Levy M, Dright A, et al. A randomized controlled pilot study of a culturally-tailored counseling intervention to increase uptake of HIV pre-exposure prophylaxis among young Black men who have sex with men in Washington, DC. *AIDS Behav* 2019; 23(1): 105–115.
- Gilbert L, Goddard-Eckrich D, Chang M, et al. Effectiveness of a culturally tailored HIV and sexually transmitted infection prevention intervention for Black women in community supervision programs: a randomized clinical trial. *JAMA* 2021; 4: e215226.
- O'Brien N, Greene S, Carter A, et al. Envisioning women-centered HIV care: perspectives from women living with HIV in Canada. *Womens Health Issues* 2017; 27(6): 721–730.
- Carter A, Loutfy M, de Pokomandy A, et al. Health-related quality-of-life and receipt of women-centered HIV care among women living with HIV in Canada. *Women Health* 2018; 58(5): 498–518.
- Lacombe-Duncan A, Bauer GR, Logie CH, et al. The HIV care cascade among transgender women with HIV in Canada: a mixed-methods study. *AIDS Patient Care STDS* 2019; 33(7): 308–322.
- Lacombe-Duncan A, Newman PA, Bauer GR, et al. Gender-affirming healthcare experiences and medical transition

- among transgender women living with HIV: a mixed-methods study. *Sex Health* 2019; 16(4): 367–376.
19. Sevelius JM, Carrico A and Johnson MO. Antiretroviral therapy adherence among transgender women living with HIV. *J Assoc Nurses AIDS Care* 2010; 21: 256–264.
 20. Sevelius JM, Deutsch MB and Grant R. The future of PrEP among transgender women: the critical role of gender affirmation in research and clinical practices. *J Int AIDS Soc* 2016; 19(7, Suppl. 6): 21105.
 21. Poteat T, Reisner SL and Radix A. HIV epidemics among transgender women. *Curr Opin HIV AIDS* 2014; 9(2): 168–173.
 22. Blackstock OJ, Platt J, Golub SA, et al. A pilot study to evaluate a novel pre-exposure prophylaxis peer outreach and navigation intervention for women at high risk for HIV infection. *AIDS Behav* 2021; 25(5): 1411–1422.
 23. Deering KN, Logie C, Krüsi A, et al. Prevalence and correlates of HIV stigma among women living with HIV in metro Vancouver, Canada. *AIDS Behav* 2021; 25(6): 1688–1698.
 24. Hunter-Jones J, Gilliam S, Davis C, et al. Process and outcome evaluation of a mindfulness-based cognitive therapy intervention for cisgender and transgender African American women living with HIV/AIDS. *AIDS Behav* 2021; 25(2): 592–603.
 25. Rosen JG, Malik M, Cooney EE, et al. Antiretroviral treatment interruptions among Black and Latina transgender women living with HIV: characterizing co-occurring, multi-level factors using the gender affirmation framework. *AIDS Behav* 2019; 23(9): 2588–2599.
 26. Sevelius JM. Gender affirmation: a framework for conceptualizing risk behavior among transgender women of color. *Sex Roles* 2013; 68(11–12): 675–689.
 27. Reisner SL, Radix A and Deutsch MB. Integrated and gender-affirming transgender clinical care and research. *J Acquir Immune Defic Syndr* 2016; 72(Suppl. 3): S235–S242.
 28. Lacombe-Duncan A, Kia H, Logie CH, et al. A qualitative exploration of barriers to HIV prevention, treatment and support: perspectives of transgender women and service providers. *Health Soc Care Community* 2021; 29(5): e33–e46.
 29. U.S.Census Bureau. QuickFacts: Michigan, 2021, <https://www.census.gov/quickfacts/fact/table/MI/PST045219>
 30. Michigan Department of Health and Human Services (MDHHS). Michigan statewide HIV surveillance report new diagnoses and prevalence tables, 2020, https://www.michigan.gov/documents/mdhhs/Michigan_Statewide_HIV_Surveillance_Report-July_2019_660527_7.pdf
 31. Michigan Department of Health and Human Services (MDHHS). HIV & STD's in Michigan—an overview, 2019, https://www.michigan.gov/documents/mdhhs/HIV_in_Michigan_an_overview_July_2019_660525_7.pdf
 32. Allen-Meares P. *A twenty-first century approach to community change: partnering to improve life outcomes for youth and families in under-served neighborhoods*. Oxford: Oxford University Press, 2017.
 33. Schulz AJ, Mentz GB, Sampson N, et al. Race and the distribution of social and physical environmental risk: a case example from the Detroit Metropolitan Area. *Du Bois Rev* 2016; 13(2): 285–304.
 34. Citizens Research Council of Michigan. Exploring Michigan's urban/rural divide, 2018, https://crcmich.org/wp-content/uploads/rpt400_Exploring_Michigans_Urban-Rural_Divide-2.pdf
 35. Bowleg L. When Black + lesbian + woman [not equal to] Black lesbian woman: the methodological challenges of qualitative and quantitative intersectionality research. *Sex Roles* 2008; 59: 312–325.
 36. Bowleg L. The problem with the phrase women and minorities: intersectionality—an important theoretical framework for public health. *Am J Public Health* 2012; 102(7): 1267–1273.
 37. Hill Collins P. *Black feminist thought: knowledge, consciousness, and the politics of empowerment*. New York: Routledge, 2000.
 38. Crenshaw K. Demarginalizing the intersection of race and sex: a Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *Univ Chicago Leg For* 1989; 1989: 8.
 39. Walloch K. HIV/AIDS in women: a disease spread by misogyny and violence. *Fem Collect: A Q Women's Stud Resour* 2009; 30: 16–20.
 40. Choi K-H, Bowleg L and Neilands TB. The effects of sexism, psychological distress, and difficult sexual situations on US women's sexual risk behaviors. *AIDS Educ Prev* 2011; 23: 397–411.
 41. Bauer GR, Hammond R, Travers R, et al. “I don't think this is theoretical; this is our lives”: how erasure impacts health care for transgender people. *J Assoc Nurses AIDS Care* 2009; 20(5): 348–361.
 42. Kleinman A and Benson P. Anthropology in the clinic: the problem of cultural competency and how to fix it. *PLoS Med* 2006; 3(10): e294.
 43. Metzl JM and Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. *Soc Sci Med* 2014; 103: 126–133.
 44. United States Census Bureau. QuickFacts: Wayne County, Michigan, 2020, <https://www.census.gov/quickfacts/waynecountymichigan>
 45. United States Census Bureau. QuickFacts: Marquette County, Michigan, 2020, <https://www.census.gov/quickfacts/fact/table/marquettecountymichigan/PST045219>
 46. McCall L. The complexity of intersectionality. *Signs* 2005; 30: 1771–1800.
 47. Braun V and Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; 3: 77–101.
 48. Braun V and Clarke V. One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Res Psychol* 2020; 18(3): 328–352.
 49. Braun V and Clarke V. To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qual Res Sport Exerc Health* 2021; 13(2): 201–216.
 50. Nowell LS, Norris JM, White DE, et al. Thematic analysis: striving to meet the trustworthiness criteria. *Int J Qual Methods* 2017; 16: 1609406917733847.
 51. Malterud K, Siersma VD and Guassora AD. Sample size in qualitative interview studies: guided by information power. *Qual Health Res* 2016; 26(13): 1753–1760.

52. Barusch A, Gringeri C and George M. Rigor in qualitative social work research: a review of strategies used in published articles. *Social Work Res* 2011; 35: 11–19.
53. Lincoln YS. Emerging criteria for quality in qualitative and interpretive research. *Qual Inquir* 1995; 1(3): 275–289.
54. Creswell JW and Poth CN. *Qualitative inquiry and research design: choosing among five approaches*. London: SAGE, 2018.
55. Morse JM. Critical analysis of strategies for determining rigor in qualitative inquiry. *Qual Health Res* 2015; 25(9): 1212–1222.
56. Rossi AL and Lopez EJ. Contextualizing competence: language and LGBT-based competency in health care. *J Homosex* 2017; 64(10): 1330–1349.
57. Reisner SL, Bradford J, Hopwood R, et al. Comprehensive transgender healthcare: the gender affirming clinical and public health model of Fenway Health. *J Urban Health* 2015; 92(3): 584–592.
58. O'Brien N, Godard-Sebillotte C, Skerritt L, et al. Assessing gaps in comprehensive HIV care across settings of care for women living with HIV in Canada. *J Womens Health* 2020; 29(11): 1475–1485.
59. Mitu K. Transgender reproductive choice and fertility preservation. *AMA J Ethics* 2016; 18: 1119–1125.
60. Howells P, Modarres M, Samuel M, et al. Experience of hormone replacement therapy in postmenopausal women living with HIV. *Post Reprod Health* 2019; 25(2): 80–85.
61. Scarsi KK, Darin KM, Chappell CA, et al. Drug–drug interactions, effectiveness, and safety of hormonal contraceptives in women living with HIV. *Drug Saf* 2016; 39(11): 1053–1072.
62. American Civil Liberties Union (ACLU). Doctors agree: gender-affirming care is life-saving care, 2021, <https://www.aclu.org/news/lgbtq-rights/doctors-agree-gender-affirming-care-is-life-saving-care/>
63. American Medical Association (AMA). AMA reinforces opposition to restrictions on transgender medical care, 2021, <https://www.ama-assn.org/press-center/press-releases/ama-reinforces-opposition-restrictions-transgender-medical-care>
64. American Academy of Pediatrics. Pediatricians say state bills would harm transgender youths, 2021, <https://www.aappublications.org/news/2021/03/09/transgender-legislation-030921>
65. López-Centeno B, Badenes-Olmedo C, Mataix-Sanjuan, Á, et al. Polypharmacy and drug-drug interactions in people living with human immunodeficiency virus in the region of Madrid, Spain: a population-based study. *Clin Infect Dis* 2020; 71: 353–362.
66. National LGBTQIA+ Health Education Center. Gender affirming hormone therapy, 2020, <https://www.lgbtqihealtheducation.org/?s=feminizing+hormone+therapy>
67. Coutin A, Wright S, Li C, et al. Missed opportunities: are residents prepared to care for transgender patients? A study of family medicine, psychiatry, endocrinology, and urology residents. *Can Med Educ J* 2018; 9(3): e41–e55.
68. Lelutiu-Weinberger C, Pollard-Thomas P, Pagano W, et al. Implementation and evaluation of a pilot training to improve transgender competency among medical staff in an urban clinic. *Transgend Health* 2016; 1(1): 45–53.
69. Allison MK, Marshall SA, Archie DS, et al. Community-engaged development, implementation, and evaluation of an interprofessional education workshop on gender-affirming care. *Transgend Health* 2019; 4(1): 280–286.
70. Stangl AL, Lloyd JK, Brady LM, et al. A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come? *J Int AIDS Soc* 2013; 16: 18734.
71. Batey DS, Whitfield S, Mulla M, et al. Adaptation and implementation of an intervention to reduce HIV-related stigma among healthcare workers in the United States: piloting of the FRESH workshop. *AIDS Patient Care STDS* 2016; 30(11): 519–527.
72. Nyblade L, Stockton MA, Giger K, et al. Stigma in health facilities: why it matters and how we can change it. *BMC Med* 2019; 17: 25.
73. Nyblade L, Srinivasan K, Mazur A, et al. HIV stigma reduction for health facility staff: development of a blended-learning intervention. *Front Public Health* 2018; 6: 165.
74. Davtyan M, Bartell SM and Lakon CM. Assessing the efficacy of a photovoice-informed HIV stigma training for health care workers. *AIDS Behav* 2020; 24(1): 65–80.
75. Goldenberg T, Reisner SL, Harper GW, et al. State policies and healthcare use among transgender people in the US. *Am J Prev Med* 2020; 59: 247–259.
76. Patterson SE, Milloy MJ, Ogilvie G, et al. The impact of criminalization of HIV non-disclosure on the healthcare engagement of women living with HIV in Canada: a comprehensive review of the evidence. *J Int AIDS Soc* 2015; 18: 20572.
77. Lacombe-Duncan A, Jadwin-Cakmak L, Trammell R, et al. “. . . Everybody else is more privileged. Then it’s us . . .”: a qualitative study exploring community responses to social determinants of health inequities and intersectional exclusion among trans women of color in Detroit, Michigan. *Sex Res Soc Policy*. Epub ahead of print 16 September 2021. DOI: 10.1007/s13178-021-00642-2
78. Conyers LM, Chiu Y-C, Shamburger-Rousseau A, et al. Common threads: an integrated HIV prevention and vocational development intervention for African American women living with HIV/AIDS. *J Health Dispar Res Pract* 2014; 7: 9.
79. Maiorana A, Sevelius J, Keatley J, et al. “She is like a sister to me.” Gender-affirming services and relationships are key to the implementation of HIV care engagement interventions with transgender women of color. *AIDS Behav* 2021; 25(Suppl. 1): 72–83.
80. Poteat TC, Reisner SL, Miller M, et al. Vulnerability to COVID-19-related harms among transgender women with and without HIV infection in the eastern and southern US. *J Acquir Immune Defic Syndr* 2020; 85(4): e67–e69.
81. Beima-Sofie K, Ortblad KF, Swanson F, et al. “Keep it going if you can”: HIV service provision for priority populations during the COVID-19 pandemic in Seattle, WA. *AIDS Behav* 2020; 24(10): 2760–2763.
82. Plemons E. *The look of a woman: facial feminization surgery and the aims of trans-medicine*. Durham, NC: Duke University Press, 2017.